

# Engaging American Indian and Alaska Native Medicare Beneficiaries: Senior Medicare Patrol Toolkit

## Prepared by International Association for Indigenous Aging

This toolkit was supported in part by grant No. 90SM0012 from the Administration on Aging (AoA), Administration for Community Living (ACL), U.S. Department of Health and Human Services (DHHS). Grantees carrying out projects under government sponsorship are encouraged to express freely their findings and conclusions. Therefore, points of view or opinions do not necessarily represent official AoA, ACL, or DHHS policy.

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# Table of Contents

## About the International Association for Indigenous Aging

The International Association for Indigenous Aging ($IA^2$) is a 501(c)(3) non-profit, educational association focused on improving the health and well-being of American Indians, Alaska Natives, and other indigenous people as they move through the aging spectrum. $IA^2$ works to:

1. Ensure the provision of appropriate and quality services and resources for indigenous elders;
2. Expand opportunities for elders' involvement in environmentalism, community participation, health maintenance, volunteerism and civic engagement, consumerism, and senior enterprise;
3. Enhance the protection of elders' rights, including their freedom from abuse and neglect and their right to autonomy;
4. Educate the public, policymakers, and practitioners about the status of indigenous elders; and
5. Improve the status of older people worldwide, especially for those in indigenous populations.

## Acknowledgements

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# Introduction

This toolkit provides a framework to assist SMP staff and volunteers in working with American Indian/Alaska Native (AI/AN) communities. We hope the toolkit will enhance your knowledge, abilities, and understanding as they pertain to Medicare fraud prevention and culturally appropriate outreach to AI/AN elders and communities.

Planning and implementing programs in American Indian tribes, tribal agencies, and urban programs requires specific knowledge and understanding of the history and cultural background of local tribes, and how differing communication styles may impact intended outcomes. This toolkit is intended to serve as a basic resource for organizations seeking to work with Native communities. Additional resources are listed within pertinent sections, as well as a section of resources at the end of the document.

The primary goals of this toolkit are to:

- Provide a brief summary of the key historical events, policies, and demographics related to AI/AN communities; and
- Provide tips about how to work effectively with AI/ANs.

# Chapter 1: American Indians/Alaska Natives

According to the 2010 Census, the phrase *American Indian or Alaska Native (AI/AN)* refers to a person having origins in any of the aboriginal peoples of North and South America (including Central America), and who maintain tribal affiliations or community attachments.

However, the widely accepted definition of an *Indian* comes from the Indian Health Care Improvement Act of 1976 which states, "An Indian is anyone who is a member of a 'recognized' tribe, with no mention of blood quantum. An individual may be considered Indian if he or she belongs to a tribe, band, or group that has been terminated since 1940, regardless of whether or not the individual lives on or near a reservation. Another category includes those members of tribes which are recognized now—or may be recognized in the future—by the state in which they reside. In addition, anyone who is a descendent, in the first or second degree, of any one of these individuals also qualifies. Eskimos, Aleuts, and other Alaska Natives are considered Indians. Anyone considered by the Secretary of the Interior to be Indian for any purpose qualifies. And finally, anyone who is determined to be Indian under regulations promulgated by the Secretary of Health and Human Services also is considered to be Indian." [1]

## Overview

The United States has a long-established, special political relationship with AI/ANs due to their tribes' statuses as **sovereign** [a] nations, as recognized in the U.S. Constitution. In exchange for land, and in compensation for the forced removal from their original homelands, the government promised, through laws, treaties, and pledges, to support and protect AI/AN people. This is known as the Federal Trust Responsibility.

AI/AN people are a diverse population, with 566 federally recognized tribes based in the rural and urban areas of 35 states. Most tribes are federally recognized, though some are state-recognized or designated by Presidential Order. Still others are unrecognized—meaning that they are not eligible for certain services, such as having access to Indian Health Services (IHS).

- In 2010, there were 324 federally recognized American Indian reservations. [2]
- In 2010, excluding Hawaiian Home Lands, there were 617 legal and statistical AI/AN areas for which the Census Bureau provides statistics. [3]

[a] ***Tribal sovereignty*** *in the United States is the inherent authority of indigenous tribes to govern themselves within the borders of the United States. The federal government recognizes tribal nations as "domestic dependent nations," and has established a number of laws attempting to clarify the relationship between federal, state, and tribal governments.*

As a legal category, **Indian Country** includes "all land within the limits of any Indian reservation, [b] all Indian communities within the borders of the United States, and all Indian allotments." [4] It also includes all federal trust lands held for AI/AN tribes. Indian Country refers to any of the self-governing American Indian communities throughout the United States; however, Alaska Natives typically reserve the term for use in describing the lower 48 states.

