Health Impact Assessment

Indian Health Services Budget and Urban Indian Budgeting Decisions

NEW MEXICO HEALTH EQUITY PARTNERSHIP

W.K. KELLOGG FOUNDATION

Santa Fe Indian Center

THE UNIVERSITY of NEW MEXICO

SANTA FE COMMUNITY FOUNDATION

Authors
Emily A. Haozous, PhD, RN, FAAN (*Chiricahua Warm Springs Fort Sill Apache)*
Valerie Rangel, MCRP
Shandra Burton, MSN, RN

New Mexico Health Equity Partnership
Technical Support Team
Richard Wright, MPH
David Gaussoin
Jinelle Scully
Jessica Jensen

Community Advisory Board

Katheryn Harris Tijerina, JD (*Comanche)*

Delight Talawepi *(Hopi)*

Anne Wheelock Gonzales, MA *(Oneida Tribe of Wisconsin)*

Nancy Davis *(Turtle Mountain Chippewa)*

David Sloan *(Diné)*

Edie Brycelea

Cyndi Woodall-Hall *(Cherokee)*

Examining the Health Effects of IHS Underfunding on the Santa Fe Urban Indian Community

Executive Summary

The Indian Health Service (IHS) provides health care for approximately 2.2 million American Indians and Alaska Natives (AIANs) in 36 states. In the US, nearly 80% of AIANs live away from their reservations, collectively this population is often classified as Urban AIANs, although they do retain their unique tribal identities even while living away from their tribal lands. For those AIANs who live away from their reservation, access to IHS facilities comes with significant limitations, most importantly restrictions on eligibility for payment for specialty care through the Purchased/Referred Care payment program.

Santa Fe, NM is home to the Santa Fe Service Unit IHS Hospital, health care provider of choice for most AIANs in Santa Fe county. From 1998-2010, the IHS was forced to operate on an outdated budget during a time when healthcare spending per capita nearly doubled. This underfunding forced the IHS to make serious cuts to facilities across the country, including cuts to the Santa Fe Service Unit IHS Hospital. This facility was also strained by additional burdens following compact 638 tribes exercising sovereignty and using IHS funds to open their own medical facilities. Although this is an important component of the government –to- government relationship with tribes, there was no adjustment made to the Santa Fe facility to fill the gap.

Health Impact Assessments (HIAs) evaluate the impact of a public policy with the goal of promoting health, health equity, and social justice. This HIA Examined the impact of the underfunding of the Santa Fe Service Unit Indian Health Service Hospital on the inter-tribal community of American Indians and Alaska Natives (AIANs) in Santa Fe County.

Through an assessment of the existing conditions, the research team collected 165 surveys from the Urban AIAN community that asked questions on health priorities, health conditions, social determinants of health, and cultural factors as they relate to the IHS hospital. The team also conducted targeted interviews with key stakeholders and qualitative interviews with 17 Urban AIANs within the community.

This assessment showed that AIANs in Santa Fe County experience substantial health disparities, with higher rates of mental distress, higher rates of poverty, unemployment, alcohol-related disease and death, and higher rates of accidental death. AIANs die at younger ages than their non-AIAN counterparts. AIAN children in New Mexico are more likely to live in poverty, have no parent in the workforce, and have no health insurance.

"I'm a college-educated person, I'm working full time, and cannot provide enough medical coverage through my job. It would cost me more than $150 **per paycheck** to cover my kids. That's $300.00 a month, and I can't pay rent, own and drive a car, keep the utilities on, **and** feed them **and** pay medical insurance. Yet, **I don't qualify for Medicaid for them either.**"

The team found that Santa Fe's Urban AIAN community was most concerned about diabetes, body size, mental health, heart disease, and addiction, both personally and in the larger AIAN community. They found that food insecurity was a serious issue, with 53% of respondents reporting the need to ration food or eat less in the last 30 days because they didn't have enough money for food. Mental health and addiction services were frequently cited as a priority need. Even in an environment with multiple options due to the expanded services offered through the ACA, the **Santa Fe Area Unit IHS Hospital is their preferred provider**.

"If you're mentally healthy, **then you know how to be physically healthy, spiritually healthy, working with your mind to make your mind healthy**, your child's relationship, your relationship with your spouse, your mother."

Based on the results of this HIA, the team made the following recommendations:

- Fund the Indian Health Service at 100% of need.
- Address food insecurity through the creation of a Food Bank and expansion of Nutrition Services to meet the needs of the Santa Fe Service Unit IHS Hospital community.
- Increase IHS funding to improve mental and behavioral health programs.
- Eliminate Purchased/ Referred Care eligibility by area service unit and replace with funding that follows the patient.

Through this research, the HIA team demonstrated the need for increased funding to address significant health disparities in Santa Fe County in the AIAN population.

This project is supported by a grant from the New Mexico Health Equity Partnership, Santa Fe Community Foundation, and the W.K. Kellogg Foundation. We would like to thank the members of the Community Advisory Board and the Santa Fe Indian Center for their generous dedication and support. We could not have completed this project without them. Any opinions expressed in this report are those of the authors and do not necessarily reflect the views of the New Mexico Health Equity Partnership, Santa Fe Community Foundation, or the W.K. Kellogg Foundation.

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We would like to thank the members of the Community Advisory Board and the Santa Fe Indian Center for their generous dedication and support. We could not have completed this project without them.

We would like to express our heartfelt gratitude to our families for their patience, support, and prayers throughout this project. You have been the bright stars guiding us on the darkest nights. Thank you.

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Study data were collected and managed using REDCap electronic data capture tools hosted at the University of New Mexico.[1] REDCap (Research Electronic Data Capture) is a secure, web-based application designed to support data capture for research studies, providing 1) an intuitive interface for validated data entry; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for importing data from external sources. REDCap is hosted through the University of New Mexico CTSC (DHHS/NIH/NCRR #8UL1TR000041). We thank them for their support.

Thank you to Valerie Rangel, MCRP for the cover art and design elements throughout this report.

[1] Paul A. Harris, Robert Taylor, Robert Thielke, Jonathon Payne, Nathaniel Gonzalez, Jose G. Conde, Research electronic data capture (REDCap) – A metadata-driven methodology and workflow process for providing translational research informatics support, J Biomed Inform. 2009 Apr;42(2):377-81.

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Chapter 1: Introduction

The Indian Health Service (IHS) is a federal agency responsible for providing health care services to individuals who can demonstrate proof of enrollment in a federally recognized American Indian or Alaska Native (AIAN) tribe. This agency is based on a government-to-government relationship between the federal government and AIAN tribes, and is based on Article 1, Section 8 of the US Constitution, established in 1787 and further refined and clarified through subsequent treaties, laws, Supreme Court decisions, and Executive Orders. The IHS provides health care for approximately 2.2 million AIANs in 36 states (IHS, 2016).

Until the passage of the **Patient Protection and Affordable Care Act (ACA)**, the annual budget for IHS was subject for renewal by congressional approval, with final approval by the sitting president. This system of budgetary renewal made the IHS vulnerable to partisan politics, most acutely felt between 2000-2008, when sitting president George W. Bush failed to ratify the IHS budget, forcing the agency to operate on its 1998 budget during a period when health care costs more than doubled. In 2010, the ACA was passed into law and with it the Indian Health Care Improvement Act was made permanent. Following the passage of the ACA, funding is still subject to approval through congress, but changes to the budget may be made annually without requiring presidential approval, allowing the budget to grow with changes to the national healthcare landscape.

To aid in reading this Health Impact Assessment, we have created a glossary to define unfamiliar terms or jargon. Any glossary term will be **purple** the first time it appears in the text. See Appendix A for the glossary.
We have also created an index for the many acronyms used in the report. See Appendix E for the Acronym Index.

Every year, representatives from the IHS work with tribal leaders, health care providers, and community members to develop the coming year's budget. This consultation process involves the identification of tribal priorities, healthcare spending needs, structural needs, and limitations of the overall system. The funding cycle starts in October at the IHS Area level, and works through the year, with tribal consultation taking place in May of the following year. There are multiple workgroups participating in the process, and regular consultation with tribal representatives and HHS (IHS, 2006).

There are approximately 2.5 million AIANs in the US (U.S. Census, 2014). Of this population, approximately 78% live away from their home reservation (NUIFC, 2015). Although these AIANs do not live on their reservation, pueblo, **rancheria**, or allotment land for all or part of the year, it would be inappropriate to assume that this group is any less connected to their diverse AIAN heritages. Yet Urban AIANs are living with tremendous unmet health needs, due to serious deficits in federal policy related to Urban AIANs.

Santa Fe County has approximately 150,000 residents. Like much of New Mexico, Santa Fe County has a special diversity that is part of the character of the state. The county is approximately 43.9% NHW (not Hispanic or Latinx), 51.3% Hispanic or Latinx, and 4.4% AIAN alone. The median household income for the entire county is $52,958, and 14.2% of the community members live at or below the federal poverty line (Census.gov). Santa Fe is a center of AIAN culture and art, and is home to the Institute of American Indian Art, the only higher learning institution in the country dedicated to AIAN art. Santa Fe has a highly diverse AIAN community, with residents from neighboring tribes as well as those from across the country.

Santa Fe is home to the Santa Fe Indian Center (SFIC), a volunteer-run non-profit organization designed by and for AIAN people with the mission of supporting, promoting, and enriching the AIAN community in Santa Fe, New Mexico. The SFIC hosts several large community events each year, including fitness- and health-oriented partnerships with Wings of America and the Santa Fe Farmers Market. The SFIC also provides emergency assistance grants for individuals and families in need, and serves as a liaison in the community between the AIAN community and non-AIAN community organizations.

Indian Health Service Budgeting Process

- October- December: Budget formulation work sessions, consultations with tribes
- February- March: National Budget formulation work session
- May: Tribal presentation of national priorities and recommendations to the National Health and Human Services Tribal Budget Formulation and Consultation Session. This includes Intradepartmental Council on Native American Affairs
- May- June: Meeting of co-chairs of National Tribal Budget Formulation Workgroup and Director of the Office of Management and Budget

Many of Santa Fe's AIAN population receives their health care through the Santa Fe Service Unit IHS Hospital, located in the center of town. Over a period of 15 years, the Santa Fe Service Unit IHS Hospital has undergone a dramatic reduction of services available within the facility. The community who is most impacted by the limited services is the Urban AIAN users of the facility, for reasons we will describe in more depth in this report. The SFIC leadership with the collaboration of a local AIAN health researcher identified the IHS budgetary process as an area for potential impact through a Health Impact Assessment (HIA). The results of this HIA are intended to inform budgetary decision-making by highlighting the needs of the Urban AIAN community in Santa Fe, as well as provide some perspective into the lived experience of those AIAN utilizers of IHS facilities who live outside of their service areas across the country.

Chapter 2: Background / History of Organization

History of the Santa Fe Indian Center

In 2015, the Santa Fe Indian Center and Emily Haozous (Chiricahua Warm Springs Fort Sill Apache) from the University of New Mexico College of Nursing met to discuss possible collaborations that could enhance the health of the Urban AIAN community in Santa Fe County. Through the generous support of the New Mexico Health Equity Partnership – Santa Fe Community Foundation, this HIA was created between December 2015 and December 2016. With this grant, Valerie Rangel joined as the Project Manager, and Shandra Burton joined as the Research Assistant.

Policy Context and Proposed Changes to the IHS Federal Budget

Currently, Urban AIAN health is considered within the IHS budget through the funding of 33 urban-centered, non-profit Urban AIAN organizations at 59 locations across the country (IHS.gov). Urban AIAN users are not included in the budgets for IHS facilities, creating an added strain on the already limited funding for those facilities which do serve Urban AIANs, such as the one located in the city of Santa Fe. The Santa Fe Service Unit IHS hospital is efficient at securing outside funding for those AIANs who do qualify for federal services, but there is still a significant shortfall each year. This HIA will provide recommendations to address these shortfalls with the intention of improving healthcare for all users of the Santa Fe Service Unit IHS hospital.

Screening

From 1998-2010, the Indian Health Service (IHS) was forced to operate on its 1998 budget, during a time when healthcare spending per capita more than doubled (Kaiser Family Foundation, 2011; National Indian Health Board, 2013). This **underfunding** forced the IHS to make serious cuts to available services at facilities throughout the country. The Indian Health Care Improvement Act (IHCIA) was permanently enacted into law with the passage of the Affordable Care Act, and currently an annual budget is submitted with projected costs based on consultation with tribal leaders and key stakeholders (www.IHS.gov). The existing budget allocates funding for only 54,000 urban American Indians residing in 59 sites nationwide, providing basic healthcare services for only 1.3% of the urban American Indian population (DHHS Fiscal Year 2016, 2015). Approximately 78% of American Indians do not live on their home reservations, making the estimated budget for urban IHS facilities at far below need (National Urban AIAN Family Coalition, 2015). Although the ACA mandates health insurance coverage for all Americans, enforced by penalty, 26.5% of Urban American Indians are without health insurance, compared to only 17.6 of the general US population (UIHI.org, 2011).

IHS budgeting takes place annually. The IHS prepares a budget that is submitted as part of the President's Budget request to congress on or before the first Monday in February for the upcoming fiscal year beginning October 1. This HIA is intended to provide critical information on the health and wellbeing of the Urban AIAN community in Santa

Fe County during the budget planning cycle for the 2018-2019 fiscal year (See figure 1, Urban Indian Levels of Policy Influence).

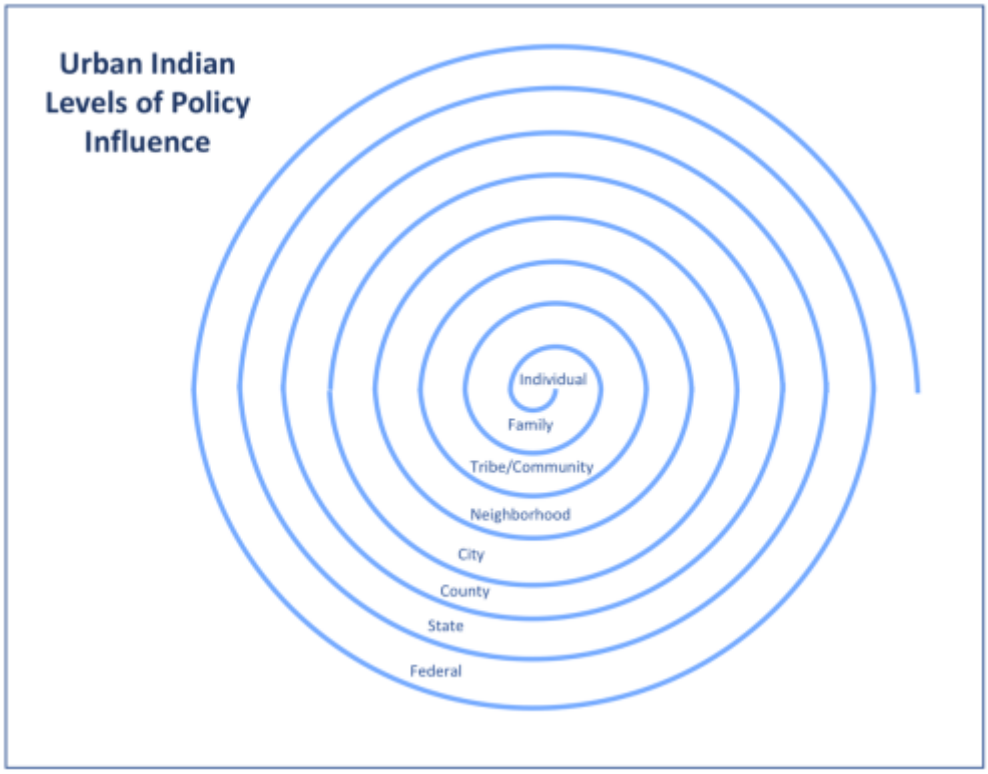

Figure 1. Urban Indian Levels of Policy Influence

AIAN Health, the Indian Health Service, & US Health Policy

Pre-Contact Period

Prior to contact from colonizing nations, AIAN tribes were highly organized, self-governed, with traditional ecological knowledge; utilizing knowledge of earth and planetary movements, plant and animal cycles to enhance their diet, heal, and maintain their health.

