RESOLUTION OF THE
NAABIK'ÍYÁTI' STANDING COMMITTEE
24th NAVAJO NATION COUNCIL -- Fourth Year, 2022

AN ACTION RELATING TO THE HEALTH, EDUCATION AND HUMAN SERVICES AND NAABIK'ÍYÁTI' COMMITTEES; APPROVING AND SUPPORTING THE NAVAJO DEPARTMENT OF HEALTH'S WRITTEN COMMENTS TO THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES ANNUAL REGIONAL TRIBAL CONSULTATION

BE IT RESOLVED:

SECTION ONE. AUTHORITY

A. The Health, Education and Human Services Committee is a standing committee of the Navajo Nation Council and is empowered to represent the Navajo Nation at local, state and federal levels in coordination with the President of the Navajo Nation and the Naabik'íyáti' Committee on proposed legislation, funding and other actions affecting health, environmental health, social services, education, veteran's services, employment, training and labor. 2 N.N.C. §§ 400(A), 401(B)(7).

B. The Naabik'íyáti' Committee is a standing committee of the Navajo Nation Council and empowered to coordinate all federal, county, and state programs with other standing committees and branches of the Navajo Nation government to provide the most efficient delivery of services to the Navajo Nation. 2 N.N.C. §§ 700(A), 701(A)(4).

SECTION TWO. FINDINGS

A. On January 26, 2021, the President of the United States issued a Presidential Memorandum on tribal consultation and strengthening Nation-to-Nation relationships that requires U.S. Department of Health and Human Services to submit a detailed plan for implementing Executive Order 13175, which charges all executive departments and agencies to engage in regular, meaningful, and robust consultation with Tribal officials in the development of federal policies that have Tribal implications.

B. Executive Order 13175 was issued on November 6, 2000, by the President of the United States, which established regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have tribal implications, to strengthen the United States government-to-government relationships with Indian tribes, and to reduce the imposition of unfunded mandates upon Indian tribes.

C. The Navajo Department of Health ("NDOH"), with the support of the Office of the President and Vice President, produced written comments for the U.S. Department of Health and Human Services in response to the "Dear Tribal Leader Letter" regarding the U.S. Department of Health and Human Services' Virtual Annual Regional Tribal Consultation attached as **Exhibit A.**

D. NDOH's written comments present the Navajo Nations priorities and concerns affecting the delivery of health care and public health services on the Navajo Nation. The comments outline the major issues and provide recommendations. **Exhibit B.**

E. The Navajo Nation 638 Tribal Organizations also produced written comments which identify critical areas of concern and recommendations. **Exhibit C.**

F. NDOH's written comments to HHS were reviewed by the Navajo Nation Department of Justice and deemed legally sufficient. **Exhibit D.**

SECTION THREE. APPROVAL

A. The Navajo Nation hereby supports Navajo Department of Health's written comments to the U.S. Department of Health and Human Services, which identifies and provides recommendations to the current health issues and concerns that affect the delivery of health care and public health services on the Navajo Nation.

CERTIFICATION

I, hereby certify that the foregoing resolution was duly considered by the Naabik'íyáti' Committee of the 24th Navajo Nation Council at a duly called meeting in Window Rock, Navajo Nation (Arizona), at which a quorum was present and that the same was passed by a vote of 19 in Favor, and 00 Opposed, on this 8th day of December 2022.

Honorable Carl R. Slater, Chairman Pro Tem
Naabik'íyáti' Committee

12/12/22
Date

Motion: Honorable Daniel E. Tso
Second: Honorable Thomas Walker, Jr.

Chairman Pro Tem Carl R. Slater not voting

DEPARTMENT OF HEALTH & HUMAN SERVICES

ice of the Secretary

Washington, D.C. 20201

April 28, 2022

Dear Tribal Leader:

I write to invite you to the 2022 U.S. Department of Health and Human Services (HHS) Annual Regional Tribal Consultation sessions that will be held virtually and in-person, with written testimony provided to HHS by e-mail. HHS remains committed to strengthening the government-to-government relationship between the Federal Government and Indian Tribes. These sessions are designed for Tribal leaders to have the opportunity to address HHS on how the Department can improve Tribal outreach and coordination, and to discuss programmatic and policy issues and concerns with Tribes.

The consultation sessions will provide Tribes opportunities to focus on regional specific issues with their respective regional HHS counterparts. The sessions also provide an opportunity for Tribal Leaders to consult with HHS headquarters leadership on national level issues. To see a list of HHS Regions, please visit: https://www.hhs.gov/about/agencies/iea/regional-offices/index.html.

Please see below for the dates of each respective consultation session, a link to register for the events in advance (where applicable), and the Regional Contact:

- May 19, 2022: **HHS Region 2**
  - Central New York Community Foundation's Community Ballroom
    431 East Fayette Street, Syracuse, 13202
  - https://www.zoomgov.com/meeting/register/vJIscuysqj4jGh6p84SNEIcRAYr9yHJffVY
  - Contact: Sean Hightower; Sean.Hightower@hhs.gov

- June 7–8, 2022: **HHS Region 8**
  - https://www.zoomgov.com/meeting/register/vJIsf-CoqD8iEzG2WbuRUsl7urxQ1EK6j_4
  - Contact: Elsa Ramirez; Elsa.Ramirez@hhs.gov

- June 15-16, 2022: **HHS Region 4**
  - https://www.zoomgov.com/meeting/register/vJItf-6sqTojG3Rul0EFo2Fp8uytCcmI5EU
  - Contact: Natalia Cales; Natalia.Cales@hhs.gov

- June 21–22, 2022: **HHS Region 3**
  - https://www.zoomgov.com/meeting/register/vJIsc-mopj0jGWEIJcueKSQMwymK0WBArVw
  - Contact: Melissa Herd; Melissa.Herd@hhs.gov

NAVAJO NATION DEPARTMENT OF JUSTICE

DOCUMENT REVIEW REQUEST FORM

☐ RESUBMITTAL

DOJ

_____
DATE / TIME
☐ 7 Day Deadline

DOC #:_____
SAS #:_____
UNIT:_____

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CLIENT TO COMPLETE			
DATE OF REQUEST:	10/5/2022	DIVISION:	Navajo Department of Health
CONTACT NAME:	Dr.Jill Jim,Exec.Dir,NDOH	DEPARTMENT:	Executive Office
PHONE NUMBER:	871-6350	E-MAIL:	jilljim@navajo-nsn.gov
TITLE OF DOCUMENT: *164 Executive Review-019536-Navajo Nation Written Comments Issue papers to the USDHHS Annual Regional Tribal Consultation, including Exhibit A-638 written comments*			

DOJ SECRETARY TO COMPLETE	
DATE/TIME IN UNIT:	REVIEWING ATTORNEY/ADVOCATE:
DATE TIME OUT OF UNIT:	

DOJ ATTORNEY / ADVOCATE COMMENTS			
REVIEWED BY: (*Print*)	Date / Time	SURNAMED BY: (*Print*)	Date / Time
DOJ Secretary Called:	for Document Pick Up on	at	By:
PICKED UP BY: (*Print*)		DATE / TIME:	

NNDOJ/DRRF-July 2013

THE NAVAJO NATION

JONATHAN NEZ | PRESIDENT MYRON LIZER | VICE PRESIDENT

Transmitted via email: consultation@hhs.gov

September 30, 2022

Marvin B. Figueroa, Director
Office of Intergovernmental and External Affairs
United States Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Re: Navajo Nation Written Comments to the U.S. Department of Health and Human Services Annual Regional Tribal Consultation

Dear Director Figueroa:

On behalf of the Navajo Nation ("Nation"), we thank you for the opportunity to provide written comments in response to your Dear Tribal Leader Letter ("DTLL") dated April 28, 2022; regarding the U.S. Department of Health and Human Services (HHS) Virtual Annual Regional Tribal Consultations for Region VIII (conducted June 7-8, 2022), Region IX (conducted 9-July 26-28, 2022), and Region VI, (conducted August 16-17, 2022).

We appreciate HHS exercising its federal trust responsibilities to conduct Tribal Consultations and foster the government-to-government relationship we have built. We look forward to enhancing our partnership and maintaining respect for our Tribal sovereignty while improving our Navajo health system and protecting public health within our communities. We further thank HHS for taking action to address many of the public health issues Indian Country is facing.

Background

In 1868, the United States signed a treaty with the Navajo Nation promising health care, education, agricultural assistance, and to improve the health and wellbeing of the Navajo people. As such, the United States government is legally and morally bound with a treaty responsibility and a sacred trust obligation to support the Nation in securing and developing our land and resources to improve the quality of life for our Tribal citizens. Our government-to-government relationship with the U.S. Federal Government is rooted in the Treaty of 1868. It is with these treaty obligations in mind that we engage in this consultation with HHS on ways to better meet the needs of Navajo families.

As the largest Native American tribe in the country, the Nation encompasses over 27,000 square-miles spanning three states – Arizona, New Mexico, and Utah – with over 400,000 members, 46% of whom reside on the Nation. The Nation collaborates with three regions of the HHS including Region VI, Region VIII, and Region IX. The Nation also works closely with the Indian Health Service's Navajo Area Office, the Albuquerque Area Office, and the Phoenix Area Office. The Navajo Health Care System is administered through coordination with the Navajo Area Indian

Health Service ("NAIHS") and consists of tribal organizations that operate facilities under PL 93-638 contracts and compacts. These facilities include the Winslow Indian Health Care Center ("WIHCC"), the Tuba City Regional Health Care Corporation, Inc ("TCRHCC"), and the Fort Defiance Indian Health Board, Inc ("FDIHB"). The Nation also has Urban Indian Health Organizations including the Navajo American for Community Action ("NACA"), and the Navajo Department of Health ("NDOH").