The term Indian Country is also understood by recognizing the many differences among the tribes. It is not a unified country, but many distinctive nations, tribes, and communities. The distinctions between each community may be political, geographic, demographic, economic, or cultural. Such diversity makes it difficult to create an all-inclusive approach for working with AI/ANs.

**AI/ANs rank at, or near the bottom, of nearly every social, health, and economic indicator.** Compared to all other race or ethnic populations, AI/ANs have the highest poverty rates (30%)—twice the national rate. [5] In 2011, the median income of AI/AN (alone) households was $35,192, compared to $50,502 for the entire nation. [6]

**Funding for programs serving AI/ANs has historically been insufficient**. With the passing of more current legislation, federal funding for AI/AN programs has increased. However, this has not been nearly enough to compensate for the decline in spending power or to overcome a long history of substandard community infrastructures. While AI/ANs' health care, for example, is legally an entitlement—much the same as Medicare and Social Security—federal appropriations for this care are discretionary (approved annually by Congress). The result, historically, has been devastating shortfalls in Indian health care programs. Much the same is true for other socio-economic arenas where unmet needs prevent tribes from raising their standards of living to those of other Americans.

> *"At least two rationales exist for ongoing federal commitments to allocate resources to [AI/AN] programs and services. The first is a fundamental desire by the U.S. to address the compelling and often Third World conditions found in many Native communities. . . . In many parts of Native America, economic and social conditions resemble the emergency states associated with natural disasters which require federal intervention. The second rationale . . . is the unique legal and political relationship between the U.S. and Indian tribes nationwide."* [7]

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[b] *An **Indian reservation** is an area of land managed by a AI/AN tribe under [the] United States Department of the Interior's Bureau of Indian Affairs. There are about 310 Indian reservations in the United States. Not all recognized tribes have a reservation—some have more than one reservation, some share reservations, and others have none. The collective geographical area of all reservations is 55,700,000 acres, representing 2.3% of the United States' 3.794 million square miles. Twelve reservations are larger than the state of Rhode Island. The majority are west of the Mississippi. Tribal sovereignty allows laws on tribal lands to vary from their surrounding areas. For example, they can allow for legal casinos on a reservation. The tribal council generally has jurisdiction over reservations. Further, different reservations have different systems of government.*

## Demographic Snapshot

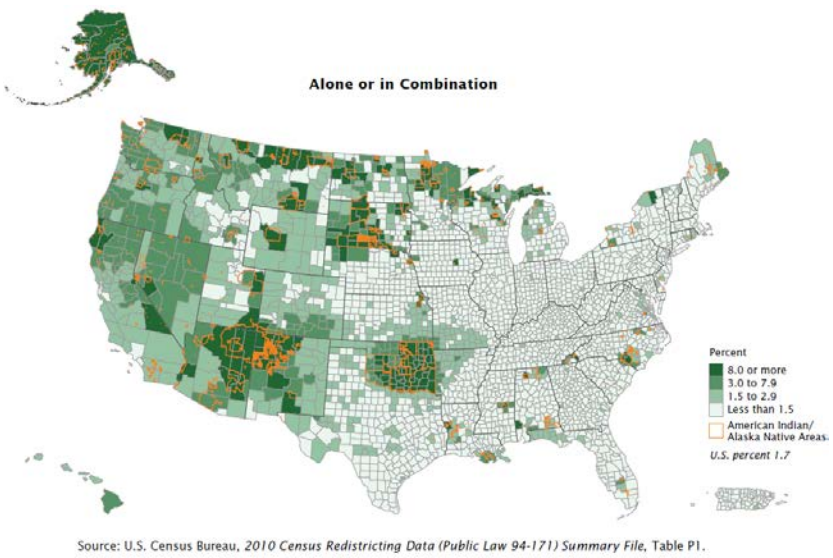
In 2010, there were 5,220,579 AI/ANs (alone or in combination), comprising 1.7% of the total United States' population of 308.7 million. This is an increase of 39% from the last Census, making it one of the fastest growing populations with a growth rate almost twice that of the total U.S. population. Of the total AI/AN population, 586,629 were 65 or older. [8] The Native population is younger than other races with an average age in 2010 of 29, compared to 37 for the United States overall.

Compared with other racial and ethnic groups in the United States, AI/ANs make up a relatively small proportion of the population. Thus, AI/ANs are often considered an "invisible minority," which makes recognition by established government-reported tracking scales ineffective and outdated.