Early Colonial Period

Between the arrival of Christopher Columbus in 1492 and the ratification of the United States constitution in 1782, a doctrine of discovery set the tone for widespread displacement, warfare, and military removal. AIAN tribes formed partnerships, partook in warfare, and survival tactics which set the tone for federal Indian policy and treaties between 1832 – 1904. During the colonization period, infectious diseases such as smallpox, measles, diphtheria, malaria, influenza, and dysentery spread because of multiple public health issues that included poor sanitation, overcrowding, and inadequate nutrition. These epidemics deeply influenced their ability to resist colonization.

Starting in the early 1600s in southwest North America, Spanish explorers were establishing missions throughout what is now New Mexico, despite much protest from the indigenous communities in the area. This period of Spanish colonialism is marked

by genocide, bloodshed, indigenous resistance, slavery, and religious persecution. Eventually there were Spanish settlements throughout the southwest, marked by their practices of genocide, religious persecution, and slavery of the local indigenous communities (Forrest, 1979).

1782: Western Expansion and Manifest Destiny

Once the US government assumed leadership over indigenous land, health policies have closely mirrored the larger philosophical policies guiding management of AIAN tribes. With western expansion in the 19th century, the imperialist belief in manifest destiny was used to justify a policy of removal and eradication of AIAN tribes. In New Mexico, this policy was most severely felt by Apaches and Navajos, best illustrated by the relocation and incarceration efforts such as the Navajos' forced relocation to Bosque Redondo, commonly known as the **Long Walk**. Apaches in southern New Mexico also experienced relocation; the Mescalero Apaches were also temporarily relocated to Bosque Redondo and Fort Stanton, and the Chiricahua Apaches were relocated to Fort Sill, in Oklahoma. Relocation created significant health crises related to starvation, infectious disease, inadequate housing, and mistreatment, as well as substantial loss of life at the hands of the military. These experiences resonate within tribes and are a source for deep intergenerational trauma and mistrust in the federal government to current day. This mistrust was reinforced by the policy of eradication that guided many decisions regarding relationships between AIANs and the federal government.

Federally funded healthcare was first mandated through policy in 1753 in the direction of restricting AIAN access to alcohol, a request that was generated from the Haudenosaunee tribes after observing the destructive effect of the drug. Liquor trade prohibitions grew to other tribes, and was followed by smallpox vaccinations after the widespread release of the vaccine in 1800. Until 1849, when the administration of AIAN affairs was transferred from the War Department to the Department of the Interior, health care for AIANs living on or near military forts was slowly evolving from the prohibition of alcohol and smallpox vaccinations to other limited and uncoordinated care services (Thierry, Brenneman, Rhoades, & Chilton, 2009).

1831: Case of Worcester v. Georgia

During the period of 1778 to 1868, at least 367 treaties were ratified by the federal government guaranteeing housing, education, health, and food services with language such as "promise of all proper care and protection" in exchange for tribal land and natural resources through eminent domain. In the case of Worcester v. Georgia (1831) Chief Justice John Marshall defined trust responsibility as the federal government, not the states, has the "authority over and responsibility' for matters relating to members of Indian tribes", and four principles of federal Indian law were established (Shelton, 2004):

1. Tribes retain all their inherent sovereignty that the federal government has not encroached upon
2. The federal government, and not states, oversees Indian affairs

3. The federal government only deals with tribal organizations or governments that it has recognized
4. The United States has assumed a trust responsibility towards Indian nations, resulting from treaty language and from the role it has assumed with respect to limiting tribal sovereignty (Shelton, 2004)

1871: Indian Appropriation Act

Although treaties were continued until 1904, the 1871 passage of the Indian Appropriation Act changed the climate for treaties as the act decreed that Indian tribes ceased to be considered independent nations for treaty negotiations. Treaty negations and the amount of sovereignty that each tribe chooses directly impacts health care services available to its constituents as related to the trust responsibility assumed by the federal government through the treaty.

After the creation of the Indian Peace Commission in 1867, funding for health-related efforts increased substantially, including specific budget items for physicians and medicines. By the 1880s, hospitals were built in some areas in association with Indian boarding schools. These hospitals were a response to the high death rates from tuberculosis and other infectious diseases within the students residing in the schools. During this period, federal policy switched from eradication to assimilation with the Dawes Act of 1887, and hospital regulations reflected this change. For example, traditional medicine practices were prohibited and medicine men were detained for practicing their indigenous healing approaches (Shelton, 2004).

1921: Snyder Act

Health care for AIANs continued with a focus on infectious disease until the Snyder Act in 1921 and the Merriam Report of 1928, both of which established the fundamental policy structure that guides the Indian Health Service as is best recognized today (Thierry, Brenneman, Rhoades, & Chilton, 2009; Shelton, 2004). The Snyder Act created several significant policies that continue to current day IHS activities (Warne & Frizzell, 2014). The Snyder Act established the funding mechanism for what would eventually become IHS as an annual appropriation determined by Congress. The act also explicitly defined the role of the federal government in providing care for AIANs, specifically focusing on promoting a community health model of **health promotion** and wellness. The act did not define how to determine eligibility for health services, nor did it define AIAN status. Shortly after the Snyder Act was passed, the Merriam Report was published, reporting research comparing Indian health services with health services of the general population. The Merriam Report described unacceptable health conditions across the country in comparison to the local non-AIAN populations. Recommendations from the Merriam Report suggested more funding for AIAN health services and reorganization of the existing health care system.

1954: Transfer Act

Although there was a short period of advocacy for tribal rights in the 1930's under the leadership of the Commissioner of Indian Affairs John Collier, an Indian reform activist, assimilation policy was renewed in the 1950's. Termination of tribes' legal existence, policies of relocation, and elimination of the nation-to-nation trust relationship of 109 tribes and bands eliminated sovereignty and caused significant devastation in AIAN communities.

Until this point, AIAN health had been overseen by the Department of the Interior, under the Bureau of Indian Affairs (BIA). The Transfer Act of 1954 was a major reorganization of the system of healthcare for AIANs, effectively establishing the IHS as we know it today. The Transfer Act moved AIAN health services from the Department of the Interior to the Department of Health, Education, and Welfare (now the Department of Health and Human Services). Shortly afterwards, in 1955 administration of the IHS was transferred from the BIA to the Surgeon General of the United States Public Health Services. These actions allowed AIAN health decisions to be made by experts in human health, removing them from the Department of the Interior, which was (and is) focused on land, natural resources, fish, and game (Thierry, et al., 2009; Warne & Frizzell, 2014).

The purpose of the Transfer Act was to "improve health services to our Indian people; to coordinate our public health system; to further our long-range objective of integration of our Indian people in our common life." - Sen Edward Thye of Minnesota, sponsor of the Transfer Act of 1954 P.L. 83-586

1975: Indian Self-Determination and Education Assistance Act

As demonstrated throughout this timeline, policy governing decision-making within IHS has closely followed larger federal trends in AIAN policies. The 1975 Indian Self-Determination and Education Assistance Act comes in the wake of the civil rights movement and reflects the activism, empowerment and the larger awareness of the unmet rights of the nation's AIAN population. It was also guided by then President Richard Nixon, who showed both political and personal interests in promoting AIAN self-determination (Bergman, Grossman, & Erdrich, 1999). The Indian Self-Determination and Education Assistance Act recognizes tribal sovereignty by creating a mechanism for tribes to take control of IHS funds to create their own health clinics, called "638 compacts," or "638 contract" reinforcing self-determination and authorizing tribes to independently control federal funds designated for IHS and BIA programs.

1976: Indian Health Care Improvement Act

Shortly after the passage of the ISDEAA, in 1975 the Indian Health Care Improvement Act (IHCIA) was passed, furthering the extent of federal support provided by the federal government while honoring sovereignty and treaty obligations. The IHCIA explicitly outlined national goals of 1) improving AIAN health and 2) making health care available to the most AIANs possible. The law provided for scholarships, billing through Medicare and Medicaid and Children's Health Insurance Program (CHIP), funding for sanitation

systems and health care facilities, and some funding for Urban AIANs (Johnson & Rhoades, 2000; Bergman, Grossman, Erdrich, 1999; Warne & Frizzell, 2014).

The Washington Consulting & Management Associates, Inc. evaluation

While the IHCIA introduced policies that reinforced the role of the federal government in implementing healthcare for American Indians, the execution of these policies was inconsistent. In 1978 an external evaluation of the IHS resource allocation criteria was completed by an external consulting firm, Washington Consulting & Management Associates, Inc. (WCMA). The purpose of the evaluation was to determine whether the data being used by IHS to allocate resources was reliable, and to provide suggestions for improving the resource allocation criteria data. The report cited the pattern of high migration amongst AIANs throughout the US as a barrier to accurate population counts. Since then it has been recognized that there were flaws from undercounts due to WCMA basing its calculations on the 1970 census data. This census is now known to undercount AIANs by as much as 70% in some tribes, further confounding the migration issue (Lujan, 1990).

Through the evaluation, the WCMA identified that the three IHS area offices that were selected for evaluation shared several common features that limited the availability of reliable data. The quality of medical records was extremely unreliable due to missing or ineligible data, missing or unfiled patient charts, a lack of verification of charted data, sloppy processes for data entry, duplicate entries, patients with multiple patient identification numbers, no systems for tracking patient information, a lack of concern and understanding regarding the billing forms, and underreporting of alcoholism.

WCMA evaluated the use of Contract Health Services (CHS) and found poor tracking of unsatisfied need when contract funds were depleted each year, no tracking of resources needed to monitor and provide technical assistance for tribes with 638 contracts, CHS providers were not completing the CHS paperwork correctly, a lack of follow-through to track care received from CHS referrals, and billing falling outside the fiscal year resulting in distorted resource utilization data. The WCMA reported that their report was limited by several policy changes within IHS that impacted the accuracy of the report, most importantly to this report was the implementation of the "on or near" regulation in the summer of 1978, limiting access to CHS dollars to those whose reservation or designated tribal land was located within their area service unit.

The 1978 external report by consulting firm WCMA reveals a bureaucracy in which there is little regard for tracking actual costs, user data, or patient need, yet rationing of care is based on population numbers that were known to underrepresent the population size.

IHS eligibility criteria

Eligibility criteria for IHS resources has changed over time, reflecting the ambiguous social, legal, and political criteria defining AIAN status. By the mid 1980's, eligibility for

IHS services became defined as being of AIAN descent and having close social and economic ties to a federally-recognized tribe, excluding non-AIAN spouses except in the case of those pregnant with an AIAN child or non-AIANs requiring services due to a public health hazard within an AIAN community (Johnson & Rhoades, 2000; www.IHS.gov). With the cost of specialty care, eligibility criteria for access to services unavailable through an IHS facility were developed, requiring individuals seeking such care (called "Contract Health Services") to live within certain defined areas. If IHS as an overall healthcare system has been chronically underfunded, the **Contract Health Services** (CHS) system of rationing care was conceived as a practical solution to further ration very limited appropriations that favored those who live on or near their reservation or assigned tribal lands. Unfortunately, the growing size of the Urban AIAN population has never been a consideration in the implementation of this policy. Per Rhoades, et al. (2000), any modification of Contract Health Services system to better meet the needs of the AIAN population has met resistance from congress. IHS changed the name of the CHS program to **Purchased/ Referred Care (P/RC)** in 2014 (See sidebar for brief explanation of Contract Health Services / Purchased/ Referred care. See Appendix B for a more in-depth description of P/RC Eligibility Criteria.)

What is Contract Health Services/ Purchased/Referred Care?

An enrolled member of a federally-recognized tribe may access any IHS facility and have access to the services provided within that facility, however there are limitations. **Purchased/ Referred Care (P/RC)**, previously known as Contract Health Services (CHS), is the name for the funding source that is used to pay for specialty care within the IHS. Funding for patients within IHS is determined based on geographic location. The nation has been divided into Areas, and those Areas are subdivided into Service Units. For example, the Santa Fe Service Unit exists within the Albuquerque Area IHS. Funding for IHS is budgeted based on the demographic characteristics of the tribes within each Service Unit. This means a person who is from a tribe that is geographically located within the Santa Fe Service Unit will be eligible for all healthcare dollars provided by that Service Unit. If that person moves and requires healthcare from an IHS facility in another Service Unit, they will not be eligible for funds reserved for P/RC for that Service Unit. That person would have to return to their home reservation to qualify for Purchased/ Referred Care funds to pay for any specialty services. Any service that requires referral to a non-IHS provider, such as specialty care (orthopedics, oncology, cardiology, for example) falls under the policies for P/RC**.**

An individual must first meet the eligibility requirements for direct care services at an IHS or tribal facility to be considered for P/RC. An individual must meet the eligibility requirements as defined by Federal regulations published in Code of Federal Regulations, at Title 42, Section 136.21 through 136.25, and Indian Health Services, Part 2, Chapter 3, "Contract Health Services" dated January 5, 1998.

The population who is most affected by the lack of access to P/RC funds is the Urban AIAN community. In Santa Fe County, this is a sizeable community, including those families who are in the city temporarily while a family member is at the Institute of American Indian Arts (IAIA), families who have been here for generations due to relocation or migration for the art market, or because they find this a good place to work, raise their families, and retire.

The Santa Fe IHS Hospital was built in 1975. For long-time residents of the region, this hospital has been a familiar resource, recognized as a reliable provider of healthcare from cradle to grave. In 1991, this facility had a full range of services, including an intensive care unit, a step-down unit, surgery and outpatient clinics, an emergency room, a 29-bed medical/pediatric service, labor and delivery, and outpatient clinics (Moss, 2011). Currently, services at the Indian hospital and urgent care in Santa Fe include: Urgent Care, Family Medicine, Internal Medicine, Pediatric Medicine, Psychiatric Medicine, Prenatal, Behavioral Health, Physical Therapy, Audiology, Dental, Optometry, Pharmacy, Nutrition, Laboratory, Public Health Nursing, and X-Ray services. The Service Unit also oversees Field Clinics in Santa Clara, Cochiti, and San Felipe Pueblos.

Indian Health Service
Santa Fe Service Unit:
San Felipe
Cochiti
Santo Domingo (Keres)
Tesuque
Pojoaque
Nambe
San Ildefonso
Santa Clara
Ohkay Owingee

In a meeting with the Chief Executive Officer and Chief Financial Officer of the Santa Fe IHS we learned that the Santa Fe IHS defines an Urban AIAN as a person enrolled in a federally recognized tribe who lives outside their service area with active use of IHS for the past 2-3 years (at least one visit per year). The Santa Fe IHS sees approximately 3,400 visitors per year. Approximately 30% of the Urban AIAN population treated at the Santa Fe IHS facility has no insurance coverage, including private insurance, Medicare, and Medicaid. Likewise, most are also not eligible for contract health service. When the users of the facility were surveyed, the current needs of the community were identified as: diabetes, physical therapy, behavioral health, optometry, pharmacy visits and refills. The Chief Executive Officer has also identified that the IHS facility needs building renovations to address plumbing and other infrastructure concerns to update the late 1970s-era building. With additional funding, the facility's leadership would like to resume same-day surgeries, and add preventative care (cancer, colonoscopies, nutritional health) and podiatry services.

Chapter 3: HIA Screening and Scoping

Health Impact Assessment Overview

A Health Impact Assessment (HIA) is a community-based project that evaluates the impact of a public policy with the goal of promoting health, **health equity**, and **social justice**. A HIA examines potential consequences of a policy and can provide recommendations that can mitigate or enhance those effects to the benefit of the population. HIAs rely strongly on community expertise for leadership, data gathering and interpretation, which enables them to align closely with community priorities. The HIA process has six steps: screening, scoping, assessment, recommendations, reporting, and evaluation and monitoring. Through this process, an HIA uses a holistic perspective on wellness to assemble existing evidence, create unbiased data, and then synthesize this information into a more comprehensive profile. This profile can be used to inform recommendations on a specific policy. The purpose of this HIA is highlight the needs of the Urban AIAN community in Santa Fe to inform IHS budgetary decision-making. This HIA will provide recommendations to address budgetary shortfalls with the intention of improving healthcare for all users of the Santa Fe Service Unit IHS Hospital.

Screening Determines the need and value of an HIA.
Scoping Determines which health impacts to evaluate, methods for analysis, and a work plan.
Assessment Provides a profile of existing health conditions and an evaluation of potential health impacts.
Recommendations Provides strategies to manage identified adverse health impacts.
Reporting Develops the HIA report and communicates findings and recommendations.
Monitoring Tracks impacts on decision-making processes and the decision itself, and impacts of the decision on health determinants.