The NDOH oversees a variety of health programs that the Nation participates in to include the Navajo Food Distribution ("NFDP") Program, Navajo Women Infant and Children ("NWIC") Program, and the Division of Aging and Long-Term Care Support ("DALTCS") Program.

Additionally, the Nation also engages in tribal consultation with other federal agencies regarding health-related matter to include the U.S. Department of Agriculture ("USDA") regarding nutrition, data management and public outreach; the U.S. Department of Justice ("DOJ") regarding the Radiation Exposure Compensation Act; the Center for Disease Control ("CDC") regarding then Tribal Epidemiology Centers Public Health Infrastructure ("TECPHI") and Good Health and Wellness in Indian County ("GHWIC") programs; and the Administration for Community Living regarding funding agreements to improve elder services and data management.

Navajo Nation Priorities

HHS must fulfill the trust responsibility with the Nation and fully fund health care and public health services to reduce escalating health and health care disparities. Most recently, CDC reported in 2021 that American Indian and Alaska Native persons are now expected to live 6.6 years less than in 2022. The true aftermath of COVID-19 is currently unknown however we do know that our healthcare systems were unprepared to combat the virus contributing to far more deaths among American Indian and Alaska Native persons compared to other ethnicities.

The nation considers the following to be priorities:

1. Advance appropriations

The nation highly supports advance appropriations for the IHS. This is absolutely necessary given that nearly every year appropriations are delayed, and multiple continuing resolutions are enacted, leading to substantial uncertainty for Tribal programs and budgets as politics play out. The impact of these delays is exacerbated by IHS's chronic underfunding, which often means programs have to cease activities during government shutdowns and delay hiring new staff as they await appropriations. The Nation was disappointed this item did not make it through Congress for FY 2023 but hopes to see it in the President's budget every year until a change is made. We appreciate the support for mandatory funding and, if passed, it would be monumental in strengthening the delivery of health services to the Navajo people and Tribal members.

2. Contract Support Cost (CSC)

The Nation strongly supports H.R. 7455, a bill to maintain the status quo and fix the disastrous

consequences of the DC Circuit *Cook Inlet* decision. The Nation was especially disappointed that IHS used that decision as the basis to drastically reduce CSC funding for one of the hospitals on our reservation that serves an otherwise unserved or underserved population of tribal citizens.

3. ARPA/COVID funding

The COVID pandemic still exists and places a strain on our health and public health programs. We ask that HHS and IHS maintain as much flexibility as possible with the special COVID resources that were appropriated. This includes requesting extensions on any funds that may expire—such as COVID testing funds—as the need to test the population continues and is perhaps even more vital given that many are returning to business as usual. While we ask that no reporting be mandated, we do support IHS asking for voluntary submissions it can share with Congress to underscore the importance of these funds to Tribal programs. Also, we believe the one-time CSC payments that accompanied some of these funds should not require further reconciliation so long as all funds are spent eventually as the accounting to do so would be extremely burdensome.

4. Infrastructure bills

We believe HHS should reach out to Tribes to educate them on how the infrastructure funds can be used to renovate, restore, or build new tribal health facilities. Instead of funds only being funneled through existing IHS facilities programs, we encourage new funds to be made available broadly to meet the existing need in Indian Country. That the Navajo Area Indian Health Service provide ongoing updated SDS listing and communication of all projects to the Tribe during these next two years before funding expires. *See also* Water and Sewer, below.

5. Tribal consultations

Tribal consultation is not just a box to be checked but means that the agency fully and meaningfully considers the input of Tribes *before* decisions are made that impact Tribes. Too often comments from tribal consultation are ignored or rejected. HHS and IHS should not impose formalistic consultation processes meant to silence tribal leaders or cut off discussions. HHS and IHS should report on the outcomes of tribal consultation so they can demonstrate how tribal comments factored into the final decision. Eliminate communication with Tribes in silos, instead have federal agencies discuss the priorities from Tribal consultations to improve the health and public health needs of the Navajo people and other nations.

6. COVID flexibilities

We encourage HHS to expand and continue many of the flexibilities deployed during the COVID-19 pandemic, most importantly those involving access to care though telehealth such as audio telehealth. For instance, the temporary changes for Medicare Telehealth Services and for Remote Physician supervision of services should be made permanent. Additionally, other Medicare Public Health Emergency revisions and flexibilities should be expanded and made permanent. The recent Medicare Physician Fee Schedule proposed rules will remove a number of "Category 3" telehealth services at the end of 2023, particularly a number of behavioral health services. This will only

decrease access to care for those that need it most. Instead, CMS should allow more Medicare services to be furnished and supervised via audio-only telephone and two-way radio when other telecommunication modalities are not available, especially given the lack of broadband and high-speed internet in Indian Country.

7. Special Diabetes Program for Indians (SDPI)

This program has been flat funded or suffered funding cuts for over a decade when it's been remarkably successful at addressing one of the most pressing health issues for Indian Country. IHS should request SDPI reauthorization at $250 million per year and request permanent renewal with funding increases for inflation. IHS should also support legislative language to transfer these funds through ISDEAA agreements and remove administrative set-asides that go to IHS as opposed to individual programs.

Based on new interpretation of law in 2022, the decision to open NOFOs be "new and open competition" will result in reduced funding for many Navajo communities and possibly leading to further health disparities. The tribal consultation to get Tribal input on this change was flawed and was not entirely viewed and approved by Tribal leaders prior to sending a dear tribal letter for input, resulting in irrelevant responses to address the true issue at stake. Meaningful tribal consultations are the utmost importance for the nation.

8. Title VI/ Self-governance expansion

HHS should support self-governance expansion beyond IHS and to other HHS constituent agencies. This restriction further inhibits Tribes from fully executing self-governance. Per the authority in statute, HHS should establish a pilot project to build upon the success of self-governance and provide a means for Tribal communities to better streamline federal resources. Expansion must occur within IHS and other HHS agencies, for example, Special Diabetes Program for Indians and IHS Behavioral Health grants.

9. Health IT modernization/RPMS replacement

The Nation supports fully funding health IT modernization and funding for all electronic health record systems used by tribal programs. This area has been ignored for too long, yet electronic health systems are necessary for modern health programs. As a result, Tribes have been forced to use outdated systems or fund necessary improvements on their own.

10. Ending competitive grant processes

HHS and IHS should seek to make new funding available on a shares or formula basis instead of through competitive grant programs that are unduly burdensome and nearly impossible for small or under resourced Tribes to access. Instead, funds should be transferred through self-determination and self-governance agreements whenever possible.

11. Encounter rate

Medicare telehealth services should be paid at the OMB encounter rate, just like Medicaid telehealth services.

12. Water/sewer funding

Access to clean water and sanitation is a basic human right. Infrastructure funding should be used to ensure every Navajo home has access to clean water.

13. Tribal healthcare workforce

IHS and Tribal providers struggle to find health care workers and compete with other markets. This has been exacerbated by the pandemic and inflation. We ask that more commissioned corps officers be assigned to Indian Country, that HRSA include tribal needs as part of its rural health workforce agenda, and that funding be provided for Graduate Medical Education in Tribal and IHS facilities.

14. Community Health Worker, Community Health Representatives, and CHAP Expansion

As a result of the pandemic, many state jurisdictions and federal agencies are investing in Community Health Workers. The Navajo Nation supports the expansion of Community Health Worker certifications and reimbursement models through the states and CMS. In addition, we also support the CHAP expansion for behavioral health professionals to address substance use disorders. All HHS agencies understand the priorities from all Tribal leaders and nations that support coexistence of community health workers, community health representatives, and CHAP.

15. Data sovereignty and research

We advise HHS agencies to respect tribal sovereignty by engaging the nation in discussions to protect individual data of tribal members and to ultimately reduce harm and increase benefits to the Navajo people. Studies like *All of Us* continue to tread a fine line when recruitment is nationwide without the approval from tribal institutional review board approvals and tribal input.

16. Committees and work groups

Ensure all agencies include tribal leadership or designated representatives in committees and are led by Tribal leaders and not federal staff. Virtual meetings have resulted in cost savings to the federal government during the pandemic. We encourage the use of hybrid meeting options be maintained. Within the Indian Health Service there are more than 10 committees/workgroups that have led to inefficiency of tribal input, inconsistency in charters, and participation from tribal leaders due to the number of committees/workgroups.

17. Fully fund Indian Health Service

We fully support the protection and increases of budgeting for the Navajo Area Indian Health Service (NAIHS) under the Department of Health and Human Services in order to improve the delivery of quality patient care and to maintain and recruit more Native Americans to work on or near tribal lands. Fully fund IHS at $50 billion annually.