## Geography of AI/AN Populations

The 566 federally recognized Indian Nations are variously called tribes, bands, nations, pueblos, Rancherias, and Native villages. Approximately 229 of these ethnically, culturally, and linguistically diverse nations are located in Alaska. More AI/AN people live in cities that are situated in the Western, Southern, or Southwestern regions of the United States. However, federally recognized tribes are spread across 35 states in the upper Midwestern, Northwestern, Southwestern, and Western regions of the lower 48 states and Alaska. Many reservations are small and isolated, and even larger ones, like the Navajo Nation, have areas that are extremely remote.

*See Appendix for additional map images.*




Source: U.S. Census Bureau, *2010 Census Redistricting Data (Public Law 94-171) Summary File*, Table P1.

Figure 1: American Indian and Alaska Native Alone or in Combination - Percentage of County Population

In 2010, the 10 American Indian reservations with the greatest numbers of AI/ANs were the:

- Navajo Nation Reservation (169,321) in Arizona, New Mexico, and Utah;
- Fort Apache Reservation (13,014), Gila River Indian Reservation (11,251), San Carlos Reservation (9,901), and Tohono O'odham Nation Reservation (9,278) in Arizona;
- Pine Ridge Reservation (16,906) in South Dakota and Nebraska;
- Rosebud Indian Reservation (9,809) in South Dakota;
- Osage Reservation (9,920) in Oklahoma; and the
- Blackfeet Indian Reservation (9,149) and Flathead Reservation (9,138) in Montana.

The ten cities with the largest number of AI/ANs included:

- New York, NY
- Los Angeles, CA
- Phoenix, AZ
- Oklahoma City, OK
- Anchorage, AK
- Tulsa, OK
- Albuquerque, NM
- Chicago, IL
- Houston, TX
- San Antonio, TX [9]

Geographic location means that those who reside, attend school, or work on reservations are often isolated from mainstream society. Diversity in cultures and regions, differences between urban and rural settings, and varying levels of access to telephones and electronic connections within the AI/AN population present challenges. For more information, please refer to the accompanying Appendix that contains detailed descriptions of AI/AN populations by region and tribal grouping.

## Geographic Fast Facts

- AI/ANs are more geographically clustered than other populations, with 62% residing in 11 states. Forty-eight percent live in the West—more than any of the other three regions of the country. [10]
- The largest tribal groups are the Cherokee, Navajo, Choctaw, Sioux, and Chippewa. [11] These five groups comprise almost 40% of all American Indians.
- Eskimo is the largest tribal group among Alaska Natives, followed by Tlingit-Haida, Alaska Athabascan, and Aleut. These four groups combined make up only 3.6% of all AI/ANs who reported tribal affiliation.
- AI/AN migration to urban areas represents one of the most significant demographic shifts in U.S. history. In 1970, 38% of all AI/ANs lived in urban areas [12]. According to the 2010 Census, 71% of all AI/ANs live in urban areas, and approximately 30% live on reservations, trust lands or bordering rural areas. [13]
- In 2010, the five states with the greatest percentage of AI/ANs (alone or in combination) were California (14%), Oklahoma (9%), Arizona (7%), Texas (6%), and New York (4%).
- The 10 cities with the greatest percentage of AI/ANs (alone or in combination) were Anchorage, AK (12%); Tulsa, OK (9%); Norman, OK, (8%); Oklahoma City, OK (6%); Billings, MT (6%); Albuquerque, NM (6%); Green Bay, WI (5%); Tacoma, WA (4%); Tempe, AZ (4%); and Tucson, AZ (4%). [14]

## Urban Indians

Prior to the 1950s, most AI/ANs resided on reservations, in nearby rural towns, or in tribal jurisdictional areas, such as in parts of Oklahoma. In the 1950s and 1960s, the federal government passed legislation to terminate its legal obligations to Indian tribes, resulting in policies and programs to assimilate Indian people into the mainstream of American society. This philosophy produced the Bureau of Indian Affairs (BIA) Relocation and Employment Assistance Programs, which enticed Indian families living on impoverished Indian reservations to relocate to various cities across the country (i.e., San Francisco, Los Angeles, Chicago, Salt Lake, Phoenix, etc.). BIA Relocation offered job training and placement, and was viewed by Indians as a way to escape poverty on the reservation. Health care was usually provided for six months through the private sector, unless the family was relocated to a city near a reservation with an IHS facility, such as Rapid City, Phoenix, and Albuquerque. Eligibility for IHS was not forfeited due to federal government relocation. The American Indian and Policy Review Commission found that in the 1950s and 1960s, the BIA relocated more than 160,000 AI/ANs to selected urban centers across the country.