Scoping

Organizational & Stakeholder History

Once the HIA was funded by New Mexico Health Equity Partnership – Santa Fe Community Foundation, Dr. Haozous and the SFIC together assembled a **Community Advisory Board**. The Advisory Board was composed of AIAN community members from across Santa Fe, and included representatives from education, arts, law, health, community organizing, and non-profit funding/finance. Members of the Advisory Board also participated in a HIA training hosted by the New Mexico Health Equity Partnership – Santa Fe Community Foundation. The first full meeting of the Advisory Board developed the mission statement of the HIA and reinforced the training on the overall HIA process.

The Community Advisory Board agreed on their roles and responsibilities, and committed to the full duration of the project. As key stakeholders, the HIA team committed to being a responsive and authentic research tool in the process of

collecting and reporting the data. We appreciated our responsibility to the community in this project, and affirmed our commitment to a transparent and methodologically sound process. Subsequent meetings were devoted to focusing the HIA to Advisory Board priorities, identifying questions from the survey bank for use in the community survey, and discussion of how to present results.

"The Santa Fe HIA will work to provide evidence and advocate for increased funding for culturally sensitive and equitable comprehensive wellness for Urban AIANs in Santa Fe County."
-Mission Statement, Community Advisory Board

Figure 3-1: Advisory Board Mission Statement Wordle

To gain a better understanding of the community context and include diverse perspectives in the participatory process of the health impact assessment, we created a table identifying key stakeholders from all sectors of the community who may be affected by, or influence the Urban AIAN population in Santa Fe. These organizations are dedicated to improving the social climate of the city and concerned with the economic impact on their organization by low-income people in the community who need physical health, employment, nutritional, and mental health care.

An attempt was made to contact all stakeholders; the summaries included in the data were representatives that agreed to be interviewed and are the people or groups that stand to be directly affected, either positively or negatively, by the funding decisions of the IHS facility in Santa Fe. Having as many stakeholders identifying the observed impacts and concerns of the Urban AIAN community, and being in support of solutions presented in this report, adds to the political clout for tribal and political leaders advocating for effective change.

The focus of the scoping process was to gather data regarding the underfunding of the Santa Fe IHS Hospital and its impacts on public services, infrastructure, living

conditions, social and economic factors as well as individual behaviors and health. An extensive literature review from scholarly journals, accredited reports, census data, state, governmental, and research organizations gathered initial data to assess the existing health conditions of the AIAN community. The Joint Commission accreditation reports documents the trend of decreased services and the facility problems associated with maintaining the existing forty-year-old facility.

Overview of Social Determinants of Health

This HIA examines the impact of underfunding of the Santa Fe IHS Hospital on the Santa Fe Urban AIAN community. We specifically focused on the inter-tribal community of Urban AIAN community in the metropolitan Santa Fe area. This topic was of importance to the Urban AIAN community because of their historic reliance on the Santa Fe IHS Hospital for health care needs and their lack of voice in IHS policy decision-making. The Santa Fe Urban AIAN community has watched as the hospital with which they felt strong emotional and political ties was eroded due to funding decisions outside their control. By conducting an HIA to document the impact that budgeting decisions and subsequent underfunding of this hospital has had on the community, we hope to establish the important role that the IHS facility has within the Urban AIAN community, and give voice to a community that has been historically disenfranchised in these policy-making processes.

It is our intention that the results and recommendations that come from this report are used to influence decisions regarding budgeting of funds to IHS facilities that provide services to communities in urban areas, including Santa Fe Area Service Unit. We are specifically suggesting that these results and recommendations inform decisions to increase funding to support care for urban populations.

We are not suggesting that funds are re-allocated away from tribal communities to urban communities within service units. As data show that large numbers of AIANs live in urban areas and are accessing IHS facilities but are not being included in the budgeting process, we are suggesting that these recommendations are taken into consideration **in addition to** existing budgets for facilities that fall within urban areas.

The value of an HIA is that it engages the public and other stakeholders throughout the process, and it considers the many layers that influence health, from the individual uncontrollable risk factors like age, genetics, and gender, to controllable risk factors like diet, exercise, addiction, and coping. The HIA then goes beyond these individual-level risk factors to place the impact of policy within a broader context, examining the impact of policy on public structures and infrastructures, living and working conditions, and social, economic, and political factors, effectively incorporating the **social determinants of health** into the data gathering and analysis

process. In this HIA, because economic stability, education, and food insecurity emerged as specific concerns we put special focus on those topics in the background investigation.

Economic Stability

Many AIAN residents of Santa Fe are temporary. They may be students of the Institute for American Indian Arts, Santa Fe University of Art & Design, living in Santa Fe during the school semesters then returning home during breaks and over the summer. Due to the lack of affordable housing, there is a steady stream of artisan merchants who travel to Santa Fe from neighboring communities on a seasonal basis, selling their fine art and jewelry on the plaza in downtown and at the historic Governor's Palace.

Per the 2013 "County of Santa Fe Housing Needs Assessment Update," Home owners have not been able to keep pace with the rising cost of home prices and data shows a gap between what local household can afford to pay for housing and what the market process demand has been increasing. In Santa Fe County, average rents have increased between 12-14% since 2004, but renters' incomes have increased by less than 4%. Fewer than half of units rented for less than $850/month, but with a third of the county's population earning less than 30% of the area median income (approximately $17,000 for a family of 3), any rent greater than $500/month is unaffordable. Unfortunately, there is a paucity of units offered in this range, and most are only one bedroom or studio apartments. The median home value in Santa Fe County was $301,000 in 2010. There is a considerable second home market in Santa Fe that has been credited with inflating home values, in 2011 one out of every four transactions was from an out-of-state address and 16% of residences in Santa Fe are owned by out-of-state residents (Housing Needs Assessment Update, 2013).

There are two housing authorities serving Santa Fe City and County. These two organizations provide 492 units of public housing, with 353 units residing in the county of Santa Fe. The wait for either public housing and/or Section 8 voucher programs is two to three years (Housing Needs Assessment, 2013).

In 2007, estimated 3,883 households live in overcrowded conditions within the City of Santa Fe, and 6% or about 3,698 households rated their living conditions as being in poor condition. It is also important to note that the housing needs of the northern pueblos in New Mexico have impacts on Santa Fe County's housing conditions. Local Native American household income is 60% of the national average and the Pueblos of Tesuque, San Ildefonso, and Pojoaque reside near the most expensive housing markets (Los Alamos and Santa Fe) (Housing Needs Assessment, 2013).

Education & Employment

Data from the Bureau of Business & Economic Research at the University of New Mexico shows the highest level of educational attainment for Santa Fe County over the past 25 years is a high school degree (21.2%), followed by 19.2% Post-Secondary Education, 20.7% Bachelor and 20.6% other college. Employment in 2009 showed a

Civilian Labor Force of 76,089 of which 71,551 individuals were employed, compared to 2015 where the Civilian Labor Force of 71,658 had only 67,767 employed. A gradual increase in wages were illustrated in 2008 the average weekly wage was $743, compared to $822 in 2014.

The top employment industries from 2008 to 2014 were: private industries, state and local government, retail trade, food services, health care and construction. In 2014, private industries employed 3,362 fewer jobs, government jobs decreased by $1,826 jobs, food service jobs increased by 413 jobs, health care employment increase by 680 jobs, while retail trade jobs decreased by 296 and construction employment decreased by 1,825 jobs. (BBER-UNM data: http://bber.unm.edu/santa-fe).

Food insecurity in Urban AIANs

While **food insecurity** is familiar to some rural and reservation-based AIANs, 60% of US counties with a Native majority experience low and very low food security rates. Food insecurity in indigenous communities is almost twice the national average, (Zielinski, 2015). Long term effects of food insecurity include low graduation rates, and increased crime, and food insecurity is known to add to stress and depression.

Impoverished AIANs often rely on assistance programs such as the Food Distribution Program on Indian Reservations (FDPIR), Supplemental Nutritional Assistance Program (SNAP), Women, Infants and Children (WIC), the National School Lunch Program (NSLP), and local food banks. Historically, rations of flour, sugar, lard, and other government produced commodities were provided on reservations, initiating a socio-cultural shift in which diet became disconnected from traditional practices, compounded by the displacement from traditional land or territories. This reliance on low-cost, easily available foods has made a profound impact on the health of indigenous communities. Subsistence living was replaced by processed foods, including foods with high sugar and salt content, and foods made with bleached, white flour. Frybread, a food that has become a staple in many AIAN diets, grew from these rations. Frybread is easily made with flour, water, salt, powdered milk, lard or oil, and baking soda, all ingredients that are inexpensive or provided for through food assistance programs (Zielinski, 2015). Limited access to nutritious, fresh foods contributes to lifelong chronic health conditions, including obesity, heart disease, diabetes, and cancer.

Access to Health Care

The foundation of today's IHS agency stemmed from an agreed upon compact that the government agreed to provide health care to members of all federally recognized tribes; therefore, doctor's visits, medication, labs/tests/screening, nutritional and mental health services should be covered by the federal government. With a fixed yearly budget of $4.6 billion, it is impossible for the federal government to provide comprehensive services, at no cost, to 2.2 million Native Americans and Alaska Natives in 35 states.

Following the passage of the IHCIA in 1976, reimbursements from Medicare, Medicaid, and CHIP have provided needed supplemental funds for IHS from services billed for patients who qualify for these programs. These funds allow tribal and Urban AIAN health programs to provide expanded services to their patient populations. Yet many AIANs refrain from purchasing health insurance or enrolling in Medicaid with the understanding that IHS services or tribal programs are provided as a federal obligation. For some AIANs there is the false understanding that IHS is health insurance, which prevents those individuals from enrolling in other health insurance or applying for available federal programs. Others assert that because the loss of traditional homelands was a trade agreement where AIANs received reservation lands, health care, public education, and protection from the government, they should not be forced to apply for Medicare, Medicaid, or purchase health insurance. With this understanding, the population who is most affected by the lack of access to P/RC funds are those who believe that all healthcare should be afforded to them by the government; for those individuals, there is a belief that any lack of providing for their medical needs is a treaty violation.

As of this writing, with the ACA the Health Insurance Marketplace benefits AIANs by providing opportunities for affordable health coverage. In states that chose to expand Medicaid (New Mexico is one of these states), AIANs may choose a private health care plan or determine eligibility and apply for Medicaid, Medicare, or CHIP. For members of a federally recognized tribe who buy private insurance in the Health Insurance Marketplace and possess an income between $24,250 and $72,750 for a family of 4 ($30,320 to $90,960 in Alaska) and qualify for premium tax credits, there are no out-of-pocket costs (for example: deductibles, copayments, and coinsurance for care). For AIANs with incomes below $24,250 or above $72,750 for a family of 4 (or below $30,320 or above $90,960 in Alaska), a limited cost sharing plan is available that promises no out-of-pocket costs from care and services at IHS or from another Indian health care provider (HealthCare.gov).

Context for AIAN Health- Intergenerational Health

Understanding AIAN health would be impossible without understanding the historical context that frames AIAN culture, society, and wellbeing. Although this report presents many dire statistics representing a picture of disparate and unequal distribution of resources, and struggles for survival in a changing world, the mere fact that we are discussing the health concerns of the Urban AIAN population speaks to the resiliency and lasting devotion of the AIAN population to their core cultural values. This must be considered when evaluating the historical and contemporary health concerns of this subpopulation of AIANs, as it is evidence that the historic federal policies of assimilation and genocide have been largely unsuccessful.

Historical trauma describes the effects of cultural suppression, oppressive policies, and traumatic treatments experienced by American Indians in North America because of colonization. The impact of European contact on the Native populations was a massive loss of life through infectious diseases and violent encounters that have been referred

to as the American Indian Holocaust (Thornton, 1987). Initially, historical trauma was described as a complex and intergenerational form of Posttraumatic Stress Disorder resulting from European conquest and colonization (Brave Heart, 1993, 1999; Duran & Duran, 1995). The theory states that intergenerational effects of Historical trauma will cause future generations to suffer mental health problems because of violence inflicted on their ancestors (Kirmayer, Gone, & Moses 2014). Unfortunately, the literature rarely discusses alternative characteristics or manifestations of historical trauma. Moreover, the assumptions of historical trauma research are often presented and accepted as if all social groups experiencing historical trauma, particularly American Indian people, would become susceptible to dysfunction or exhibit other signs of psychological or social distress (Denham, 2008).

Prior to colonization, AIAN nations relied on traditional cultural knowledge and traditions passed on by oral history through subsequent generations. An unintentional result of western colonial expansion was the decline of Native populations by infectious disease and loss of language and traditions and incorporating transgenerational fear of Western healthcare and medicine. In many Native communities, rates of suicide, alcoholism, and domestic and sexual violence are far higher than national averages and, in some communities, have increased during the last 20 years (Kirmayer, Gone, & Moses 2014).

"A focus on community resilience moves beyond personal traits and abilities to emphasize systemic and structural issues that might be causes of or solutions to personal and community suffering. Examining community resilience is helpful in both recognizing the devastating effects of colonialism and genocide as well as recognizing the persistence and survival that American Indian communities embody today" (Vizenor, 2008).

To heal from historical trauma and the issues associated with forced assimilation, marginalization, religious suppression and forced residential/boarding schools which changed the culture of Native Americans, there must first be an acknowledgement of the traumatic history that has taken place. Respect and value of the diverse AIAN nations must resonate through mainstream culture, and an emphasis made on revitalizing culture through the perpetuation of traditional ecological knowledge and restoration of indigenous languages.

According to Palacios (2008), recognizing underlying historical legacies and the context of the Native population's experience can help us develop ways to provide the best and most comprehensive care for the AIAN communities aimed at eliminating health disparities and enhancing optimal health outcomes and life opportunities. The process for healing historical trauma warrants community discussions on social injustices, educational classes regarding native health and wellness, re-training on cultural

traditions and food ways, participation in religious activities promoting physical and mental health. A focus on success stories and the resilience of the AIAN community, can help to eradicate the grief of past traumas, and create new historical narratives for future generations.

New research has established that intergenerational trauma has important health effects, and **epigenetics** reinforces the ancient AIAN understanding that we are all related; global climate change confirms indigenous knowledge that an insult to the earth will be felt by the people who are living upon its surface. The lasting effects from residential schools play out in the lives of great grandchildren, and the daily stresses of poverty, abuse, and trauma have been established to shorten people's lives in a process that is known as weathering (Palacios & Portillo, 2009). In the AIAN worldview, environmental, physical, mental, and emotional health are all linked and interdependent, each requiring the other for wellness to exist. Using this model, if there is unresolved grief in the indigenous mind from the loss of land, trauma to body or family, then physical health will be fleeting (Walters, et al., 2011).

Existing Conditions for Each Health Determinant

Assessing health disparities of American Indian and Alaska Native (AIAN) communities is complex; health disparities may be related to cultural, genetic, historical, socioeconomic circumstances of persons and the places where they live and work, behavioral factors, as well as access and utilization of health care. We can tie together the impact of these multiple factors by examining specific health outcomes that act as canaries in the coal mines. These health outcomes act as proxy measures for the larger social determinants of health that impact the lives of the people in a specific group. Through measuring the disparate rates of disease and mortality through the study of **epidemiology**, we have a small window into the effect that economic stability, education, access to healthcare, neighborhood and environmental context, and food security have on the health of a community.

Epidemiology – Existing Data

In general, compared with other groups nationwide, AIAN adults are more likely to have poorer health, more unmet medical needs due to cost, and higher rates of diabetes, trouble hearing, activity limitations, experienced feelings of psychological distress in the past 30 days, and are more likely to be current smokers and drinkers compared to other adults. AIANs experience higher rates of risky behaviors, poorer health status and health conditions and lower utilization of health services. AIANs also face higher mortality rates from tuberculosis, chronic liver disease, cirrhosis, accidents, diabetes, pneumonia, suicide and homicide compared with other racial and ethnic groups. Substantial health disparities such as heart disease, tuberculosis, sexually transmitted diseases ad injuries are the leading cause of death. The prevalence of diabetes is higher among AIAN population (16.5%) than any other group; AIANs are 2.8 times more likely to be diagnosed with diabetes than other races in the US (IHS, 2015b).