Major Issues and Recommendations

PL 93-638 Tribal Organizations

The Indian Self-Determination Act ("ISDA") gives Native American Tribes the opportunity to provide their own health care services under PL 93-638. The Nation is committed to be successful in managing its own healthcare delivery program under ISDA but there is a need for support from the leaders of the HHS and Indian Health Service ("IHS") in addressing numerous health care issues to include the following:

1. Nursing / Staffing Shortages

IHS and Tribal health care facilities that operate under PL 93-638 struggle to recruit and retain qualified nursing professionals causing significant nursing and staffing shortages for facilities that serve Indian Country. These shortages are growing at an exponential rate resulting in closures of beds and a reduction of services overall affecting the ability of IHS and Tribal health care facilities to provide quality health care to Native American communities. The most recent data obtained from WIHCC indicates they are experiencing a 37% registered nurse ("RN") vacancy rate for FY 22 and TCRHCC indicates they are experiencing a 35% RN vacancy rate. The ruralness of tribal communities makes RN shortages extremely concerning especially given that only 16% of RNs live in rural areas (Terry et al., 2021).[1]

In 2018, the Government Accountability Office ("GAO") published a report which found the overall vacancy rates at IHS sites for physicians, nurses, nurse practitioners, certified nurse anesthetists, certified nurse midwives, physician assistants, dentists, and pharmacist at approximately 25%, ranging from 13 to 31% across these areas.[2] According to another report of the reevaluation of RN supply and demand, the shortage of registered nurses is projected to spread nationwide between 2016 and 2030, with the South and West experiencing the highest rates of RN shortage.[3]

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[1] Terry, D., Peck, B., Baker, E., & Schmitz, D. (2021). The Rural Nursing Workforce Hierarchy of Needs: Decision-Making concerning Future Rural Healthcare Employment. *Healthcare (Basel, Switzerland)*, *9*(9), 1232. https://doi.org/10.3390/healthcare9091232

[2] U.S. Government Accountability Office. (2020, June 11). *Indian Health Service: Agency faces ongoing challenges filling provider vacancies*. Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies | U.S. GAO. Retrieved September 1, 2022, from https://www.gao.gov/products/gao-18-580

[3] Zhang, X., Tai, D., Pforsich, H., & Lin, V. W. (2018). United States Registered Nurse Workforce Report Card and Shortage Forecast: A Revisit. *American journal of medical quality : the official journal of the American College of Medical Quality*, *33*(3), 229–236. https://doi.org/10.1177/1062860617738328

According to the American Association of Colleges of Nursing, contributing factors impacting the nursing shortage include:

- The aging nursing workforce – a significant portion of the nursing workforce is nearing retirement age.

- The changing demographics – the aging population, increased need for health care, impact of the COVID-19 pandemic.

- Insufficient staffing – resulting in increased stress levels, negative impacts on job satisfaction, decrease in the quality of patient care, and decrease in time the nurses spend with patients.

- Shortage of nursing school faculty – which restricts nursing program enrollments. Education is of utmost importance because educating and graduating students will increase the nursing workforce as current nurses retire or move away from the bedside.

Furthermore, the COVID-19 pandemic has exacerbated nursing shortages as many RNs have left the medical field due to burnout. The lack of RNs in 2021 had prompted the American Nurses Association to ask the HHS to declare the nursing shortage a national crisis. Without intervention from HHS, the nursing shortage will continue rise affecting the ability of our PL 93-638 facilities to care for patients.

Recommendation: The below contains suggestions to address the nursing shortage which is expected to improve recruitment and retention in rural Native healthcare facilities:

- Establish a directive for all schools and school boards to strongly promote health field studies for students of all ages.

- Prioritize the scholarship funding for health field studies with nursing at the top tier.

- Establish and/or increase nursing scholarship opportunities (loan repayment, funding for undergraduate, and graduate nursing degrees).

- Increase funding and availability for the IHS Scholarship, IHS Loan Repayment Program, National Health Service Corps Loan Repayment Programs, Nurse Corps Loan Repayment Program, and Faculty Loan Repayment Program.

- Support and pass legislation for Loan Forgiveness Programs for nurses and health care providers.

- Establish a college of nursing at colleges and universities and establish financial support for these programs, promoting enrollment for students to get into nursing programs and/or other health related fields.

- Further memoranda of understanding and/or agreements (MOU/MOA) with surrounding colleges and universities to increase Native American enrollment in nursing programs and/or other health related fields.

- Increase access for housing through the housing programs or tribal entities, to build rent-to-own homes or home ownership programs to increase retention of registered nurses who come from local service areas.

- Increase funding for ongoing training and skill-building for all existing staff, to maintain quality health care and to keep up with changing health issues, technology, and systems.

- Support cross-training of existing staff to cover multiple areas. Support training centers and development of learning communities to share challenges and best practices.

- Increase funding and flexibility for IHS and Tribal health care facilities for salary & benefits, and contract costs to recruit and retain a competent and skilled nursing workforce.

2. Substance Abuse Treatment

Since the 1990's, substance abuse has been a major challenge for the United States exacerbated by the opioid epidemic. The misuse and overprescribing of opioids has caused large rates of hospitalization and death, a direct result from overdoses. According to the Arizona Department of Health and Human Services, there have been over 13,000 visits involving suspected drug overdose in 2022. The CDC further reported that Native American communities had the highest drug overdose rate in 2015 as well as the largest percentage of deaths from 1999-2015. The Navajo Area Office within the IHS health network had over 7,000 overdose deaths related to overuse and over prescription of opioids. An audit by the Inspector General of the HHS revealed that five IHS hospitals, including facilities within the Navajo Area Region, did not follow the correct protocols for prescribing or dispensing opioids. While many facilities within the Navajo Area have the ability to treat opioid misuse, it can only be achieved through outpatient clinics. Currently there are no resources available for inpatient substance abuse treatment.

Recommendation: The Nation would like to make the following suggestions to combat opioid and other substance abuse addictions:

- HHS provide waivers on grants that support access to opioid-related treatment, prevention, and recovery, similar to waivers received by states, to cover treatment through their Medicaid programs. Rural areas receive relatively low levels of direct funding compared to metropolitan areas.

- HHS work with IHS on publishing resources and media materials to raise awareness of the epidemic and efforts to prevent its escalation within the Navajo language, establishing

culturally relevant material.

- CMS offer flexibility to 638 facilities, similar to states, allowing them to apply for new funding/expenditure authority to address one of the biggest barriers to treatment; allowing for Medicaid to pay for inpatient treatment facilities located on the Nation.

- HHS collaborate with SAMHSA, Center for Mental Health Service (CMHS) and Center Substance Use Prevention (CSUP) on funding opportunities and 638 capacity; especially for construction of inpatient treatment facilities.

- HHS to collaborate with Federal, State, and Tribal Governments for financing opportunities and "demonstration projects" to build an inpatient opioid treatment facility and healing center that would combine native healing modalities, medical care, and medication.

Navajo Nation Department of Health Programs

1. Colorectal Cancer and Cancer Prevention

Colorectal cancer is one of the leading diagnosed cancers within in Tribal communities per 100,000 persons[4]. As a detectable cancer, there needs to be increased resources for disease prevention in Indian County. Limited access to colonoscopy services, colon cancer tracking software, and tribally based educational toolkits exists on the Nation[5]. During the pandemic many individuals were left with few or limited screening services that will likely contribute to late-stage cancer diagnosis in the future.

NDOH receives limited funding to provide breast and cervical cancer screenings. Cancer is the second leading cause of death for both Navajo genders age-adjusted (117.9/100,000) according to the Navajo Nation Mortality Report, 2015-2017[6]. The Cancer Among the Navajo 2005-2013 Report indicates that colorectal cancer is the second most commonly diagnosed cancer (by count) among Navajo people (245 per 100,000)[7]. Compared to non-natives, cancer that has been detected occurs more frequently in the regional stage (33.2% vs. 31.3%) whereas most non-natives are detected in localized stage (39.2% vs. 31.3%). In 2015, statistics show that colorectal screening rates ranged between 35.7% and 44.1 % for the Navajo people. These number are well below the Healthy People 2030 target of 74.4 percent[8].

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[4] U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2021 submission data (1999–2019): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; www.cdc.gov/cancer/dataviz, June 2022.

[5] Northwest Tribal Colorectal Cancer Screening Toolkit, CRC-Toolkit-9-3-2014.pdf (npaihb.org)

[6] Navajo Epidemiology Center, Navajo Department of Health, www.nec.navajo-nsn.gov, NavajoNation_MortalityReport.pdf (navajo-nsn.gov)

[7] Navajo Epidemiology Center, Navajo Department of Health, www.nec.navajo-nsn.gov Cancer Among Navajo_2018 Spread.pdf (navajo-nsn.gov)

[8] US Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Health People 2030, Increase the proportion of adults who get screened for colorectal cancer — C-07 - Healthy People 2030 | health.gov

The CDC has a National Colorectal Cancer Control Program that currently funds two tribal organizations out of 35 awarded grantees. This component of cancer control is woefully underfunded on a national scale but the lack is particularly seen in Indian Country. Limited funding for colorectal cancer prevention impacts basic support education, patient navigation, and screenings; potentially leading to late-stage diagnosis. Additionally, there have been few culturally appropriate resources available at the community level which is concerning given that most of the at-risk population suffer from language barriers (Navajo being their primary language). Without a program on the Nation to improve access and implement evidence-based interventions, colorectal screening rates will remain low in comparison to non-Natives and National screening rate targets. The Nation does not have direct access to cancer data at the local, state, or federal level which limits the understanding of cancer morbidity and mortality on the Nation. Vital records do not have the appropriate data on cancer mortality, whereas clinical and cancer registries may have more in-depth information on diagnosis and treatment disparities.