AIANs have a shorter life-span than people from other races and ethnicities in the US due to these risk factors. AIANs in Santa Fe County live shorter lives than non-Hispanic Whites (NHWs); a boy baby born in 2016 will die six years sooner than a NHW boy, and a girl baby will die 2.6 years earlier. This difference in life expectancy extends throughout the lifespan until an individual is 85 years and older. For those who are very old, AIANs live longer- women live a full year longer and men life 6 months longer than NHW counterparts. The average age of death for AIANs in Santa Fe County in 61 years, a dramatic contrast to NHWs (74.1 years), but closer to the Hispanic/Latinx average age of death (67.4) years) (NM Department of Health Vital Statistics).

The leading causes of death in AIANS in the southwest reflect the national trends and help explain the younger age at death (See table 3.2: Leading Causes of Death). In AIAN men, accidental death, suicide and assault rate in the top ten causes of death; and in AIAN women accidental death rates third in contrast to sixth in NHW women. Likewise, chronic liver disease, kidney disease, and diabetes mellitus in both AIAN men and women can be connected to lifestyle factors that would contribute to earlier mortality, these are not seen at the same rates in the NHW population. Although these factors are present in the leading cause of death tables, it should also be noted that heart disease and cancer are present in the top two causes of death for women and second and third for men; closely paralleling the causes of death for NHWs.

Youth

Youth well-being in New Mexico has historically ranked very low. The ranking is based on 16 indicators, including measures of poverty, employment, housing, education, and health outcomes like birth rates, birth weight, health insurance status, and teen drug and alcohol abuse rates. In 2016, New Mexico ranked 49th, improving from 50th in 2015. (See Figure 3-2: AIAN Child Health in New Mexico).

M	AIAN	NHW
1	Accidents	Heart Disease
2	Heart Disease	Cancer
3	Cancer	Chronic Lower Respiratory Dz
4	Chronic Liver Disease	Accidents
5	Diabetes Mellitus	Stroke
6	Suicide	Suicide
7	Assault	Flu/Pneumonia
8	Flu/Pneumonia	Diabetes Mellitus
9	Stroke	
10	Kidney Disease	Chronic Liver Disease

F	AIAN	NHW
1	Cancer	Heart Disease
2	Heart Disease	Cancer
3	Accidents	Chronic Lower Respiratory Dz
4	Diabetes Mellitus	Stroke
5	Chronic Liver Disease	Alzheimer's Disease
6	Flu/Pneumonia	Accidents
7	Stroke	Flu/Pneumonia
8	Kidney Disease	Diabetes Mellitus
9	Septicemia	Kidney Disease
10	Chronic Lower Respiratory Dz	Septicemia

Table 3-1: Leading Causes of Death, AIAN & NHW (Source: Espey, et al., 2014)

Despite the higher rates of poverty and low insurance, the infant mortality rate for NHWs is 5.2/1,000 live births, 3.8/1,000 in the AIAN population. The birth rate for teens age 15-19 is 20/1,000 NHWs and 45/1,000 AIANs. It is important to note that teen birth rates should consider cultural factors, including the value given to young mothering in some AIAN communities.

The youth suicide rate for AIANs is also lower than in the NHW population, (AIAN- 4.4/100,000; NHW- 6.6/100,000), as is the infant mortality rate (AIAN- 3.8/1,000 live births; NHW- 5.2/1,000 live births) (Annie E. Casey Datacenter). Statewide rates

(all races/ethnicities) for teens ages 12-17 who have abused alcohol or drugs in the past year are improving, from 10% in 2009/2010 to 5% in 2013-2014.

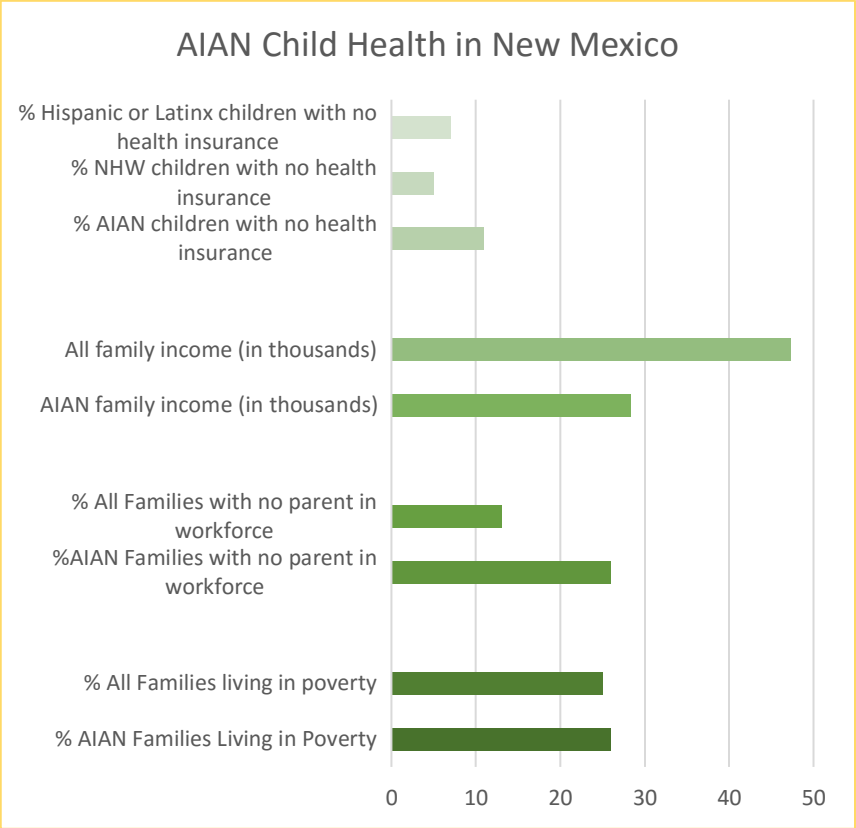

Figure 3-2: AIAN Child Health in New Mexico

Women's Health

Women's health is closely tied to child health in some measures. Prenatal care and normal birthweight babies are both metrics that indicate important factors about a mother's health- small babies may be premature or have experienced intrauterine growth restriction, a condition that occurs from problems with the placenta, the mother's health, or the baby. Mothers who smoke cigarettes, use drugs or alcohol are more likely to have low birthweight babies. Very young mothers also tend to birth smaller babies (http://www.stanfordchildrens.org/). Mothers who receive prenatal care during pregnancy are less likely to birth low birthweight babies, making this an important indicator of a woman's access to care and overall health at the time of her child's birth. AIAN and NHWs in New Mexico share the same percentage of normal birthrate babies, with 92% of babies born to both races at normal weight (Annie E. Casey Datacenter).

Adult Health

Adult health among Urban AIANs is defined by striking health disparities. AIAN's in the southwestern US are 2.6 times more likely to die between the ages of 25-44 than NHWs, and 50% more likely to die between the ages of 45-64 (Espy et al., 2014). This difference in lifespan can be attributed to many factors, starting with the social determinants of health, also known as the context in which a person lives, works, grows, and ages. AIANs have higher rates of poverty, unemployment, homelessness, and are less likely to own their own homes (NUIFC, 2015). These social determinants of health contribute strongly to poorer health outcomes, either directly through poor access to healthcare, or indirectly by increasing risk for mental illness, alcoholism and drug abuse, chronic stress, obesity, and other conditions that then lead to life-limiting health conditions like diabetes, heart disease (and metabolic syndrome), hypertension, liver disease, cerebrovascular disease, and cancer.

From 2011-2014, the leading causes for AIANs hospitalization in Santa Fe County closely mirror the global health picture that has emerged surrounding AIANs, particularly when examining health with the consideration of all influencing factors (See Table 3-3). This is the goal of a holistic health impact assessment-taking the broad view from the social, economic, and political factors, living and working conditions, public services and infrastructure, individual behavior, and individual factors.

The causes for hospitalization for AIANs in Santa Fe County reflect a community that is living with major health concerns stemming from **health disparities** across the social determinants spectrum, such as mental health and alcohol/substance use concerns (unintentional injury, psychosis, suicide, anemia, assault), obesity (heart disease, cancer, diabetes mellitus, cholelithiasis), and poor access to healthcare (septicemia, cancer, bowel obstruction, essential hypertension).

Three leading concerns for AIANs in Santa Fe are cardiovascular disease, cancer, and diabetes mellitus. In northeast New Mexico, almost three times as many AIAN men as NHW men had been told they had angina or heart disease, the rates were close to even for AIAN and NHW women (AIAN women- 1.3% compared to NHW women- 1.5%). Cancer **incidence** for AIANs is lower than in NHWs, but the **mortality** rate is higher, this difference in mortality indicates a clear disparity in access to care for AIANs.

Leading Causes for Hospitalization, Santa Fe County- AIAN:

1. Septicemia
2. Heart Disease
3. Cellulitis
4. Psychosis
5. Pneumonia
6. Fractures
7. Malignant Neoplasm (Cancer)
8. Diabetes Mellitus
9. Cerebrovascular Disease
10. Complications of Surgical and Medical Care

Figure 0-3: Leading Causes for Hospitalization, Santa Fe County- AIANs

Mental Health

Depression is one of the most common mental health disorders and is a risk factor for suicide and suicide attempts. Nationally, AIAN communities have higher rates of depression than any other racial group. According to the World Health Organization report, American Indian adolescents have the highest rate of suicide among 15- to 24-year-olds in the United States (34 per 100,000, compared to 11 per 100,000 for the overall U.S. population), and that suicide has been the second leading cause of death for American Indian youth ages 15 to 24 for the past 20 years (U.S. Department of Health and Human Services, 2004). American Indian youth are also more likely to have substance abuse problems, including starting to drink at a younger age and experiencing negative consequences of using substances (Beauvais, 1992, 1996). In Santa Fe County, frequent mental distress (past 30 days) was reported at a rate of 14.3% for AIAN people compared to 11.8% for NHW people (NM Dept. of Health).

In Santa Fe County, **alcohol** is a factor in **more than twice as many** American Indian/ Alaska Native **deaths** than in non-Hispanic whites.

AIAN communities are most at risk among all racial/ethnic groups in New Mexico for alcohol and substance abuse related deaths. Research shows that AIAN youth are initiating alcohol and drug use earlier than their non-native counterparts (NMIBIS). In Santa Fe County 94.7/ 100,000 of AIAN deaths are related to alcohol, compared to 39.7/ 100,000 of NHW deaths. In addition, 20.4/100,000 of AIAN deaths are related to unintentional drug overdose compared to 20.6/100,000 of NHW deaths in Santa Fe County.

Suicide is a devastating and all too frequent event among AIAN people. Risk factors include mental health disorders and substance abuse (IHS, 2015b). In the state of New Mexico, suicidal behaviors are a serious public health problem and a major cause of morbidity and mortality. In 2014, suicide was reported as the eighth leading cause of death in New Mexico; and the second leading cause of death for persons 15-39 years of age. In Santa Fe County AIAN people had a suicide rate of 5.4% compared to 25.4% for NHW people (NM Dept. of Health). The lack of adequate funding and barriers to accessing health care, especially mental health and substance abuse treatment restricts the availability of services. Limited access to behavioral health services, adverse childhood events, stigma associated with seeking care for emotional distress, and the normalization of substance use disorders have all contributed to high levels of mental health disorders in the AIAN population nationwide.

Sexual Health

Like most other health conditions, sexual health in AIANs features observable disparities in comparison to NHWs. Nationwide, rates for chlamydia, gonorrhea, and secondary syphilis are 1.2 to 4.6 times higher than those rates for NHWs (IHS Surveillance Report- STDs, 2014). Although young women are most affected, rates continue throughout the lifespan, with rates for most sexually transmitted infections at more than double that of NHWs in both men and women for chlamydia and gonorrhea in older adults (ages 45+) in the Albuquerque area. More than 1/3 of AIAN men and women have been tested for HIV/AIDS, according to Behavioral Risk Factor Surveillance System surveys (NM IBIS, 2012; 2014), which is slightly fewer than in the general population (45%) (CDC, 2010).

Pathways Diagram

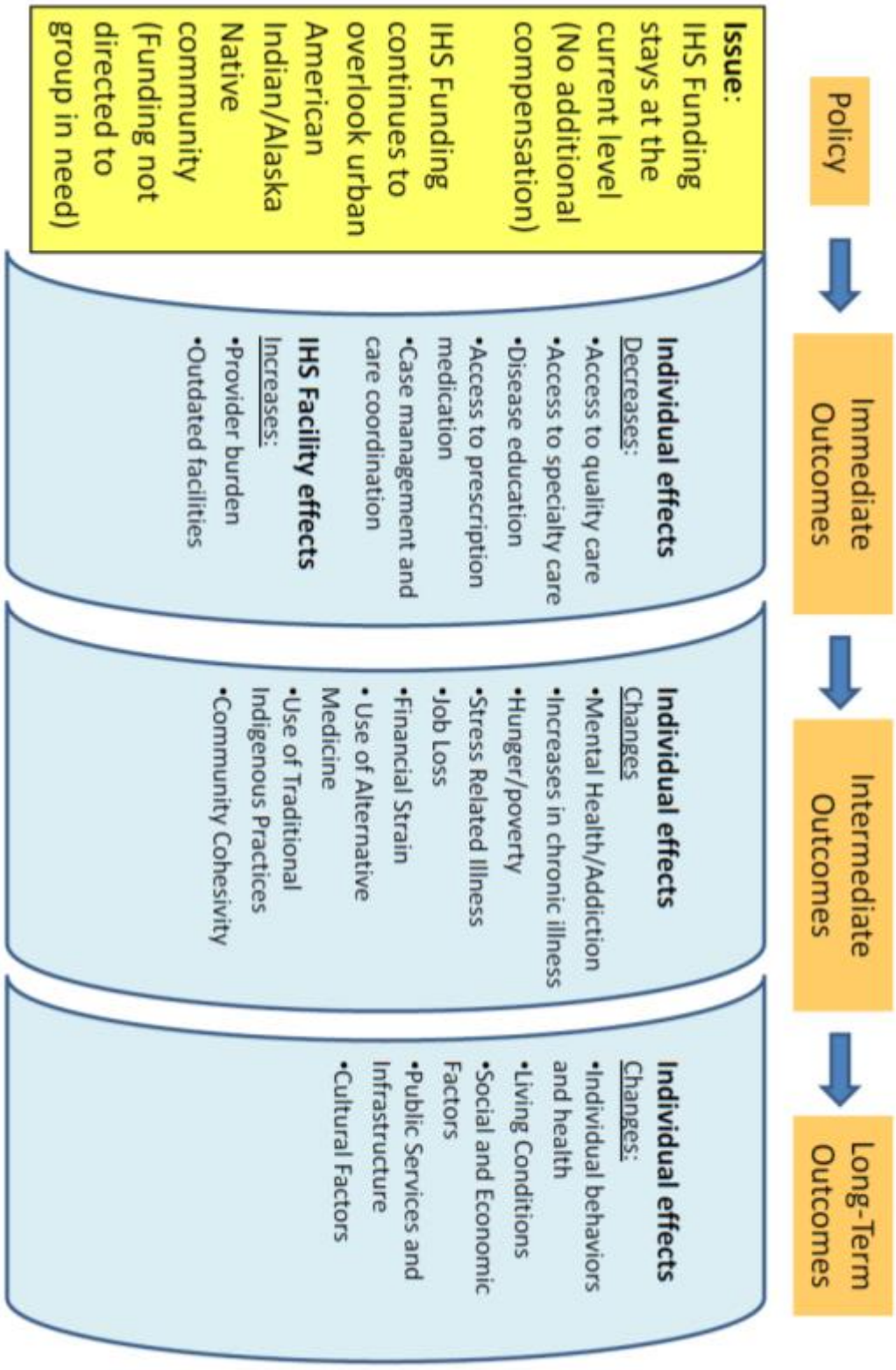

Figure 3-4: Pathways Diagram

Chapter 4: Assessment and Impacts

Methodology and how the Community was Involved

We conducted a review of existing data to form an understanding of the health status of AIANs in the southwest and nationwide. Data sources included the IHS website and fact sheets, the
Santa Fe IHS, the New Mexico Department of Health, the Centers for Disease Control, the Annie E. Casey Kid's Count! Annual Report, the Surveillance, Epidemiology, and End Results Tumor Registry, the Joint Commission, and the New Mexico Department of Vital Statistics.

We obtained a 65-page needs assessment survey bank of questions from the Southwest Tribal Epidemiology Center. In a series of meetings with the Advisory Board, we reviewed the full survey bank and we identified the key priorities for the HIA. During those meetings, we narrowed the survey questions to those which addressed our priorities (See Table 4-1: Community Advisory Board Priorities). The revised survey was 12-pages long and included multiple choice, yes or no, and ranked items as well as fill-in the blank or short answer questions. The survey was available in pencil and paper and online formats. We provided all survey participants with a $5.00 gift card in recognition of their time.

We also interviewed a subset of participants who indicated interest in participating in a qualitative interview. These conversations took place over the phone or in person and lasted 20-60 minutes. People who volunteered for an individual conversation received a $50.00 gift card in recognition of their time and contributions to the project.

Community Advisory Board Key Priorities (not ranked)

- Diabetes
- Cancer
- Preventable disease
- Poverty
- Violence in the home
- Cardiovascular disease
- Behavioral health (substance use/ abuse & mental illness)
- Obesity
- AIDS/ infectious disease
- Sexual health
- Healthy behaviors
- Cultural knowledge and behaviors

Table 4-1: Community Advisory Board Priorities

We compiled the data we collected from the existing resources with the data from the surveys and interviews for analysis. We analyzed the data for overall trends in the data as well as general and specific descriptive statistics. Our analysis was guided by the Advisory Board, with feedback as to which areas were most concerning to the community at large and which of our results might be best explored at more depth. This process was completed with the guidance of the New Mexico Health Equity Partnership – Santa Fe Community Foundation, a key partner in the generation of this report and recommendations.

HIA Survey / Focus Group Demographics

We collected 165 surveys over a four-month period in the summer and fall of 2016. Surveys were distributed at community events, through members of the Urban AIAN community, and through online distribution via a web-based data collection tool (REDCap). We did not require all questions to be completed in the survey, so response totals do not always equal *N*=165.

Survey Results: Demographics

There was nearly a 2:1 female to male ratio of respondents. Survey participants ranged in age from 18 to 80, with a mean age of 44. However, most participants were between the ages 35-44. The next largest age group was born between 1960-1969 which represented 19% of survey participants. The third largest age group was born between 1970-1979 representing 18% of the sample.

When asked, "What best describes you?" 75% stated they are enrolled or registered member of a tribe/nation/pueblo. 7% were descendants of a tribe/nation/pueblo and only 4% of the respondents consider themselves to be part of a tribe/nation/pueblo, but were not enrolled (5% were none of the above). Of the survey respondents, 156 different tribes were represented. Most participants were from Pueblo, Navajo Nation/Diné, or Northern Plains tribes. 58% of respondents were from southwest tribes, 12% were from Northern Plains tribes, 10% were from Southern Plains tribes, 1% were from Pacific Northwest Tribes, and 19% gave no answer. There was some overlap of regions due to intermarriage across tribes.

Table 1. Demographic Characteristics

Characteristics	%	(*N*=165)
Gender		
Male	29.71	41
Female	69.57	96
Other	0.72	1
Age		
18-24	9.45	12
25-34	17.32	22
35-44	23.62	30
45-54	18.9	24
55-64	19.69	25
65+	11.02	14
Education Attained		
11th Grade	3.05	4
High School Diploma or GED	39.42	54
Associates Degree	23.36	32
Bachelors Degree	24.09	33
Masters Degree	3.65	5
Professional Degree	2.92	4
I prefer not to answer	2.65	5
Income		
< $10,000	17.91	24
$10,000-$19,999	11.94	16
$20,000-$29,999	13.43	18
$30,000-$49,999	19.40	26
$50,000-$74,999	9.7	13
More than $75,000	9.7	13
I prefer not to answer	17.91	24
Number of Children		
0	47.15	58
1	13.82	17
2	19.51	24
3	15.45	19
4	4.07	5

Table 4-2: Demographic Characteristics

Almost half of the respondents (47%) did not have children. Of those who did have children, they ranged up to 4 children, with a mean number of 1.2 and a median number of 2 children.

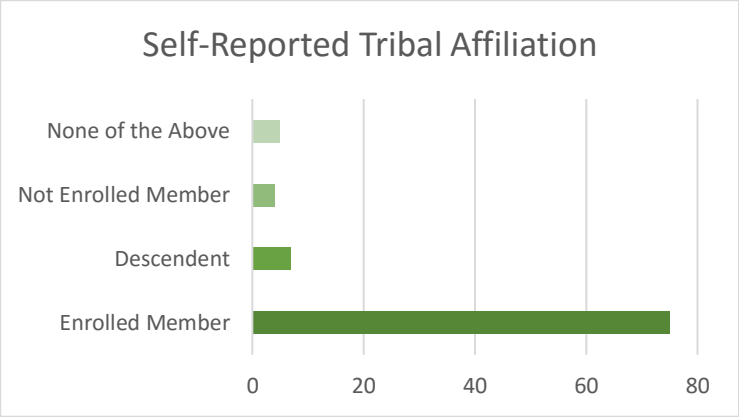

Figure 4-1: Self-Reported Tribal Affiliation

The average educational background for the sample is a high school diploma. Nearly 40% of the sample had a high school diploma or GED. Almost 65% of the respondents had either an associates or bachelor's degree, and another 9% had a graduate or professional degree. Average education was 13.5 years, or just a little less than an associate's degree. The average income was approximately $36,000, with 19% of the respondents stating they preferred not to answer, 18.6% earning less than $10,000/year, and the next largest group earning between $30,000-$49,999/year.

According to the Centers for Disease Control, a person's **body mass index (BMI)** represents a moderately accurate screening tool for weight category, and these categories have been correlated through health research to metabolic and other disease outcomes (CDC, 2015). BMI categories of underweight, normal or healthy weight, overweight, and obesity correlate to a person's percentage of body fat, although BMI is not a direct measure of body fat. The mean BMI for respondents was 30.2, indicating that the average fell within the obese range for body size category. When sorted by sex, men's body size was largely clustered in the overweight and obese ranges but women were clustered in the healthy / normal range and obese ranges (See Table 4-2: Percent of Respondents per BMI Category, by Gender).

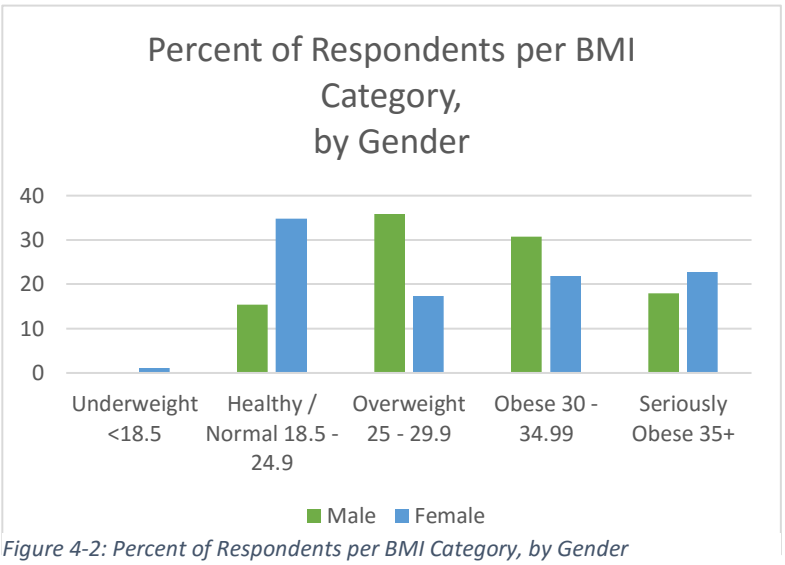

Figure 4-2: Percent of Respondents per BMI Category, by Gender

Community Health

In the survey, we asked people to rank their health concerns based on how important they felt the concerns were in their homes and in their communities. We also asked people to identify which health problems were present in their home, and what health problems they were currently living with. Based on their responses we learned about the health priorities for the Urban AIAN community, and the general wellness for the participants in the survey (See Table 4-3: Participant and Community Health, Ranked by Importance). Unsurprisingly, the highest priority for most of the participants was closely linked to diabetes. Across all categories, responses could be linked to diabetes or body size. The next trend we observed was the high ranking of conditions related to mental health and behavioral health. In five of the six categories, mental/behavioral health-linked responses ranked within the top four priorities for people as being concerning for their household or for their household.

Participant and Community Health, Ranked by Importance

Community Health

	Most Important Health Problem	%		Least Healthy Behavior	%		Most Negative Problem	%
1	Diabetes	62.79	1	Overweight	44.27	1	Chronic Disease	66.26
2	Heart Disease/Stroke	29.84*	2	Lack Exercise	41.54*	2	Poor Nutrition	52.76
3	Obesity	37.98	3	Alcohol and drugs	42.86	3	No access to quality healthcare	44.17
4	Suicide	28.57*	4	Poor Diet	37.3	4	Mental Illness	44.17
5	Cancer	31.5	5	Loss of traditional language	30.4	5	Lack of respect for AIAN culture	36.2

Household Health

	Top Health Problem in Household	%		Most Commonly Reported Diagnoses	%		Leading Health-Related Concerns	%
1	Overweight	54.94	1	Pre-diabetes	25.77	1	Weight	46.91
2	Diabetes	38.27	1	High Blood Pressure	25.77	2	Stress	46.3
3	Depression	34.97	2	Depression/mental illness	19.02	3	Affordable healthy eating/ cost of food	29.63
4	Cancer	14.72	3	Other	13.5	4	Out of shape, Barriers to exercise	27.28
5	Heart Disease/Stroke	12.27	4	High cholesterol	12.27	5	Diabetes/ kidney	15.48

Table 4-3: Participant and Community Health, Ranked by Importance

Although there is value in simply seeing what it is that participants view as important compared to their health concerns and conditions, there are larger public health implications to these data worth mentioning in this report. These statistics are important because they can be directly related to IHS and the experience of being an Urban AIAN. This discussion must be framed within the backdrop of the IHS as a treaty obligated right guaranteed to all AIANs who are enrolled members of federally-recognized tribes.

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Comparing the Urban AIAN health to the general population in Santa Fe reveals important disparities. Although the Urban AIAN respondents were similar in percentage reporting obesity (AIAN- 54%, NHW- 53%), the rate of self-reported diabetes diagnosis in the AIAN survey respondents was more than 3 times higher than in the NHW population (AIAN- 38%, NHW- 8%). Type 2 diabetes is closely linked to obesity, but the disparity in diabetes incidence between AIANs in comparison to similar NHWs is not easily explained by biological factors alone. The Santa Fe IHS does receive earmarked funding through the Special Diabetes Program for Indians (SDPI), which includes comprehensive diabetes training for clinicians, resources for patients and clinicians, and self-management education and support materials (IHS, 2014a). Despite these available resources, the Urban AIAN respondents still identified obesity, diabetes, and access to quality healthcare as major personal and community concerns. This result may be due in part to perceived issues with access to care and other knowledge gaps reported by the survey respondents. As one interview participant with diabetes stated:

> *Participant*: The doctors usually recommend that we see a nutritionist but ... like we don't know where to go from there.
> *Interviewer*: That's a good point. All right so, what would you like to see?
> *Participant*: I mean ... just basically somebody you can talk to, to develop like a plan, like an eating plan to help you know people like me with diabetes, so that we understand how the whole sugar thing works and stuff.
> *Interviewer*: OK. Would you be interested in classes on cooking or pamphlets, posters, what kind of things might be helpful to you, that you would like to see there?
> *Participant*: I think the pamphlets would be a good start. I would honestly want to go to classes because then it would give us like a hands-on experience so that way we can fully understand how that whole thing works. (Interview 13)

Additionally, heart disease and high cholesterol were highly ranked as health problems in the household or community. The SDPI has an associated Healthy Heart Initiative designed to build awareness around heart disease in IHS-serving communities. According to the 2014 IHS Report to Congress on the SDPI, the program has shown good success in improving diabetes and cardiovascular outcomes in AIAN communities. In Santa Fe County, heart disease is the third leading cause of death for AIANs, contrasting the data in the greater Southwest region, where heart disease falls second; cancer is the leading cause of death both locally and regionally (NMDOH, 2016; Espy, et al., 2014).

These results suggest that the Healthy Heart Initiative has been successful in improving awareness about heart disease, particularly in the ranking of heart disease as a higher concern than cancer in the community.

Even with good results from the Health Heart Initiative, for those Urban AIANs who cannot prevent cardiovascular disease through risk factor management, IHS has limited available resources. The facility can measure heart rhythms through electrocardiography, but patients must be referred out for treatment and management of suspected cardiovascular disease. For those who do not have health insurance or Medicare/Medicaid, this referral requires payment through Purchased/Referred Care. If ineligible, the patient must pay out-of-pocket. The following interview segment describes this situation:

> Well, like I said, some things like they don't have the equipment or they don't have the departments. That's why they sent a lot of us patients outside to see a private doctor. And then if you don't have insurance, or if you're not on Medicaid, you have to pay out-of-pocket. So, a couple of times, my husband- like he had to have a ... I think it was his heart. Something about his heart, and he couldn't afford to pay for that. So, he couldn't go to it. We didn't have the money to pay for the examination and for the visits. (Interview 11)

Finally, with the attention to diabetes and heart disease, it would be a mistake to overlook the fundamental concern participants had with obesity in their own households and in the community. Although not often discussed in this population, the Centers for Medicare and Medicaid Services (CMS) has approved bariatric surgery for the treatment of obesity in Medicare beneficiaries who have a BMI $\geq$ 35, have at least one co-morbidity related to obesity, and have been previously unsuccessful with medical treatment for obesity. In this survey, 21.4% of respondents had a BMI of at least 35. Although bariatric surgery is an approved treatment and has been shown to have good outcomes for the right patients, this option was not brought up by this sample. As the following participant quote shows, some care options are simply out of reach for individuals who have limited access to healthcare, regardless of their life-saving potential.

> *Interviewer*: OK would you suggest any changes that the doctors could do to make you feel better or to provide better health care for you?
> *Participant*: Oh yeah. I think they could do a lot of improvements, but I don't know what kind of improvements that could help me. I don't know for sure. But there are a lot of things that could be done for my health and if I ask them. I have a lot of weight and I ask them what else can I do, and 'there's probably nothing they can help me with'. They told me that, so I don't know. (Interview 10)

Food and Food Insecurity

Risk for diabetes is strongly correlated to body size. Although our nutritional assessment was not comprehensive, we did learn that respondents preferred water and coffee over soft drinks and alcohol, and the majority ate more meat than vegetables. The majority

(55%) ate more meat than vegetables. 65% of respondents frequented a fast food restaurant 5 times or fewer in the past 30 days, 22% visited a restaurant between 6-10 times in the same time period.

Another major concern for 87% of Santa Fe Urban AIANs is the cost of food and its nutritional value, while 53% indicated that they had to eat less or ration their food often or sometimes in the past 12 months because they didn't have enough money for food. For those who utilize Nutritional Services for themselves or their family, the most made use of: Food stamps (28%), Free or reduced school lunch programs (29%), school breakfast programs (18%) and Summer Food Services Programs (15%). Most respondents (89%) were concerned about the nutritional value of food, and 19% of respondents were unsure or didn't know if there was information about diet and nutrition in their community.

Mental and Behavioral Health

Unfortunately, mental health and behavioral health does not receive the same attention or federal funding earmarks as diabetes within the IHS system. In all categories, respondents ranked variables related to mental/behavioral health as concerning to their personal or community health. Depression, alcohol and drug use, stress, mental illness, and suicide were all ranked in the top four important problems or behaviors. Although the Santa Fe IHS does provide psychiatric medicine and behavioral health care across the age span, there is no access to emergency care, inpatient psychiatric care, addiction medicine, or long term alcohol or drug treatment. The selection of mental/behavioral health as a leading health concern for the respondents suggests this is an unmet need for the Urban AIAN community in Santa Fe. In a ranked list of 10 health care services not currently being offered by the Santa Fe IHS, substance abuse detox ranked 6th on the list, with 23% of the respondents indicating this as a priority need.

Survey Question 29: Please indicate which of the following services you would like to see offered at the Santa Fe Indian Health Service Hospital.