Recommendations:

- Increase funding availability for colorectal cancer screening to tribal programs to address cancer awareness, navigation, and screening rates.

- Provide technical support to cancer prevention and treatment programs to implement evidence-based interventions at the health system and clinic levels.

- Address collaboration and technical support for tribal programs to access and link to existing cancer registries and data sources from federal and state agencies to generate appropriate grants or reports which will serve to help strengthen the goal of reducing the impact of cancer among the Navajo population.

2. Injury Prevention Among Youth

In the mid-1950s, the Navajo Health Education Program was established to prevent chronic diseases and health conditions. The goal was to have Navajo citizens value a healthy lifestyle. The Nation adopted the Youth Risk Behavior Surveillance Survey (YRBSS), a Centers for Disease Control and Prevention surveillance tool to eliminate negative social determinates of health and health inequalities. The survey identifies six health risk behaviors which contribute to the leading causes of death. In 2017, the Navajo YRBSS reported 8,289 middle school and 9,023 high school participants were at risk of injury from violence which has become a primary area of concern for the Nation.

In 2020, accidents (unintentional injury) ranked as the fourth leading cause of death in the US and the Navajo Epidemiology Center ("NEC") reported that it was ranked first in the US[9]. Additionally, the Navajo specific 2017 YRBSS identified twenty-nine percent of high school youth texted or emailed while driving a car in the past month. The potential impacts involved in distracted

[9] USDOT. *Traffic Safety Facts.* New Jersey : National Traffic Highway Safety Administration, 2021. p. 7.

driving include fatal crashes and death. In general, students who texted or emailed while driving are at risk of other behaviors such as not wearing a seatbelt, likely to ride with someone who has been drinking alcohol and drinking while intoxicated (MMWR, 2020). Identifying these behavior risks is important to take into consideration as it can contribute to early death.

Recommendations:

- Increase funding for youth-based prevention activities within school health programs at schools, including summer education programs. Funding should include infrastructure funds; many tribal communities do not have facilities to host youth-based programs.

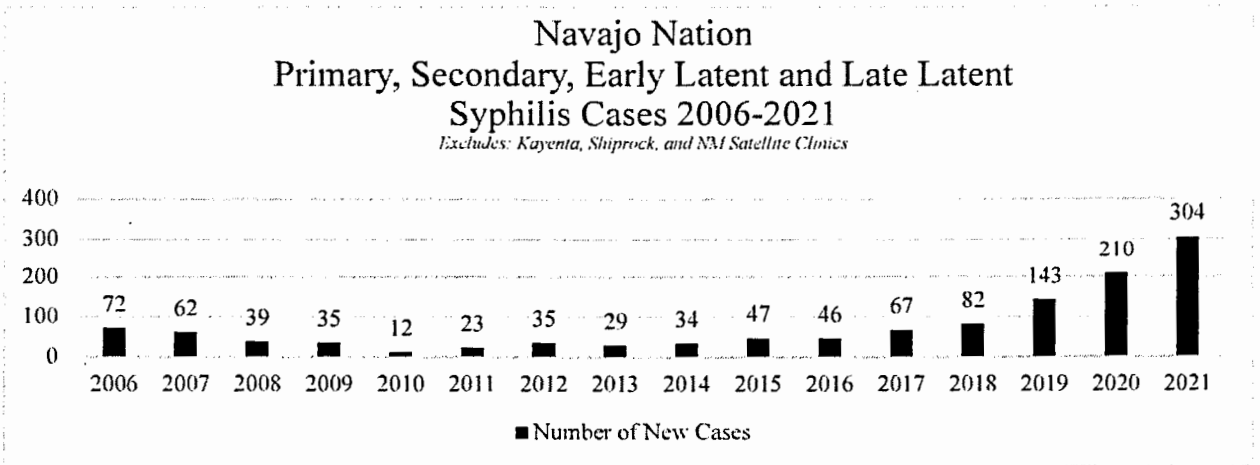
- Develop Native specific campaigns that direct education to parents, youth, and communities for prevention on distracted driving.

- Collaborate with Tribal communities to develop or modify practice and evidence-based programs aimed at reducing distracted driving and unintentional injuries.

3. Infectious and Communicable Diseases

The Navajo Infectious Disease Control and Prevention Program focuses on infectious and communicable disease prevention. The Nation's goal is to work towards the prevention and elimination of sexually transmitted infections, as well as tuberculosis. Through case investigations, contact investigations, and constant collaboration with the federal and tribal health facilities, the health and wellbeing of clients are ongoing priority.

The increasing number of new infections pertaining to syphilis, HIV, and TB infections is not new, but continues to be prevalent and requires constant monitoring and attention to alleviate the surge in cases. The pandemic has highlighted a need to address syphilis and the climbing monkeypox epidemic. Currently there is only one confirmed case of monkeypox on the Nation that has required immediate coordination across multiple agencies. Additionally, in 2021 syphilis transmission has increased during the pandemic meeting the classification requirements of an outbreak; compared to previous years (see Figure below).



Recommendations:

- Increase funding for infectious and communicable diseases programs to ensure proper trainings and resources are available to meet the demanding need of cases for prevention and treatment.

- CDC to provide increase funding opportunities and technical assistance to build capacity for contact tracing, case investigation, and managing care within tribal health systems. IHS does not provide budget line items for infectious and communicable disease program; therefore, existing funding have to be leveraged. HIV is a budget line-item within the IHS budget.

- Encourage collaboration between IHS, state agencies, and Tribal programs to address outbreaks.

4. Behavioral Health

The impacts of the COVID-19 pandemic reflect the various socioeconomic challenges of the Navajo and Native American population in the U.S. According to Arrazola et al. (2020) American Indians/Alaska Natives (AI/ANs) experience a greater incidence of COVID-19 than non-natives and reported "cumulative incidence of laboratory-confirmed COVID-19 cases among AI/AN persons were 3.5 times that among White persons[10]." At previous tribal consultations, the Nation indicated that the social, behavioral health and mental health and co-occurring disorder disparities continue to affect the Navajo population. More recently, added complexities as a result of COVID-19 have strained the Nation's system of care with the IHS, Tribal health organizations, and Tribal programs by creating a greater need to address substance use, mental health, and co-occurring disorder issues with culturally responsive and spiritual-based approaches to address the diverse needs of the Navajo people.

There is limited funding to address the impact of COVID-19 and its aftermath as it relates to substance abuse and co-occurring disorders among the Navajo population. There is also a lack of funding for Tribal nations to build the infrastructure necessary for detox services, transitional housing, and crisis response team services to address the behavioral health crisis.

Due to limited coordination of federal agencies to elevate behavioral health needs, duplication of efforts across agencies may occur but must be avoided to increase productivity, effectiveness, and efficiency. The Nation needs more collaboration with IHS, other federal, and state resources through memoranda of understanding or agreements to allow individuals to timely receive medical and ambulatory detox services. Overall, the development of a detox facility would increase the levels of care for substance use and reoccurring treatment services.

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[10] Arrazola J, Masiello MM, Joshi S, et al. COVID-19 Mortality Among American Indian and Alaska Native Persons — 14 States, January–June 2020. MMWR Morb Mortal Wkly Rep 2020;69:1853–1856. DOI: http://dx.doi.org/10.15585/mmwr.mm6949a3

Also, the priority to continue developing a culturally responsive Crisis Response Team (CRT) network within a Crisis Response Program (CRP) on the Nation remains unmet. A CRP would enable trained and certified teams of providers across the spectrum to respond to a variety of behavioral and mental health issues with a Crisis Response Hotline and Crisis Response Mobile Teams through the implementation of 988.

Recommendations:

- Increase support and funding to address the devastating impact of COVID-19 and its aftermath as it relates to co-occurring disorders among the Navajo people including all Tribal communities and the necessity for construction of a detox center for services, transitional housing with treatment services, development of crisis response team services, and infrastructure funds.

- IHS should collaborate with the NDOH - Division of Behavioral and Mental Health Services (DBMHS) to allow the use of all resources to address the behavioral health, mental health and co-occurring issues in a holistic and cultural manner while continuing to explore avenues for current and future funding; and to sustain recruitment and retention of personnel and program initiatives to decrease the socioeconomic effects of COVID-19 on the Nation. This includes full participation in the mental health coalition that formed as result of the COVID-19 pandemic.

5. Navajo Special Diabetes Program

The Navajo Special Diabetes Program (NSDP) was established in June 1999 within the NDOH. The NSDP has seven (7) Service Area offices and a Central Administrative office across the Nation. NSDP diabetes prevention consists of community-based diabetes prevention education and nutrition education.

NSDP's best practices require key measures; numbers and percent of individuals in our target group who received education on any diabetes topic, either in a group or individual setting. The target population encompasses the ages between 10 to 55 years old who have a diagnosis of Diabetes Type 2, pre-diabetic, and vulnerable populations, who reside within the Nation.

The Nation does not believe that the SDPI program should not be part of the 2023 SDPI competitive grant review process because the Nation's SDPI program has been maintained and sustained funding compliance for the past twenty years and has consistently met or exceeded the goals. The NSDP grant is at the end of five-year grant cycle and grantees were allowed no cost extensions to carry funding forward into the new calendar year; if not allowed this has potential for reduction in workforce and an offset with budgets. Additionally, for the past 10 years, NSDP received a fix amount of annual funding to administer the NSDP program. While the amount awarded in year one of the grant is the same as year 7, the monetary value has decreased due to rising costs of inflation and the public health pandemic.