	Ranked List	% Selected
1	Dental Specialists: Oral Surgeon, Periodontist, Endodontist	39.26
2	Same Day Surgery	38.04
3	Obstetric Care	34.97
4	Colonoscopy/Endoscopy	29.45
5	Mammogram	28.22
6	Substance Abuse Detox	22.70
7	Integrative Medicine (acupuncture, massage, guided imagery, Chinese Medicine)	20.86
8	Dialysis	21.47
9	Podiatry	17.79
10	Inpatient Psychiatric Unit	15.95
11	Other	4.91

Table 4-4: Ranked Wish-List of Services Not Currently Offered

In interviews, respondents frequently discussed their unmet needs for mental health care. Availability of quality behavioral and mental health care was recognized as a gap in the Santa Fe IHS system. Respondents discussed their ability to access some care, but identified limitations in the care- there were few providers,

there was a poor match in personalities with the providers, and there was a perceived stigma felt by patients from some providers. Respondents also described limitations in treatment for chemical addictions, most notably treatment for alcohol abuse and drug and alcohol prevention programs. As one interview participant reflected, putting a stronger emphasis on mental health from an indigenous perspective could have radical implications on community health:

> If you're mentally healthy, then you know how to be physically healthy, spiritually healthy, working with your mind to make your mind healthy, your child's relationship, your relationship with your spouse, your mother. You need to give your mind what it needs to answer the questions in your head. Am I doing it right? Am I going in the right directions? (Interview 2)

Access to Care

Access to healthcare is an important predictor for the overall health of a community. Through the ACA, the Urban AIAN community should have better access to care than ever before. New Mexico is an exchange state, allowing residents who qualify access to Medicaid. This is particularly salient for the Urban AIAN community, for whom annual income is considerably lower than the general population. For those who do not have employer-provided health insurance and do not qualify for Medicaid, subsidized health insurance allows for affordable health insurance available through a state-based marketplace.

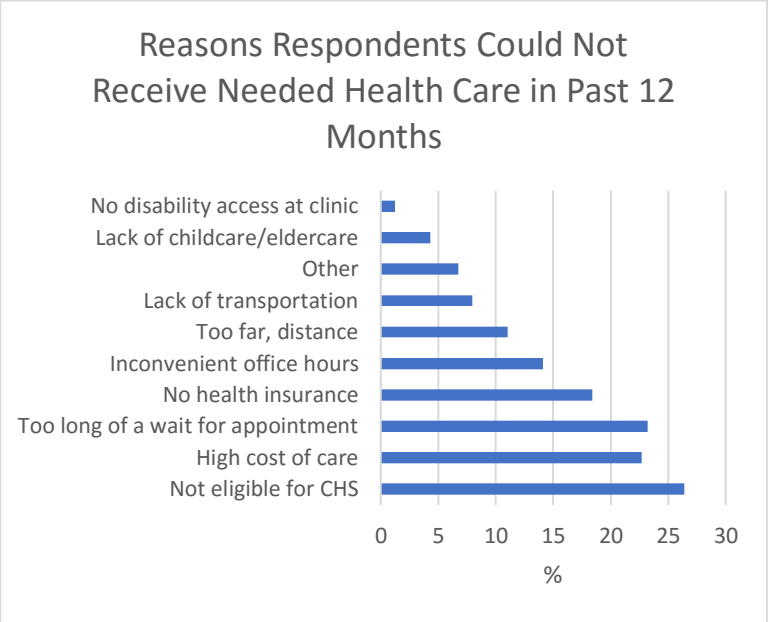


Table 4-5: Reasons Respondents Could Not Receive Health Care

Understanding that healthcare access is a key social determinant of health, we used a range of questions to assess healthcare access; including questions about insurance coverage, transportation, access to P/RC, denial of care from IHS, preferred health care provider, and number of months without health care in the past year. We also asked about basic usage, including healthcare provider of choice, last physical, and frequency of scheduled preventative care. While there is health insurance available to the respondents through the ACA, access to healthcare was identified as an issue for a portion of the respondents.

We learned that a large percentage of the community was making use of available resources for health insurance, including Medicare (16.5%), Medicaid (34%), and employer provided insurance (25%). Only 13.5% of respondents claimed no insurance

coverage. Almost two-thirds of the respondents preferred seeking healthcare from IHS, followed by 11% who go to the emergency room and another 11% who go to a private physician. Yet more than half (54.6%) stated that there had been a time in the past 12 months when they needed healthcare but could not get it. The most common reason for not receiving healthcare was because the respondent was not P/RC-eligible (See Appendix G for eligibility criteria) 29% of respondents had been denied care at IHS in the past, and 53% had put off seeking care for a condition because it could not be treated at the Santa Fe Service Unit IHS Hospital.

> "I've never had insurance. I did have it for a year, but then the premiums went up so I dropped it. I know a lot of people complain, but I'm really grateful to have it. I've never lived in my own service area so I've never lived in a place where I had full access. **As an adult, looking back, the number one thing I wish would happen is that the federal dollars would follow us wherever we lived instead of being allocated to where our tribes were.**" Interview 4

While access to P/RC was the most glaring barrier to care that emerged from the qualitative and quantitative data, respondents also described other systems-oriented barriers that further complicated patient efforts to receive care from the Santa Fe IHS hospital. While their overall satisfaction with the care provided was good and opinions about the individual health care providers were overwhelmingly positive, respondents described a health care system that was replete with bureaucratic processes that functioned as barriers to seeing these health care providers.

In the survey, respondents were asked to write in answers to the following questions:

1) What are the strengths and assets of the Santa Fe IHS Hospital?
2) What barriers, if any, do you see to receiving health care at the Santa Fe IHS Hospital?

From these two questions, we learned that the respondents feel very positively about the IHS hospital staff and healthcare providers. They had specific praise for their clinicians and stated that the staff is friendly, helpful, knowledgeable compassionate, and dedicated. The data reflected a **strong sense of ownership for the Santa Fe Area Unit IHS Hospital**, with respondents observing that the hospital holds history and tradition, provides a sense of community, and has a feeling of home. A recent remodel and update of the appointments system was seen a positive change, although some noted that there was a lack of appointment availability with the new system, and others felt that there have been frequent shifts in the appointments system making it difficult to keep track of how to best get in to see a clinician. Survey data supported the overall satisfaction data, with almost 50% of respondents indicating they were satisfied or very satisfied with their health care, and only 12% indicating dissatisfaction. Although these data vary from those collected by IHS, they reflect a wider sample that includes responses from individuals who have made the choice not to use the Santa Fe IHS facility due to their dissatisfaction with the care.

"The biggest [barrier] is in not being contract eligible. Lack of state of the art equipment, Lack of full Federal funding for all Native Nations equally. Indian Health Services isn't what it claims, because their internal policies call for discrimination of one tribal group against another..."
– write in response

Despite the positive feeling for the hospital, respondents provided rich detail regarding barriers to care within the system. Predictably, limited availability to specialty care due to the P/RC payment system and limited budget was highly criticized. Additionally, respondents commented frequently on the lack of available services, or on the diminishing services available through the hospital. For some, these limitations were perceived as discriminatory against out-of-service area tribes. This was particularly evident amongst participants who self-identified as Navajo in their comments.

Some respondents noted in their comments that the sum effect of the barriers to care was delay or avoid seeking care when possible.

"Navajos don't qualify for a lot of services, even though we've been going there for over 20 years. We have to go to Gallup or [an]other hospital."
– write in response

"They take too long, and have very limited services, other than common colds. They usually just give you ibuprofen and send you home. **I only go there if I'm deathly ill and have no other choice."**
– write in response

Preventative Care

The US Preventive Services Task Force recommends that men and women screen for lipid disorders (high cholesterol) starting at age 20 if they are at increased risk for coronary heart disease. As risk factors include the presence of obesity, diabetes, or a family history of cardiovascular disease before age 50 in male relatives and age 60 in female relatives, and because heart disease is a leading cause of death in this population, cholesterol screening is indicated for a large portion of the people who responded to the survey. To get a sense of preventative care usage, we asked participants to recall their most recent screening tests commonly done as part of regular primary care. Our survey asked if they had a cholesterol test 1-3 years ago, 4-5 years ago, 5+ years, not sure, or never. Of the respondents, 55% of men and 64% of women had been screened in the past five years and 18% of men and 4% of women had a cholesterol test 5+ years ago.

We also asked respondents when they had last visited a doctor for a routine checkup, which we distinguished as being separate from an exam for an illness, injury, or

condition. 83% of the respondents had seen a provider for a routine checkup in the past two years, with the sample indicating that women were seeking regular health care more frequently than men and people between ages 25-44 seeking fewer checkups in the past year than in other age groups. These results suggest that while there are barriers to care, self-reported primary care access is high, allowing for good preventative care opportunities within those people who responded to this survey.

> Our treaty rights gave us that care. My address limits me from having access from the things that my fellow tribal members have access to. That really bothers me. **I just think, overall, it's a 19th century way of looking at a 20th century problem.** Our populations have shifted in such a dramatic way. Our populations are more urban than they are reservation, policy-wise, that needs to be considered. I don't know how, what the solution is, I just know that it doesn't work for complete care. God forbid you need surgery and you don't live in your service area. **That's what they gave up all their land for, for crying out loud.** (Interview 4)

Impact Predictions

In assessing the variables measured in this HIA, we evaluated the outcomes and social determinants of health that we determined could be impacted by the recommendations proposed based on this work, as described in the Impact Predictions Table (see Table 4-6: Impact Predictions Table).

Impact Predictions Table					
Health Indicator	**Direction***	**Magnitude**	**Severity**	**Likelihood**	**Distribution****
Health Outcome: High-acuity co-morbid conditions (examples: metabolic syndrome, cancer + heart disease, alcoholism + diabetes)	Negative. High acuity co-morbid conditions ↑ due to rising costs of healthcare and ↓ access to affordable specialty care.	Medium-High. Aging population + ↓ access to preventative care, and a ↑ portion of the population unable to access PRC= ↑ high acuity co-morbid conditions (expected impact unknown due changing administration)	High. high-acuity co-morbid conditions are additive = creating life-threatening conditions with long term side effects or fatal. *Frequently are preventable or can be mediated if managed in early stages.*	Likely. Due to the high %age of the sample who rely on IHS for healthcare yet are ineligible for PRC= ↑ likelihood of ↑ impact over time if no change to existing policies.	Self-pay insurance holders who are PRC-ineligible All PRC-ineligible IHS patients
Social Determinant of Health: Food Insecurity	Negative. ↑ poverty + and ↓ water + ↓ agriculture + ↑ cost of food and housing	Medium. ↑ costs of food = increased fat, salt, sugar, and carbohydrate intake with ↓ nutritional value.	High. Malnutrition = high blood pressure, diabetes, ↓ dental health, ↓ mental health, ↓ wellness. Prolonged malnutrition = serious vitamin deficiency and developmental delays in children.	Likely. Economic, educational, and health access contribute to ↑ food insecurity	AI/AN population living within the region.
Health Outcome: Mental illness/ addiction/ chemical dependence	Stable to Negative. ↑ poverty +	Negative. Chemical dependency = ↑ burden on AIAN community currently. ↑Suicide rates = ↓ cycle of mental illness	High. Mental illness, chemical dependency contributes to ↑ comorbidity, community distress, intimate partner violence, mortality	Highly Likely. Current Problem considered crisis in many communities	All AIANs
Social Determinant of Health: Access to Health Care	Negative. health conditions are likely to ↑ due to ↑ costs of healthcare + ↓ access to affordable specialty care.	Medium-High. Burden of health care costs leads to ↑ rates of stress = ↑ stress-related illness.	High Urban AI/AN patients unable to access needed specialty care = ↓ oral health, ↑ cancer and heart disease morbidity/ mortality, ↑ behavioral health issues- addiction, ↑ premature death from accidental poisonings, homicide, automobile accidents (alcohol/drug abuse correlates)	Likely. IHS is at 50% of funding, ↓ funding for Urban AIAN community	Urban AIANs, but does impact all AIANs who use IHS and family members of AIANs who use IHS

* Direction indicates how this variable will most likely trend if changes are not made to existing policy. **Distribution indicates the population most likely to be impacted by the current policies

Table 4-6: Impact Predictions Table

Chapter 5: Recommendations

We submit the following four recommendations for consideration based on the work from this HIA:

1. Fund the Indian Health Service at 100% of need.

Justification: AIANs experience a low life expectancy, with higher incidence rates of many preventable diseases. Funding the Indian Health Service (and Compact 638 centers) at 100% of need will allow the federal government to honor their treaty obligations with sovereign AIAN nations. Through provision of full funding, health outcomes will improve, allowing for longer life expectancy, better quality of life, and decreases in chronic illness for users of the IHS.

2. Address food insecurity through the creation of a Food Bank and expansion of Nutrition Services to meet the needs of the Santa Fe Service Unit IHS Hospital community.

Justification: Food insecurity was identified as a serious problem for more than half of the survey respondents in this HIA. Extending regional resources to create a food bank that operates from the Santa Fe Service Unit IHS Hospital will bring needed nutritional resources to the community where they can easily access them. Extending nutritional services beyond the Special Diabetes Program Initiative (SDPI) will allow for nutritional education that reaches the full IHS audience long before diabetes prevention is an imminent concern, maximizing preventative health. This will improve overall health in the community and broaden nutritional health within the community.

3. Increase IHS funding to improve mental and behavioral health programs.

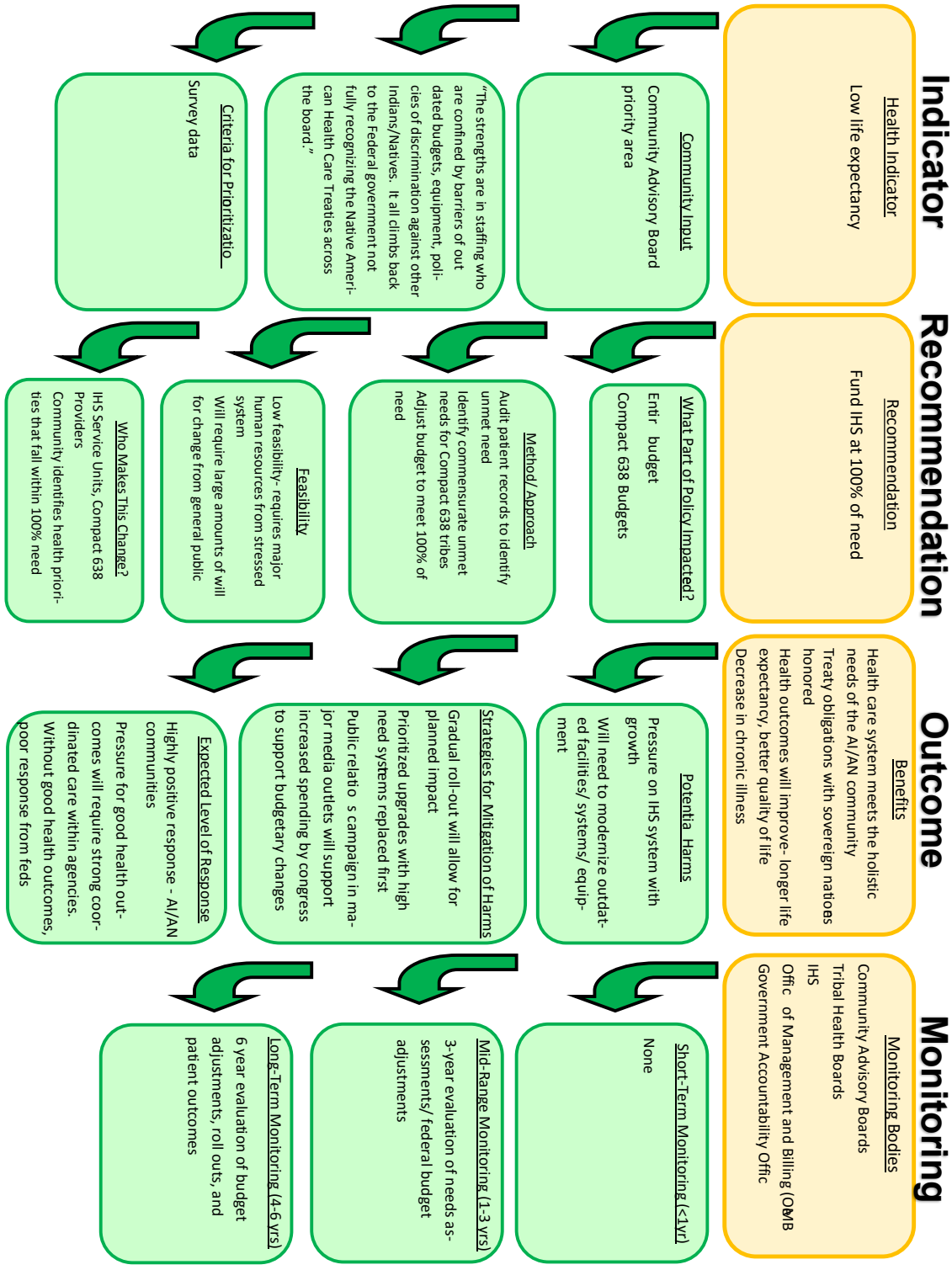
Justification: Mental and behavioral health needs were identified as specific concerns by respondents in this HIA. While there are some limited services available, we recommend that funding increase to mental and behavioral health programs to allow for more access to periodic psychiatric care, couples therapy, inpatient and outpatient addiction services, inpatient and outpatient psychiatric care, and emergency psychiatric care. Benefits from addressing this need may include decreased rates of premature death from alcohol, drug abuse, and mental illness.