The Nation is also concerned with the timeliness for providing the Notice of Award, as this most recent award notice was issued late, in the second quarter of the Calendar Year (CY), causing issues within budgets, (e.g. salaries, contractual services, and other means to sustain services).

Recommendations:

- HHS to allow for no cost extension for FY22 grantees to encumber funds into 2023 to allow for grantees that received FY22 funds to obligate.
    - The need to expend funds in a manner that is feasible to programs considering their internal financial processes. The No Cost Extension would allow procurements to close properly for funds that were obligated during the fiscal year.
- For grantees that are awarded SDPI funds in the new grant cycle, issue Notice of Grant Awards early in the FY rather than later in the year.
    - The grants awarded in a timely manner would help avoid disruption in services.
- Increase award amounts for grantees with larger target and vulnerable populations.
    - The demand for increased diabetes prevention and intervention services on the Navajo Nation is significant. Over the past 10 years, the population has grown exponentially and there is an upsurge of individuals that are borderline diabetic or have been diagnosed with diabetes.
    - The financial resources from HHS to support the demand has remained the same despite these growing trends and inflation in the current economic markets.

6. Public Health Emergency Preparedness (PHEP) Program

The Public Health Emergency Preparedness (PHEP) Program builds and strengthens the Nation's ability to respond to public health threats that impact the Nation. The CDC's role is to ensure the PHEP grant provides technical assistance and support to enhance public health capabilities and address challenges in preparing for, response to and recovery from public health emergencies.

The Nation is capitalizing on the implementation of the Pandemic and All Hazard Preparedness Re-Authorization Act of 2013, that is strategically located across the Nation, in Arizona, New Mexico, and Utah.

Work performed on building a comprehensive public health emergency system designed to achieve full capabilities is unattainable because PHEP funds awarded to the Nation is disallowed for use outside the State of Arizona and other needs. Therefore, the building of community resiliency on the Nation is unachievable because Utah and New Mexico Navajos combined population of over 100,000 residents are not included in PHEP funding. The current PHEP funding practice is based on cooperative agreements; and the three states present three separate and

different Medical Countermeasure Plans to the Nation to implement for only portions of the Nation's geography and population.

The dollar amount received annually is not sufficient for the Nation; the COVID-19 Pandemic has proven that the Nation's PHEP program needs additional personnel and its own operations center. The Navajo Nation Public Health Emergency Preparedness Program funding needs to be directly funded by CDC. Grants have restrictions that do not allow certain purchases for supplies, equipment, and personnel related to the Emergency Preparedness. The program has the potential to expand and grow, however due to limited funds, there are only two personnel servicing then entire Nation with many needs to allow for the program to be comprehensive.

Recommendations:

- The PHEP Program funds be awarded directly to the Nation based on enrolled members.
    - Nation should be funded directly from CDC, instead of going through the states such as the AZDHS.
    - Currently the Nation resides in three states – AZ, UT, and NM.
    - CDC currently supports the Navajo Nation PHEP Program for AZ only, while the other two states are not supported.
- Provide technical assistance to build a model with the Nation's Health Command Center with multi-jurisdictional capacity to operate in a tri-state, multi-county, Indian Country environment.
- Provide technical assistance to build an emergency communication system for the whole Nation's jurisdiction.

7. Navajo Epidemiology Center

American Indians and Alaska Natives including the Nation often have difficulty accessing funds from federal agencies (i.e., CDC, IHS, or SAMSHA) for a variety of reasons - Tribes may not be directly eligible due to legislative or administrative restrictions, Funding Opportunity Announcements (FOA) may not be inclusive of culturally or linguistically based programs, or Tribes may not have the internal capacity to write competitive packages when competing with other highly resourced entities like state and local health departments. For example, funds that were granted out in FY 2016 by CDC, approximately 52% (or ~$3.4 billion) were granted out to governmental entities. Ninety-one percent of that funding was granted to state governments specifically, while far less was granted out to Tribal governments (~35 million). Tribes are often at a disadvantage when competing against states or local governments that may have a greater degree of resources available to dedicate to grant writing.

The Nation is a large tribe both geographically and by population, located in three states (Arizona, New Mexico and Utah). Therefore, additional resources are critical to the delivery of public health services on the Nation. For example, CDC provides significant funding to state and local health departments, for HIV, hepatitis C, diabetes, cancer and sexually transmitted diseases but benefits rarely flow in an equitable manner to Tribes within those states or localities.

The Navajo Epidemiology Center ("NEC"), as a Public Health Authority, conducts the following activities for the Navajo Nation and additional resources are needed for staffing and operational costs: Infectious disease epidemiology, chronic disease epidemiology, maternal and child health epidemiology, behavioral health epidemiology, injury prevention, vital statistics, Navajo Nation Health Survey, suicide prevention, health research, etc.

NEC plans to develop a health information technology and data system infrastructure in order to congregate data from multiple sources into a single database (data warehouse) so a single query engine can be used for data analysis and reporting. The infrastructure will benefit the people of the Nation with improved access to public health information, thereby, addressing health care disparities and improving quality of health care and services for the Navajo people.

The infrastructure will regularly examine outcome measures to:

- Track and evaluate progress toward goals
- Guide policy decisions, priorities and long-range strategic plans
- Develop, focus and streamline data collection and reporting capacity
- Provide comprehensive information of Navajo Nation's health and health care system

Long term goals include:

- Develop an indicator-based information system with interface programming to allow for customized querying of health information
- Build disease surveillance and reporting systems
- Develop electronic vital statistics registry
- Develop methods to analyze data, including development of innovative information systems
- Substantially improve the use of health information to guide health policy decisions and evaluate efforts to assure the health of the Navajo people

Support is needed for health information technology, data system infrastructure, data modernization and data managed by federal agencies of American Indian/Alaskan Native peoples. Additionally, there remains a need for improvement for tribal access to funding opportunities as well as requiring states to engage with tribes when tribal numbers are utilized for the funding they receive.

Furthermore, the Nation has not been able to access the same level of workforce capacity building, despite the greater health disparities and public health needs. For example, the CDC supports the

workforce capacity of states by allowing states to request a staff detail from the CDC in lieu of funding that would be provided for project grants for preventive health services. States opting for a staff detail have been able to host Career Epidemiology Field Officers (CEFOs) and Epidemic Intelligence Service (EIS) officers, and these officers have proven to be valuable assets to their hosting governments. A skilled workforce is critical to delivering quality public health services on the Nation. Concurrently, the NEC has been a host site for the CDC Public Health Associate Program (PHAP).

Recommendations:

- Federal agencies (CDC, IHS, SAMHSA and NIH) work with Tribes to write a policy that creates a process for proactive review of FOAs to ensure Tribal inclusion and relevance.

- Federal agencies work to bring Tribal public health funding in parity with state and local governments by requiring states to include Tribes in their use and distribution of grant funding.

- Federal agencies to consider an annual funding mechanism that is stable and consistent in levels.

    - NEC, which is funded wholly by cooperative agreements, experiences loss of staff based on ending of funding cycles and misses or skips in the pay schedule to employees due to delayed Notice of Awards (NOA) or lengthy approvals by tribal government administrative offices.

- Tribal governments be permitted the same opportunities as state governments and federal agencies to play an active role in encouraging more meaningful state and Tribal engagement.

- Federal agencies to include the Nation and other tribes in the data modernization efforts.

    - This includes identifying and securing federal and state funding to support the proposed health information technology and data system infrastructure as a method of improving health care on the tribal lands.

- IHS and HHS provide technical assistance, guidance and sustainable operations funding to the Nation as it strives to develop the proposed health information technology and data system infrastructure.

- HHS needs to hold agencies managing, storing, and analyzing AI/AN data accountable, and access to data that should be governed by tribal epidemiology centers as public health

authorities as identified in the Government Accountability Office (GAO) report "Tribal Epidemiology Centers, HHS Actions Needed to enhance Data Access" (March 2022).

- CDC, IHS, and SAMHSA to recognize the NEC as having the capacity to host a CEFO and EIS Officer(s) to assist with disease surveillance and outbreak activities on the Navajo Nation.

- Funding Opportunity Announcement (FOA), where they are not specifically excluded by law, the opportunity for a workforce detail - such as a CEFO and EIS Officer - should be extended to Tribes (including the Nation) in all cases where Tribes are not specifically excluded.

    - In cases where a specific exclusion(s) exists, CDC provide information regarding the legal or regulatory language detailing such exclusion(s).

- Current funding offered to tribes should be evaluated to provide support to tribes to provide educational opportunities to pursue graduate and doctoral degrees in public health services for current employees.

- Provide funding for employee housing to support visiting professionals that aid in providing assistance to the NDOH.

    - Funding for construction of employee housing would be beneficial to both visiting professionals and employees of NDOH.

8. Division of Behavioral and Mental Health Services (DBMHS)

As previously mentioned, the impact of the COVID-19 pandemic reflects the various socioeconomic challenges of Native Americans who have experienced a greater incidence of COVID-19 than among non-Natives. At previous Tribal Consultations, the Nation indicated that the social, behavioral health and mental health/co-occurring disorder disparities continue to affect the Navajo population. More recently, added complexities as a result of COVID-19 have strained the Nation's systems of care with IHS, PL-638 facilities, and the NDOH programs by creating a greater need to address substance abuse, mental health and co-occurring disorder issues with a culturally responsive and spiritual-based approach to address the diverse needs of the Navajo people. DBMHS has received previous grants under SAMHSA for substance abuse related and mental health issues. However, SAMHSA only provides grant funding for an allotted timeframe which is difficult to sustain after the funding has ended.

Additionally, DBMHS offers traditional treatment services to Native American/Navajo clients which is essential for holistic healing of substance abuse and mental issues. Currently, for these types of services, DBMHS is not able to bill for third party reimbursements with Medicaid.

Recommendations:

- Provide additional funding for related grant projects to sustain services that have been implemented and that have become essential to address substance abuse related and mental health issues.
    - This impacts the continuation of efforts to expand treatment and community services that have been in place with partners and stakeholders.
- Allow the billing for traditional healing treatment services to expand substance abuse and co-occurring mental health services that increases capacity and sustainability.

9. Community Health Representative Program (CHR)

The Nation's CHR Program was established December 11, 1968 through Resolution CD-109-68 by the Nation's Council which is available through the Navajo Area Indian Health Services. The goals of the program are to prevent health disparities through public health to improve the overall health in our communities through education, prevention, patient care, and outreach services. Community Health Workers (CHWs) are required to obtain a Certified Nursing Assistant or Certified Medical Assistant, BLS CPR & First Aid with AED training, Diabetes Skill Care, NIMS-ICS 100, 200, 230, 242, 300, 317, 400, 700, 800 to ensure they are prepared to respond to an emergency.

Due to physical and natural emergencies, CHWs are the first to be called upon to respond to assist in these emergencies throughout the Nation. Tribal and State Officials, as well as county and other programs who reach out to the CHR Program immediately as they have established rapport and are familiar with the community and the community members therefore CHR Program is vital when it comes to responding to emergencies. Currently there are not enough investments in CHW's restricting the scope and abilities CHWs can provide to the community.

Recommendation:

- Increase funding for Emergency Management within Navajo Nation to ensure CHWs are all trained and resources are available.
- First Responder Certification to be included in CHR Scope of Work
- Emergency Management resources available to CHR Program to respond to emergencies

10. Administration for Community Living (ACL) / Division of Aging and Long-Term Care Support (DALTCS)

Division of Aging and Long-Term Care Support (DALTCS) was created under Title VI of the Older American Act in 1979, back when we were recognized as Navajo Area Agency on Aging

(NAAA). DALTCS currently has 80 senior centers across the Navajo Nation that span into the State of Utah, Arizona, and New Mexico. We provide nutritional meals either in the congregate setting or home delivery. We also provide transportation, supportive, social, educational, and health promotions.

DALTCS receives many "alerts" throughout the fiscal year via Title III funding. Due to short timelines to get funds budgeted, reviewed, and approved by five (5) different departments within the Nation, resulting in a reversion of funds. Additionally, DALTCS funding from all 3 states is not based on current elder population rather funding is allocated based on data from 1979 Tri State Agreement. The agreement is outdated and does not reflect the needs of today's elderly population.

Recommendations:

- Limit or delete "alerts" for whole fiscal year to avoid reversion. Provide one allocation that can adequately cover whole fiscal year.

- Meet with stakeholders to bring Tri-State Agreement current to reflect present population counts and needs.

- DALTCS suggests using Arizona DAARS system for data entry that can be shared to ACL, New Mexico, and Utah.

11. Navajo Nation Department of Emergency Medical Service (NNDEMS)

NNDEMS is a dedicated progressive service focused on providing quality and emergent care. Expanded advanced life support capabilities and transport services are pre-eminent and NNDEMS is dedicated to ensuring that members of the Navajo Nation have access to such services.

Ambulance services on the Navajo reservation were non-existent until 1965 when the Navajo Nation Police Department assumed the responsibility although they were met with significant challenges such as limited resources, geographical barriers, and lack of equipment. Over the last 22 years, NNDEMS has evolved thanks to the joint efforts of the Navajo Navajo, IHS Navajo Area Office, and the Navajo Health Authority. It was not until September of 1980 where the Navajo Nation EMS program was created and received special appropriation for IHS-EMS systems. However, in 1982 the EMS program suffered a 17% decrease in funding resulting in crippled projects and a fleet reduction from 118 positions to 84 positions. Since then, the Navajo Nation EMS program has had difficulty meeting the needs of the Nation due to staffing shortages, lack of equipment, and lack of funding.

NNDEMS is an integral component of a rural community's prehospital medical emergency infrastructure. The NNDEMS provides direct services to an estimated population of 314,600. The estimated total EMS calls for 2021 was 31,500. A total of 9,100 claims were submitted to third party payers in 2021 but the revenue generated did not fully meet the budgetary needs to improve and expand EMS services and acquire additional qualified personnel. Support is needed from HHS and the Indian Health Service in order to expand EMS services.

HHS, in partnership with the IHS, must increase or establish funding to meet the growing emergency medical services of Native Americans. There is a need to increase funding under the IHS Hospitals & Clinics budget line-item account or establish a specific budget line-item authority/account for Tribal Emergency Medical Service (TEMS) Programs to meet the growing medical emergency needs of American Indians and Alaska Natives (AI/AN). Inadequate funding has prevented upgrading and purchasing of new equipment, including the latest emergency medical technology and software programs to keep current with advancing technology.

Recommendations:

- Acquire essential resources (medical and non-medical equipment, information technology infrastructure for both hardware and software, and preventative maintenance to support the infrastructure); and to hire administrative support personnel to implement these systems.

- To bring up standards for training of EMS personnel in a rural healthcare setting. As our user population increases with chronic comorbidities, the need for advance training is ever more evident during transport when hospitalization is the only option ordered.

- Recruitment and retention of qualified EMT personnel and paramedics to provide direct services.

- Expand and sustain services for the Navajo Nation through the following:

    - Research to examine how to efficiently and sufficiently reimburse low volume and rural EMS services to improve quality of care and develop third party reimbursement infrastructure.

    - Establish a Hospital & Clinic budget category for rural EMS programs, as they continue to strive and deliver essential patient transport services for the underserved population that receive services in remote healthcare settings that is under resourced.

Closing

We are pleased with the Biden-Harris Administration's Executive Memorandum on Tribal Consultation and strengthening Nation-to-Nation Relationships. We believe it is a step towards engaging in more meaningful communication between the Federal Government and Indian Nations across the country.

Tribes are sovereign nations and have been consistently asking for federal agencies to adhere to their treaty obligations and all of our Tribal Nations have that inherent sovereignty based on the United States' trust responsibility to Tribal Members, therefore, this should be the basis for any government-to-government consultation. In Congress, they passed specific laws to provide for Indian health care, including laws establishing the Indian health care system and those providing

structure and detail to the delivery of care, such as the Indian Health Care Improvement Act that requires the Federal health services to maintain and improve the health of the Indians based on our Treaty rights.

As Native Americans, we are inherently resilient, and have survived many challenges and generations of ills. We know our issues and priorities, our lands, our traditions, culture, and the needs of our communities to best serve our people.

As we recover from the pandemic, we finally have a seat at the table and look forward to new opportunities for our Tribal Nations through federal funding initiatives. Together, we can build a better future for tribes but, we must continue our advocacy for our treaty rights and ensure that we are understood by federal agencies in order for to provide basic and essential public health services for our people.

Overall, we sincerely hope that HHS will take these recommendations into consideration to further enhance the delivery of healthcare services to improve the health and well-being of the Navajo people in accordance with the federal trust responsibilities and the Treaty of 1868.

If you have any further questions, please contact Lashawna R. Tso, Executive Director of the Navajo Nation Washington Office at (202) 682-7390 or email at ltso@nnwo.org or Dr. Jill Jim, Ph.D., MHA, MPH, Executive Director of the Navajo Department of Health at (928) 871-6350 or email at jilljim@navajo-nsn.gov. *Ahéhee'* (thank you).

Sincerely,

Jonathan Nez, *President*
THE NAVAJO NATION

Myron Lizer, *Vice President*
THE NAVAJO NATION

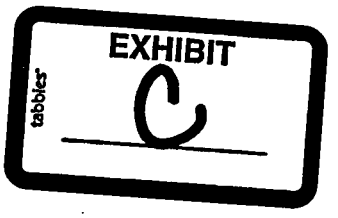

EXHIBIT A

638 Tribal Organization

Issue Papers/Written Comments

638 Tribal Organization Issue Papers/Written Comments

1. **Tuba City Regional Health Care Center (TCRHCC):**

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TCRHCC Written Comments:

a) CMS creates programs, i.e. CMS Innovation program, and Tribal programs are not allowed to veer from the OMB rate, so we are not allowed to participate. TTAG has many of these issues on their radar, but CMS Tribal Advisory only answers that "it would take a legislative fix".
b) The CMS Strategic Plan and Health Equity Framework did not go through tribal consultation, when tribal members are being affected by health inequities.
c) Many of the issues we have is with I.H.S. being underfunded. (i.e., cancer, elder care, unfunded facility replacement).

2. **Winslow Indian Health Care Center (WIHCC)#1:**

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HEALTH & HUMAN SERVICE
TRIBAL CONSULTATION POSITION PAPER
WINSLOW INDIAN HEALTH CARE CENTER

INTRODUCTION:

Indian Health Service (IHS) and Tribal health care facilities continue to experience a critical nursing shortage and struggle to recruit and retain qualified nursing professionals to work in facilities serving Indian Country. The nursing shortage is growing at an exponential rate for IHS and Tribal health care facilities. As these critical nursing shortages continue, closures of beds and reduction of services will continue at an alarming rate, affecting the ability of IHS and Tribal health care facilities to provide quality health care to Native American communities.