4. Eliminate Purchased/ Referred Care eligibility by area service unit and replace with funding that follows the patient.

Justification: Allocation and budgeting of P/RC funds based on Service Unit population does not account for the considerable AIAN population living away from their service unit. By changing this policy to link funding to the patient, the funding allows for more equitable distribution of payment for AIAN healthcare, allows for P/RC access for out-of- service-area AIANs which will improve health outcomes, and it would decrease use of urgent care, emergency room visits, and out-of-pocket healthcare costs for Urban AIANs.

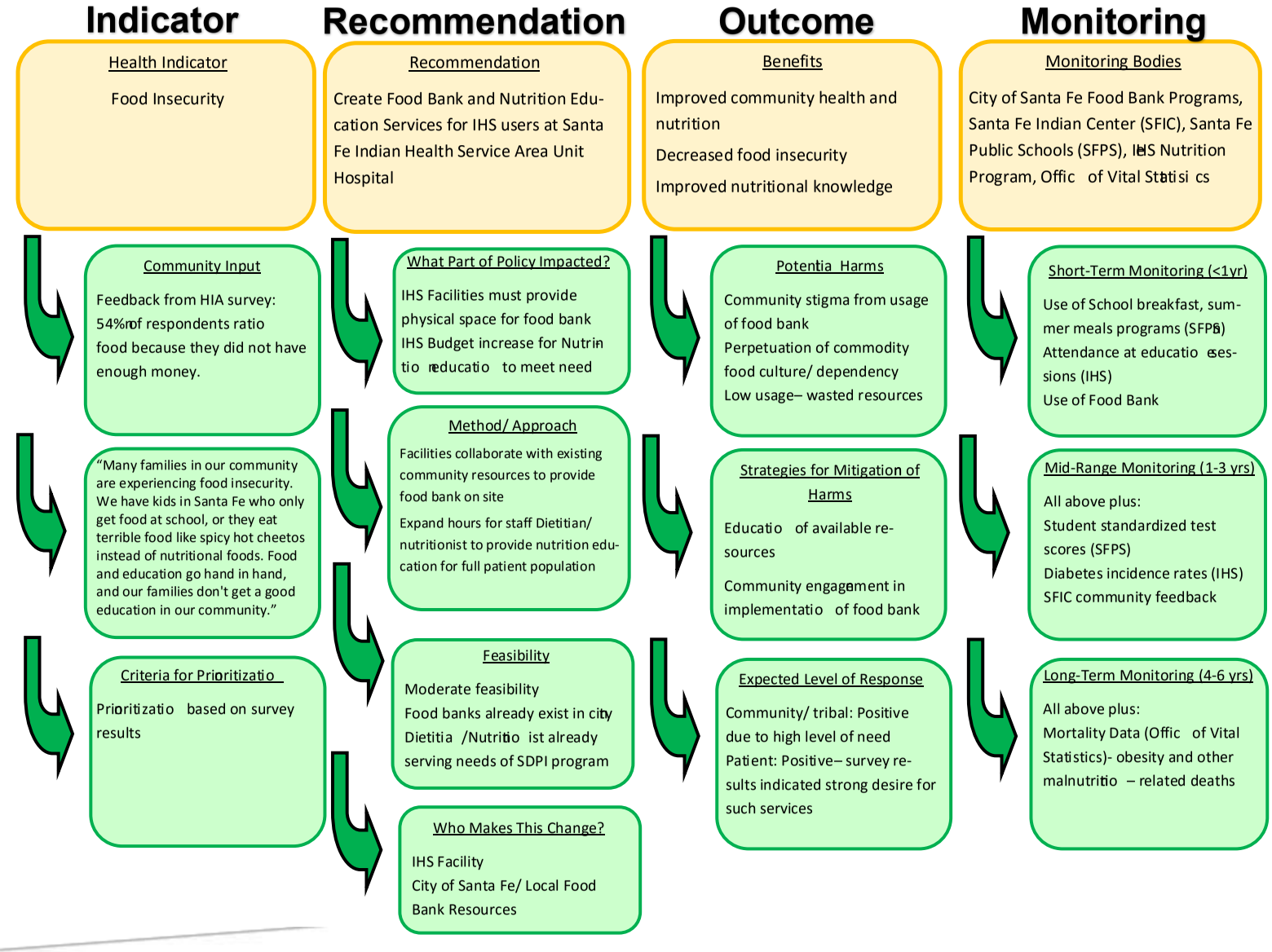
Recommendation 1

Fund IHS at 100% of need



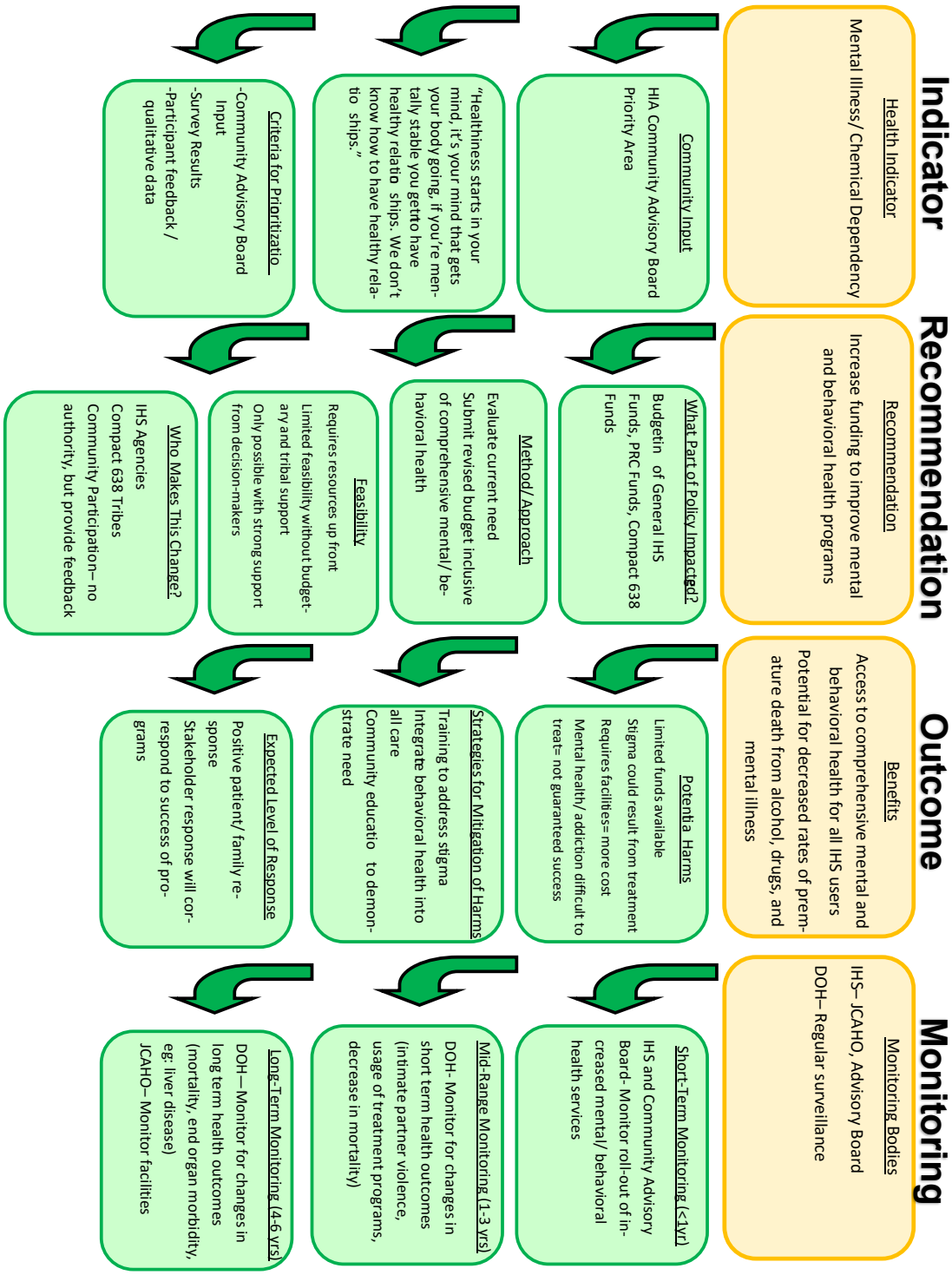
Recommendation 2

Create food bank and nutrition services for all IHS users at Santa Fe IHS Area Unit Hospital



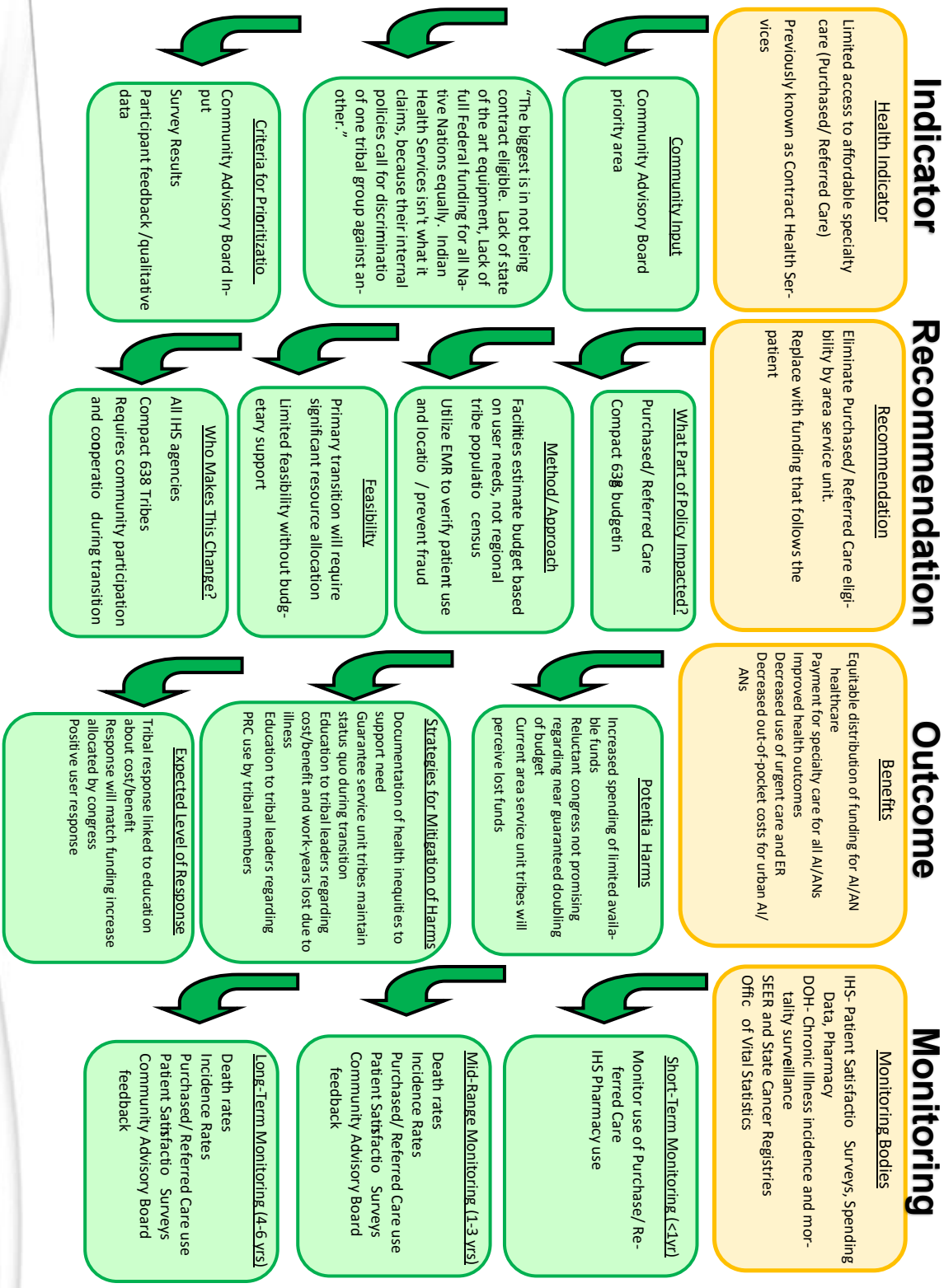
Recommendation 3

Increase funding to improve access to mental / behavioral health programs



Recommendation 4

Eliminate P/RC eligibility by area service unit and replace with funding that follows the patient



HIA Limitations

Although we did our best to collect a representative sample, because much of the data were collected in the summer these results may not include the unique perspectives of those AIANs who travel on the powwow circuit or those who spend the school year in Santa Fe at IAIA but return to their home communities during the summer. This research was also conducted in the summer of 2016, during which the Dakota Access Pipeline protests were taking place. We may have missed the perspectives of those individuals who were participating in activist activities related to that action. As is common with research with AIAN communities, this research does not reflect the opinions or experiences of those individuals who chose not to participate in research for personal or political reasons. Unfortunately, there may be a high degree of overlap between those people who refrain from accessing IHS services and those who participate in research, so it is noted that this voice is a gap in this report.

Conclusion

In conclusion, we hope that this report has demonstrated the need for increased funding for the Santa Fe Area Unit IHS Hospital to better support the population accessing the hospital. Through this research we learned that the Urban AIAN community has a strong tie to the Santa Fe Area Unit IHS Hospital, with trust in the health care providers, and a feeling of ownership for the facility. Even in an environment with multiple options due to the expanded services offered through the ACA, the Santa Fe Area Unit IHS Hospital is their preferred provider. We are grateful to the community and stakeholders who participated in this HIA, their enthusiastic support reinforced for us the high level of investment present in the community related to supporting this facility. We wish to conclude by expressing our gratitude to all those who have devoted energy, time, and expertise to the IHS, their service is what has made this facility the provider of choice for the Urban AIAN community, and one worth fighting for.

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Appendices

Appendix A: Glossary

Body mass index (BMI)- A person's weight in kilograms divided by the square of height in meters. A high BMI can be an indicator of body size/ obesity. BMI is often used as a screening tool for health conditions related to weight or nutrition disorders.

Community Advisory Board- A group of people from a community who serve as representatives of the community, The board may represent the general public or a special interest group from within that community. The board often acts as a go-between, relaying information between a research team and the community they represent.

Contract Health Services- Now known as Purchased/Referred Care is the system of payment for specialty care within the Indian Health Service. See Appendix B.

Dietitian- a health professional who has completed a 4-year bachelor degree in Nutrition and Dietetics or a 3-year science degree followed by a masters degree in Nutrition and Dietetics, and is an expert in prescribing therapeutic nutrition. Within the IHS, a dietitian must have at minimum a bachelors degree in dietetics.

Epidemiology- the study of patterns, distributions, and determinants of health-related states or events (including disease) and the application of this study to the control of diseases and other health problems (World Health Organization definition).

Epigenetics- the study of changes in organisms caused by modification of gene expression rather than alteration of the genetic code itself: *epigenetics has transformed the way we think about genomes*. Epigenetics is particularly relevant in AIAN health because it establishes that trauma experienced in one generation can be passed down to the next generation through changes in gene expression.

Health disparities- The presence of unequal health outcomes, often due to political or social conditions that are outside of a person's control.

Health equity- attainment of the highest level of health for all people, with specific efforts made to ensure all people have full and equal access to any and all resources that would contribute to complete and total health.

Health promotion- A philosophy of wellness in which people are enabled and encouraged to take control over their health. This approach takes a public health perspective that looks beyond the individual to be inclusive of the social and environmental health of a community.