ISSUE: Nursing Recruitment and Retention

BACKGROUND:

In 2018, the Government Accountability Office (GAO) published a report, *"Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies (GAO-18-580),"* which found overall vacancy rates at federal/IHS sites for physicians, nurses, nurse practitioners, certified nurse anesthetists, certified nurse midwives, physician assistants, dentists, and pharmacist to be around 25%, ranging from 13 to 31% across these areas. According to a reevaluation of registered nurse (RN) supply and demand by Zhang et al. (2018), the shortage of registered nurses is projected to spread countrywide between 2016 and 2030, with the RN shortage most severe in the South and West. Winslow Indian Health Care Center (WIHCC) is experiencing a prolonged shortage with the RN vacancy rate at 37% and one to two nurses leaving per month for FY 2022. As of FY 2021, Tuba City Regional Health Care Corporation (TCRHCC) had a RN vacancy rate of 35% with an average of three to four nurses leaving per month.

The COVID-19 Pandemic has escalated concerns for the nursing shortage. Many nurses stepped away from the bedside in early 2020 during the beginning of the COVID-19 pandemic which further increased the vacancy rates stated above. The lack of bedside nurses in 2021 has been increasing and this has prompted the American Nurses Association to ask the US Department of Health and Human Services to declare the nursing shortage a national crisis in 2021 (American Nurses Association, 2021). The current nursing shortage affects our ability to care for patients in our native communities and this will continue to worsen as the pandemic continues with no signs of slowing in sight.

Another aspect to consider when addressing the nursing shortage is the rural setting of our healthcare facilities. Multiple studies have been done looking at attracting nursing to rural areas. Only 16% of RNs live in rural areas so it is important to identify what factors affect a nurse's decision when choosing to practice at a rural healthcare facility (Terry et al., 2021) A study performed in 2021 entitled, *"The Rural Nursing Workforce Hierarchy of Needs: Decision-Making concerning Future Rural Healthcare Employment,"* identified unique elements for choosing rural nursing which included easy access to education, a livable wage with affordable housing, providing high quality care, and a supportive work environment (Terry et al., 2021).

The recommendations listed below address these elements that will improve recruitment and retention in our rural Native healthcare facilities.

Contributing factors impacting the nursing shortage include (American Association of Colleges of Nursing [AACN], 2020):

- The aging nursing workforce – a significant portion of the nursing workforce is nearing retirement age.
- The changing demographics – the aging population, increased need for health care, impact of the COVID-19 pandemic.
- Insufficient staffing – resulting in increased stress levels, negative impacts on job satisfaction, decreased quality of patient care, decreased time nurses spend with patients.
- Shortage of nursing school faculty – which restricts nursing program enrollments. Education is of utmost importance because educating and graduating students will increase the nursing workforce as current nurses retire or move away from the bedside.

In an effort to address these critical issues, a resolution was drafted and approved by WIHCC Board of Directors (BOD) and Management Team on October 1, 2021. This resolution called upon the leadership of the Navajo Nation Council along with the Navajo Nation Government to call attention to the nursing shortage and to address the critical concern of the nursing shortage. On January 12, 2022 WIHCC Nursing Leaders presented to the Navajo Nation Council, Health Education Human Services Committee on the shortage of nurses.

Multiple studies (AACN, 2018) have demonstrated positive impacts on patient care if there are adequate levels of RN staffing: every 10% increase in bachelor's degree nurses was associated with a 7% decrease in patient mortality; higher nurse staffing levels were associated with lower mortality rates, lower failure-to-rescue incidents, lower rates of infection, and shorter hospital stays; decreasing nurse burnout was found to improve the well-being of nurses and improve the quality of patient care.

RECOMMENDATIONS:

In order to address the critical nursing shortage, it is recommended to increase access to national, state, and tribal programs for ear-marked and/or supplemental funding for nursing recruitment and retention:

- Establishing a directive for all schools and school boards to strongly promote health field studies for students of all ages.
- Prioritizing the Scholarship funding for health field studies with nursing as the top tier.
- Establish and/or increase nursing scholarship opportunities (loan repayment, funding for undergraduate and graduate nursing degrees).
- Increase funding and availability for the IHS Scholarship, IHS Loan Repayment Program, National Health Service Corps Loan Repayment Programs, Nurse Corps Loan Repayment Program, and Faculty Loan Repayment Program.
- Support and pass legislation for Loan Forgiveness Programs for nurses and health care providers.
- Establish a college of nursing at Colleges and Universities and establishing financial support for these programs, promoting enrollment for students to get into nursing programs and/or other health related fields.
- Furthering the MOUs/MOAs with surrounding colleges and universities to increase Native American enrollment in nursing programs and/or other health related fields.
- Increasing access for housing through the housing programs or tribal entities, to build rent-to-own homes or home ownership programs as one way of ensuring retention of registered nurses who are from local service areas.
- Increase funding for ongoing training and skill-building for all existing staff, to maintain quality health care and to keep up with changing health issues, technology, and systems. Support cross-training of existing staff to cover multiple areas. Support training centers and development of learning communities to share challenges and best practices.
- Increase funding and flexibility for IHS and Tribal health care facilities for salary & benefits, and contract costs in order to recruit and retain a competent, skilled nursing workforce.

3. WIHCC#2:

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HEALTH & HUMAN SERVICE TRIBAL CONSULTATION POSITION PAPER WINSLOW INDIAN HEALTH CARE CENTER

INTRODUCTION:

The Winslow Indian Health Care Center, Inc. (WIHCC) is a private, non-profit organization under
P.L. 93-638 on the Navajo Nation. The Indian Self-Determination Act (ISDA) gives American Indians the opportunity to provide for their own health care. The Navajo Nation is committed to be successful in managing its own healthcare delivery program under ISDA but there is a need for support from the leaders of the Department Health & Human Service (DHHS) and Indian Health Service (IHS) in addressing numerous health care issues. WIHCC is submitting the following issues for discussions and consideration.

ISSUE: Residential Treatment & Psychiatric Beds for Substance Abuse Treatment

BACKGROUND:

Opioid prescription use has rapidly increased since 1990's. As a result, there has been a dramatic increase in misuse, overdose and deaths associated with opioids across the U.S. Federal, state and local agencies are developing ways to combat the epidemic. Arizona continues to see increasing deaths and overdoses due to prescription and illegal opioids. According to the Arizona Department of Health Services, there have been over 13,000 visits involving suspected drug overdose in 2022 alone During their 2021 treatment capacity survey, the Arizona Department of Health Services identified 48 treatment clinics that had to temporarily close as a result of the COVID-19 pandemic, This significantly impacts access to care for Arizonans seeking mental health or substance abuse treatment.

The Centers for Disease Control and Prevention (CDC) reported that AI/AN communities had the highest drug overdose death rates in 2015 and the largest percentage increase in deaths from 1999 to 2015 when compared with other racial and ethnic groups. In Navajo Area alone, prescription and illegal opioids have led to more than 7,300 overdose deaths from 2014 through 2016. The opioid misuse has not only led to the loss of Navajo people but Navajo culture as well. According to Navajo Nation President Jonathan Nez, "generations of children are going to grow up without their parents, and, for far too many, outside of the Navajo Nation the loss of their family and their culture will have a negative impact on their lives and on the vitality of the Navajo Nation as a whole." An audit conducted by Health and Human Services Office of Inspector General (HHS OIG) to analyze and compare opioid prescribing and dispensing practices and IT operations at five IHS hospitals. Results of the audit indicated that all five hospitals, including several from Navajo

Area, did not always follow the Indian Health Manual when prescribing and dispensing opioids.

While many facilities in Navajo Area have to the ability to treat opioid misuse on an outpatient basis, there is currently no resources for inpatient treatment.

IMPACT:
Even though opioids are an issue nationwide, abuse of other substances (e.g. alcohol) remain a bigger issue in the WIHCC area. Behavioral/mental health is always a hot topic and suicide is still one of the top causes of death in Navajo area. Substance abuse and psychiatric disorders are not synonymous, but often linked; sometimes substance use leads to a psychiatric reactions and sometimes mental health issues can lead to substance use to self-medicate. Plus there is just a short of behavioral health providers in general. It is the only area of medical staff at WIHCC that has consistent vacancies/turnover

RECOMMENDATIONS:

- HHS has issued over $800 million in grants to support access to opioid-related treatment, prevention, and recovery, while making it easier for states to receive waivers to cover treatment through their Medicaid programs. The same logic and waivers need to be offered to 638 organizations in rural areas; as rural areas receive relatively low levels of direct funding compared to metro areas.

- HHS has published resources and media materials to raise awareness of the epidemic and efforts to prevent its escalation; with 638 recommending that similar media materials be culturally relevant and printed in the Navajo language.

- CMS offer to 638 facilities the flexibility that is offered to states to apply for new funding/expenditure authority to address one of the biggest barriers to treatment; so that Medicaid can pay for inpatient treatment facilities located on Navajo Nation.

- Collaborate with SAMHSA, Center for Mental Health Service (CMHS) and Center Substance Use Prevention (CSUP) on funding opportunities and 638 capacity; most especially for construction of inpatient treatment facilities---reference P.L. 114-198: The Comprehensive Addiction and Recovery Act.

- Collaborate with Federal, State, and Navajo Nation for financing opportunities and "demonstration project" to build an inpatient opioid treatment facility and healing center that would combine native healing modalities, medical care, and medication.

References:

ADHS. (2021, September 30). *Arizona Treatment Capacity Survey Analysis*. www.adhs.org

4. FDIHB:

Dr. Sandi Adkins
CEO, Fort Defiance Indian Hospital Board, Inc
P.O. Box 649
Fort Defiance, AZ 86504
(928) 729-8000
www.fdihb.org

FDIHB Written Comments:

a) **Lack of Funding for Patient Care Expansion:**
We are dealing with the effects of an Indian Health Service (IHS) planning process that never envisioned something like COVID-19. As you know, the IHS uses a heavily bureaucratic methodology for building hospitals and clinics. Data is collected decades before a hospital is designed, approved by Congress and then built.

When the new hospital in Fort Defiance was opened in 2002, it was already out of date and too small to handle the healthcare needs of the community. This has been highlighted by the pandemic where all healthcare facilities within the Navajo Nation, including Fort Defiance, are faced with trying to find space for patients that allows them to be cared for with decency and respect. The pandemic makes it imperative that we immediately address the need for more space.

b) **Increase Overall Funding for IHS:**
The overall funding for IHS needs to be increased in order to improve the management of chronic disease states that impact our community members. IHS should also be considered as a mandatory appropriation for funding similar to the Veteran's Administration current funding strategy. Patient care is impacted severely by lapses in appropriation which results in sequestration and delays in funding to healthcare organizations.

c) **Increase Affordable Housing on the Navajo Nation:**
Recruiting and retaining qualified Navajo staff is imperative to the overall success of Self-Determined organizations like FDIHB Inc. The lack of housing for Navajo Tribal members who choose a career in healthcare, makes it very difficult to attract and keep Tribal members working in their own communities. Our Navajo staff need to be able to find housing in the area which doesn't require significant commutes to FDIHB. Sometimes the decision to pick one job offer over another is based on how far an applicant has to commute. Healthcare facilities located in areas with few to no housing options have a harder time recruiting and retaining qualified Navajo staff members.

Document No. 019536 Date Issued: 10/05/2022

EXECUTIVE OFFICIAL REVIEW

EXHIBIT D

Title of Document: NDOH& 638 Issue Papers for USDHHS-ARTC Contact Name: JIM, JILL

Program/Division: DEPARTMENT OF HEALTH

Email: jilljim@navajo-nsn.gov Phone Number: (928) 871-6350

			Sufficient	Insufficient
☐	**Business Site Lease**			
	1. Division:	Date:	☐	☐
	2. Office of the Controller:	Date:	☐	☐
	(only if Procurement Clearance is not issued within 30 days of the initiation of the E.O. review)			
	3. Office of the Attorney General:	Date:	☐	☐
☐	**Business and Industrial Development Financing, Veteran Loans, (i.e. Loan, Loan Guarantee and Investment) or Delegation of Approving and/or Management Authority of Leasing transactions**			
	1. Division:	Date:	☐	☐
	2. Office of the Attorney General:	Date:	☐	☐
☐	**Fund Management Plan, Expenditure Plans, Carry Over Requests, Budget Modifications**			
	1. Office of Management and Budget:	Date:	☐	☐
	2. Office of the Controller:	Date:	☐	☐
	3. Office of the Attorney General:	Date:	☐	☐
☐	**Navajo Housing Authority Request for Release of Funds**			
	1. NNEPA:	Date:	☐	☐
	2. Office of the Attorney General:	Date:	☐	☐
☐	**Lease Purchase Agreements**			
	1. Office of the Controller:	Date:	☐	☐
	(recommendation only)			
	2. Office of the Attorney General:	Date:	☐	☐
☐	**Grant Applications**			
	1. Office of Management and Budget:	Date:	☐	☐
	2. Office of the Controller:	Date:	☐	☐
	3. Office of the Attorney General:	Date:	☐	☐
☐	**Five Management Plan of the Local Governance Act, Delegation of an Approving Authority from a Standing Committee, Local Ordinances (Local Government Units), or Plans of Operation/Division Policies Requiring Committee Approval**			
	1. Division:	Date:	☐	☐
	2. Office of the Attorney General:	Date:	☐	☐
☐	**Relinquishment of Navajo Membership**			
	1. Land Department:	Date:	☐	☐
	2. Elections:	Date:	☐	☐
	3. Office of the Attorney General:	Date:	☐	☐

Pursuant to 2 N.N.C. § 164 and Executive Order Number 07-2013

			Sufficient	Insufficient
☐ **Land Withdrawal or Relinquishment for Commercial Purposes**				
1. Division:		Date:	☐	☐
2. Office of the Attorney General:		Date:	☐	☐
☐ **Land Withdrawals for Non-Commercial Purposes, General Land Leases and Resource Leases**				
1. NLD		Date:	☐	☐
2. F&W		Date:	☐	☐
3. HPD		Date:	☐	☐
4. Minerals		Date:	☐	☐
5. NNEPA		Date:	☐	☐
6. DNR		Date:	☐	☐
7. DOJ		Date:	☐	☐
☐ **Rights of Way**				
1. NLD		Date:	☐	☐
2. F&W		Date:	☐	☐
3. HPD		Date:	☐	☐
4. Minerals		Date:	☐	☐
5. NNEPA		Date:	☐	☐
6. Office of the Attorney General:		Date:	☐	☐
7. OPVP		Date:	☐	☐
☐ **Oil and Gas Prospecting Permits, Drilling and Exploration Permits, Mining Permit, Mining Lease**				
1. Minerals		Date:	☐	☐
2. OPVP		Date:	☐	☐
3. NLD		Date:	☐	☐
☐ **Assignment of Mineral Lease**				
1. Minerals		Date:	☐	☐
2. DNR		Date:	☐	☐
3. DOJ		Date:	☐	☐
☐ **ROW (where there has been no delegation of authority to the Navajo Land Department to grant the Nation's consent to a ROW)**				
1. NLD		Date:	☐	☐
2. F&W		Date:	☐	☐
3. HPD		Date:	☐	☐
4. Minerals		Date:	☐	☐
5. NNEPA		Date:	☐	☐
6. DNR		Date:	☐	☐
7. DOJ		Date:	☐	☐
8. OPVP		Date:	☐	☐
☒ **OTHER:**				
1. Navajo Department of Health		Date: 10/5/22	☑	☐
2. Navajo Department of Justice		Date: 10/17/22	☒	☐
3. Office of the President/Vice Pres		Date: 10/17/2022	☑	☐
4.		Date:	☐	☐
5.		Date:	☐	☐

NAVAJO NATION DEPARTMENT OF JUSTICE

☐ RESUBMITTAL

DOCUMENT REVIEW REQUEST FORM

RECEIVED
OCT – 5 2022
DEPARTMENT OF JUSTICE
ADMINISTRATION

DOJ
10-5-22@ 107p
DATE / TIME
☐ 7 Day Deadline
DOC #: 19536
SAS #:
UNIT: HSN

*** FOR NNDOJ USE ONLY - DO NOT CHANGE OR REVISE FORM. VARIATIONS OF THIS FORM WILL NOT BE ACCEPTED. ***

CLIENT TO COMPLETE

DATE OF REQUEST:	10/5/2022	DIVISION:	Navajo Department of Health
CONTACT NAME:	Dr.Jill Jim,Exec.Dir,NDOH	DEPARTMENT:	Executive Office
PHONE NUMBER:	871-6350	E-MAIL:	jilljim@navajo-nsn.gov

TITLE OF DOCUMENT: *164 Executive Review-019536-Navajo Nation Written Comments Issue papers to the USDHHS Annual Regional Tribal Consultation, including Exhibit A-638 written comments*

DOJ SECRETARY TO COMPLETE

DATE/TIME IN UNIT: 10/5/22@2pm REVIEWING ATTORNEY/ADVOCATE: MBN

DATE TIME OUT OF UNIT: 10/12/2022@ 4:20pm

DOJ ATTORNEY / ADVOCATE COMMENTS

Legally sufficient. Forward for surname.

REVIEWED BY: (*Print*)	Date / Time	SURNAMED BY: (*Print*)	Date / Time
Michelle Begay Nakai	10/07/22 4:10 pm		10/12/22

DOJ Secretary Called: EMAILED: jilljim for Document Pick Up on 10/12/2022 at 4:20pm By: CP

PICKED UP BY: (*Print*) DATE / TIME:

NAVAJO NATION

12/8/2022

Naa'bik'iyati' Committee Regular Meeting

11:58:29 AM

Amd# to Amd#	New Business: Consent Agenda	PASSED
MOT Tso, D	Item A. -Legislations:	
SEC Walker, T	0194-22; 0196-22; 0222-22; 0223-22; 0230-22; 0217-22	

Yeas : 19 **Nays : 0** **Excused : 3** **Not Voting : 1**

Yea : 19

Begay, E	Daniels	Nez, R	Walker, T
Begay, P	Freeland, M	Smith	Wauneka, E
Brown	Halona, P	Stewart, W	Yazzie
Charles-Newton	Henio, J	Tso, C	Yellowhair
Crotty	James, V	Tso, D	

Nay : 0

Excused : 3

Tso, O	Damon	Begay, K

Not Voting : 1

Tso, E

Presiding Speaker: Slater, C