Incidence- From epidemiology. The number of new cases of a disease in a year. This should not be confused with prevalence, which is the number of total cases in a year. Incidence only counts those people who are *diagnosed* with the disease or condition in that year (or other set period of time).

Long Walk- The traumatic deportation of the Navajo (*Diné)* people from their ancestral homelands to the Bosque Redondo in eastern New Mexico in 1864. The 300-mile walk and subsequent internment at Bosque Redondo was a miserable failure from all persepctives.

Mortality- From epidemiology. The number of deaths from a disease in a year.

Nutritionist- non-accredited title used by individuals wishing to provide food and nutrition-related advice. This title is not regulated by law and training for nutritionists varies greatly. A Public Health Nutritionist may have a master's degree in Public Health Nutrition. Within the IHS, a nutritionist must have at minimum a bachelors degree in Nutrition Sciences.

Patient Protection and Affordable Care Act (ACA)- "Obamacare"- a federal healthcare policy that mandated healthcare coverage for all Americans, permanently authorized the Indian Healthcare Improvement Act, required that children be covered on their parent's insurance until age 26, mandated coverage for preventative care, and prevented insurance companies from denying coverage for pre-existing conditions.

Purchased/Referred Care- Previously known as Contract Health Services (CHS), Purchased/Referred Care is the system of payment for specialty care within the Indian Health Service. See Appendix B.

Rancheria- Designated tribal land, specific to California.

Social determinants of health- the conditions in a person's physical and social world that influence their health. These include but aren't limited to: the amount of money they have to live on, the amount and quality of food they have to eat, where they life, who they live with, their access to clean air and water, their housing, their access to education and employment, and their access to exercise, sunlight, and positive social interactions.

Social justice- A value or value system that asserts that all people are inherently entitled to equal resources, rights, and opportunities without imposed barriers to access in any predetermined manner. These values include the belief that it is the work of society to bring aid to those who do not have access to the resources they need.

Underfunding- In contrast to de-funding, when a program is eliminated completely, underfunding is the lack of funding to match the budgetary need. While de-funding will remove a program or force it to find other sources for sustainability, underfunding is a pernicious approach to fiscal management that slowly erodes a program over a period of time.

Appendix B: Purchased/ Referred Care Eligibility Criteria

An individual must first meet the eligibility requirements for direct care services at an IHS or tribal facility to be considered for Purchased/Referred Care (P/RC). An individual must meet the eligibility requirements as defined by Federal regulations published in Code of Federal Regulations (CFR), at Title 42, Section 136.21 through 136.25, and Indian Health Services, Part 2, Chapter 3, "Contract Health Services" dated January 5, 1998.
The most common reasons for a denial of Contract Health Services by Santa Fe IHS are:

- not living on or rear a reservation or within a contract health service delivery area (CHSDA),
- Lack of appropriate documentation of Indian descent
- Being diagnosed with a medical problem that does not fall within the medical priority set by the Santa Fe Service Unit
- Failure to apply for all other possible resources available to pay for care since IHS is the "payer of last resort"
- Failure to obtain prior approval from the Contract Health Office for non-emergency treatment by a non-IHS facility or provider
- Failure to notify the IHS facility within 72 hours of receiving emergency care at a non-IHS facility

Purchased/Referred Care (P/RC) funds are used to supplement and provide for other health care needs not available to eligible individuals seeking care at an IHS or tribal facility. Purchased/Referred Care may be denied for eligibility due to late or failure to submit notification requirements. Treatment for health care services are determined based on relative medical need and may be denied if not considered a medical priority, or where use of alternate resources is more appropriate.
Strict stipulations are required for Purchased/Referred Care (P/RC) funds to be applied. A 72-hour notification to the P/RC program must be made by the individual, provider, hospital, or someone on behalf of the individual in emergency cases where care is needed immediately. For the elderly and disabled (individuals that cannot physically/mentally notify the P/RC program), the notification requirement may be submitted up to 30-days.
(Reference:
https://www.ihs.gov/PRC/index.cfm?module=chs_requirements_priorities_of_care)
Priorities for contract health services are established by the P/RC. Priority of care covered by P/RC is determined by five levels of medical priority. Due to the amount of funding and the volume of need by the population, the P/RC can only provide authorization for funds to the highest priority medical services; Level I. These are emergency care services or services that prevent the immediate threat to life, limb, or senses.

The P/RC determines medical priorities levels as follows:

I. Emergent or Acutely Urgent Care Services: are diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual necessitate the use of the most accessible health care available and capable of furnishing such services. Diagnosis and treatment of injuries or medical conditions that if left untreated, would result in uncertain but potentially grave outcomes.

II. Preventive Care Services: are distinguished from emergency care, sophisticated diagnostic procedures, treatment of acute conditions, and care primarily intended for symptomatic relief or chronic maintenance. Most services listed as Priority Level II are available at IHS direct care facilities. If no direct care capabilities are available at the IHS or Tribal direct care facility, preventative services can be purchased using CHS funds

III. Primary and Secondary Care Services: include inpatient and outpatient care services that involve the treatment of prevalent illnesses or conditions that have a significant impact on morbidity and mortality. This involves treatment for conditions that may be delayed without progressive loss of function or risk of life, limb, or senses. It also includes services that may not be available at many IHS facilities and/or may require specialty consultation.

IV. Chronic Tertiary Care Services: are services that (1) are not essential for initial/emergent diagnosis or therapy, (2) have less impact on mortality than morbidity, or (3) are high cost, are elective, and often require tertiary care facilities. These services are not readily available from direct care IHS facilities.

V. Excluded Services: includes cosmetic procedures, although they may be granted if one of the listed procedures, normally considered cosmetic, is necessary for proper mechanical function or psychological reasons, and experimental or excluded services. Examples of payment for direct care services that cannot be reimbursed with CHS funds are on-call hours, after hours or weekend pay, holiday coverage (e.g., for x-ray, laboratory, pharmacy).

Elective Referrals Initiated by IHS Providers

Patients are often referred to outside doctors and specialists for consultation, outpatient care, inpatient care, or for elective procedures. All referrals are reviewed and authorized only when the care is deemed medically necessary and falls within established medical priorities. Further consultation may be considered necessary to determine whether the needed care is within established medical priorities, and potential morbidity of the individual.

Referrals are based on the condition and the rate of deterioration of the patient's condition, potential morbidity if the desired care is not rendered, whether the benefit from the evaluation or treatment is likely to cure or improve the condition, or if the procedure experimental or purely cosmetic. Individuals do have the right to appeal denial of payment and are offered opportunities for appeal.

P/RC funds are not expended for services accessible and available at IHS facilities. Access to P/RC funds requires that individuals must first apply for and use all alternate resources that are available such as Medicare A and B, state Medicaid, state or other federal health program, and private insurance. The Indian Health Services are considered a resource and therefore IHS is the "pay or of last resort" of persons defined as eligible for P/RC, notwithstanding any state or local law or regulation to the contrary.

Tribal members residing on their home reservation are eligible for health care at an IHS facility and P/RC service provider and coverage is extended up to 180 days from the date that an individual moves from their reservation to an urban area. After 180 days, health care coverage

continues at any IHS facility with the proper proof of Indian ancestry and documentation. P/RC health care coverage continues with the establishment of residency on another reservation.

Establishment of a new chart is required at the nearest IHS facility location of new residency. Some programs or portions of programs in a Service Unit area may be tribally operated rather than federally run, in which case the clinic or facility may restrict services to members of their own tribe. If a member of a federally recognized tribe tried to obtain care from a Pueblo operated hospital or clinic in New Mexico, they are likely to be denied care unless they were a member of that pueblo.

The Indian Health Service receives federal appropriations annually and differs in that it is not an entitlement program such as Medicare or Medicaid, and services paid by P/RC are not provided by HIS providers. A patient referral must be made, reviewed by P/RC, then determined as eligible, with life-threatening illnesses or emergency case injuries given highest priority. Unfortunately, the U.S. Congress has appropriated fund to cover an estimated 60% of health care needs, which means that the IHS formulary (list of drugs and medicines available from IHS pharmacies) may not include all drugs and medicines necessary for individuals. Surgeries health care or alternative treatments may not be paid for by the local Service unit, and funds from P/RC may also not be available based on funding.

Appendix C. Reporting

SF-HIA Communication Plan

The Santa Fe Health Impact Assessment has investigated the impact of underfunding which has forced the IHS to make serious cuts to available services at facilities throughout the country. This information will provide important insights on the health effects of the budgetary decisions made by the federal government on IHS, and can be used to inform tribal, city and state decision makers, as well as advocates and experts at the national level and in other states regarding future budgetary proposals.

Strategic Approach

The Santa Fe Health Impact Assessment goal is to partner with the Santa Fe Indian Center to use the HIA to support advocate for increased IHS funding by providing qualitative data on the positive and negative aspects of HIS health care. The report will also include the present needs and recommendations of the Urban AIAN community, as well as policy recommendations for the proposed federal legislation on the IHS annual budget.

A successful report rollout will achieve the following objectives:

- Provide data and research that informs discussions about health disparities in the Urban AIAN community
- Provide data and research that informs budgetary decision makers about the impacts of underfunding which forced the IHS to make serious cuts to available services at facilities throughout the country
- Inform public health advocates, tribal leaders, and leaders who will publicly support the HIA findings
- Provide the Urban AIAN community with a voice and opportunity to share their concerns and suggestions for building a healthier community

To achieve these objectives HIP will use the following approach:

- Conduct targeted media outreach to Indian community (Indian Country Today, the Navajo Times), and local and national news (CNN) reporter who can share the published findings and share the link to the SF-HIA
- Publish report, executive summary, and resource information on the Santa Fe Indian Center webpage, fb social media sites
- Release the report at a briefing at universities and public health forums where there are compelling panelists who will reach target audiences.
- Facilitate sharing and discussion of report findings with ally audiences

Target Audiences

- Tribal Council leaders of surrounding tribes

- Committee Members and administrative staff of Santa Fe IHS
- Governor of New Mexico
- Tribal communities of similar size throughout the United States

Partners and Allies – Who can provide also inform elected officials

- Santa Fe HIA Advisory Committee
- Santa Fe Indian Center Board Members
- Public Health Advocates and Organizations
- Public Health Funders

Activities

1. Conduct targeted media outreach to Indian community (Indian Country Today, the Navajo Times), and local and national news (CNN) reporter who can share the published findings and share the link to the SF-HIA
    - Simon Moya-Smith-Editor of Indian Country Today
    - Vincent Shilling-Author of Indian Country Today
    - UNM-College of Nursing
    - CNAH-list serve
    - Albuquerque Journal
    - Santa Fe New Mexican
    - CNN and MSN news

    Activities:
    - Contact journalist
    - Forward Executive Summary, Op-Ed, or press release

2. Publish report, executive summary, and resource information on the Santa Fe Indian Center webpage, fb social media sites

    Activities:
    - Contact webpage keeper of the SFIC and HEP websites
    - Forward Executive Summary
    - Encourage re-posting of blogs/guest blogging/social media posts of blogs

3. Release the report at a briefing at universities and public health forums where there are compelling panelists who will reach target audiences.

    Activities
    - Look for opportunities to be a panelist and events to brief public health advocates who may include:
        - University health leaders

- Physician s
- Member(s) of the report's advisory committee
- Tribal council representatives
- Public Health conferences and events

4. Facilitate sharing and discussion of report findings

   Activities
   - Draft a press release about Community outreach events
   - Work with HEP and members of the advisory committee to create an invitation list to distribute the report findings
   - Participate in community outreach events (target audience: AIAN community)
   - Email list includes state policymakers, the public health & health care communities, partners and allies

Timeline

Communications activities will occur between November, 2016 –January, 2017, before the annual IHS budgetary review begins. Communications materials should be distributed to local and regional tribal agencies prior to budget review process and ready to be distributed to similar size cities with high Urban AIAN populations.

Timeframe	Activity	Responsible party	Target Audience
Conduct targeted media outreach to Indian community (Indian Country Today, the Navajo Times), and local and national news (CNN) reporter who can share the published findings and share the link to the SF-HIA			**Media**
January	Reach out to media sources	VR, EH	
	Forward Executive Summary, Op-Ed, or press release	VR, EH	
Publish report, executive summary, and resource information on the Santa Fe Indian Center webpage, fb social media sites			**Media**
January	Contact webpage keeper of the SFIC and HEP websites	VR, EH	
	Forward Executive Summary to web sources and send via email lists	VR, EH	
	Encourage re-posting of blogs/guest blogging/social media posts of blogs	VR, EH	
Release the report at a briefing at universities and public health forums where there are compelling panelists who will reach target audiences.			**Health Allies and Decision Makers**
Jan 31, 2017	Look for opportunities to be a panelist and events to brief public health advocates	VR, EH	

Timeframe	Activity	Responsible party	Target Audience
	Forward Executive Summary, Op-Ed, press release, report	VR, EH	
	Set-up follow up meeting with Santa Fe IHS	VR, EH	
Release the report at a briefing at universities and public health forums where there are compelling panelists who will reach target audiences.			**Health Allies and Decision Makers**
Feb-March 31, 2017	Draft a press release about Community outreach events	VR, EH	
	Work with HEP and members of the advisory committee to create an invitation list to distribute the report findings	VR, EH	
	Participate in community outreach events (target audience: AIAN community)	VR, EH	
	Email list includes state policymakers, the public health & health care communities, partners and allies	VR, EH	

Appendix D: Evaluation and Monitoring

Although this HIA is dedicated to documenting a demonstrated need for budget revision that considers the health of the Urban AIAN community in Santa Fe, we would be remiss in submitting these recommendations without also suggesting a plan for monitoring. As these recommendations are diverse in their scope, the monitoring plan is correspondingly broad. Stakeholders are encouraged to engage in monitoring potential changes that may arise as a result of this HIA, and engage in continued revision of the monitoring plan based on new developments that occur over time.

Monitoring should consider the following factors:

- Human impacts- Are there changes to quality of life, economics, access to care?
- Structural impacts- Are there changes to implementation of healthcare policy at the local and national level?
- Policy change- What changes are taking place in the policy arena that may result in corresponding human or structural impacts?
- Historical variables- Are there changes in the political environment that hinder or promote implementation of recommendations?
- Actual Data- Inclusion of periodic data scans to capture real-time changes in health outcomes.

Indicator	Agency Responsible for Monitoring	Timing
Health Indicators		
Urban AIAN health outcomes	Department of Health, SEER, Indian Health Service, Office of Vital Statistics	Annual
Medication Expenditures	IHS Pharmacy, Medicare/Medicaid billing data	Annual
Death Rates	Office of Vital Statistics, IHS	Annual
Hospital use data (ER, Inpatient, Psychiatric)	Christus St. Vincents, Presbyterian, UNMH, DOH	Annual
Community Wellness		
Population growth/ change	City and County of Santa Fe	Annual
Job growth/ change	City and County of Santa Fe	Annual
Employment Rates	City and County of Santa Fe	Annual
High School Promotion/Graduation rates	Santa Fe Public Schools	Annual
Community/Cultural Cohesivity		
Participation in AIAN community Events	Santa Fe Indian Center	Annual
Health Policy		
Transition to per-patient funding for specialty care within IHS	Santa Fe Indian Center, Tribes, IHS, Lawmakers, Community Activists	Annual
Building improvements for IHS Facilities	IHS, Santa Fe Indian Center	Annual

Appendix E: Acronym Index

ACA – Patient Protection and Affordable Care Act (Obamacare)
AIAN – American Indian and Alaska Native
BMI – Body mass index
CDC – Centers for Disease Control
CHIP – Children's Health Insurance Program
CHS – Contract Health Services
CMS – Centers for Medicare and Medicaid Services
DHHS – Department of Health and Human Services
FDPIR – Food Distribution Program on Indian Reservations
HEP – New Mexico Health Equity Partnership
HIA – Health Impact Assessment
IAIA – Institute of American Indian Arts
IHCIA – Indian Health Care Improvement Act
IHS – Indian Health Service
ISDEAA – Indian Self-Determination and Education Assistance Act
NMDOH – New Mexico Department of Health
NSLP – National School Lunch Program
P/ RC – Purchased / Referred Care
SDPI – Special Diabetes Program for Indians
SFIC – Santa Fe Indian Center
SNAP – Supplemental Nutritional Assistance Program
WCMA – Washington Consulting & Management Associates, Inc.
WIC – Women, Infants and Children