In the late 1960s, urban Indian community leaders began advocating at local, state, and federal levels for culturally appropriate health programs addressing the unique social, cultural, and health needs of AI/ANs residing in urban settings. These community-based grassroots efforts resulted in programs

targeting health and outreach services to urban Indian communities. Programs developed at that time were, in many cases, staffed by volunteers, offering outreach and referral-type services and limited primary care, and were maintaining programs in storefront settings with limited budgets.

In response to the efforts of urban Indian community leaders in the 1960s, Congress appropriated funds in 1966, through the IHS for a pilot urban Indian clinic in Rapid City. Later, in 1973, Congress appropriated funds to study unmet urban Indian health needs in Minneapolis. The findings of this study documented cultural, economic, and access barriers to health care and led to Congressional appropriations under the Snyder Act of 1921 to support emerging urban Indian clinics in several BIA relocation cities, i.e., Seattle, San Francisco, Tulsa, and Dallas.

The awareness of the poor health status of all Indian people continued to grow and, in 1976, Congress passed the Indian Health Care Improvement Act (IHCIA), Public Law 94-437. This law is considered health care reform legislation that was created to improve the health and well-being of all AI/ANs. Title V of the IHCIA targets specific funding for the development of programs for AI/ANs residing in urban areas. Since the passage of this landmark legislation, amendments to Title V of the IHCIA have strengthened urban Indian health programs, enabling them to expand to direct medical, alcohol, mental health, HIV, health promotion, and disease prevention services. (P.L. 100-713, P.L. 101-630, P.L. 102-573)

*Today, 71% of all AI/ANs identified in the 2010 Census reside off-reservation. This figure includes 427,100 eligible urban Indian active users who reside in geographic locations with access to an IHS or tribal facility.*

Currently, urban Indian health indicators underscore the shared challenges of urban Indians and their non-urban counterparts:

- Compared to the general population, urban Indians have:
  - 38% higher rates of accidental deaths;
  - 54% higher rates of diabetes;
  - 126% higher rates of liver disease and cirrhosis; and
  - 178% higher rates of alcohol-related deaths. [15]
- Urban Indian women have considerably lower rates of prenatal care with higher rates of infant mortality than even their reservation counterparts within the same state. [16]

Indicators of economic stability (or the lack thereof) are also particularly stark for urban Indians.

- The poverty rate of urban Indians is 20.3%, compared to 12.7% for the general urban population. [17]
- The unemployment rate of urban Indians is 1.7 times higher than that of non-Indians in urban areas. [18]
- Urban Indians are 1.7 times less likely to have high school diplomas than their non-Indian counterparts. [19]
- Long-term economic stability is also undermined by the fact that:
  - Urban Indians are three times more likely to be homeless than non-Indians. [20]
  - Homeownership rates for urban Indians are less than 46%, compared to 62% for their non-Indian counterparts. [21]

## Socioeconomic Characteristics

AI/AN social and economic characteristics vary considerably by area type. In 2010, for example, 34% of the AI/AN (alone) population living in tribal areas was under 18 years of age, compared to 26% in nonmetropolitan counties. The AI/AN (alone) poverty rate ranged from 32% in tribal areas to 25% in the surrounding counties, and the unemployment rate ranged from 16% in tribal areas to 12% in other nonmetropolitan counties.

As might be expected, conditions for Native people worsened significantly during the Great Recession of 2008. The declines in employment and income were similar to non-AI/AN populations, but the AI/AN population, on average, started from a more financially vulnerable situation.

In tribal areas, the new economic activity includes large-scale investments by the tribes themselves, which are reportedly being conducted in a more businesslike manner than previous tribal enterprises.

## Housing

Housing problems for AI/AN households relate to the quantity, quality, and price of housing.

- From 2006 to 2010, 65,000 AI/AN households (8.1%) were overcrowded, which was much higher than the national average of 3.1%.
- This pattern continues with housing quality, where almost 3% of AI/AN households lacked complete plumbing facilities from 2006 to 2010, which was more than five times the share for all households.
- A similar share of AI/AN households lacked complete kitchen facilities, which was 3.5 times as high as the national average. [22]

Housing affordability is the most common problem for AI/AN households.

- From 2006 to 2010, almost 4 out of 10 AI/AN households were paying more than 30% of their income on housing costs (cost burdened).
- Almost 2 out of 10 were paying more than 50% (severely cost burdened). [23]

Unlike the changes in facilities and overcrowding, housing affordability problems are on the rise. The cost-burdened rate went up 5.9 percentage points for AI/AN households from 2000 to 2010. In these areas, the Native American Housing Assistance and Self-Determination Act is the dominant framework for the delivery of housing assistance.

- Compared with non-Indians nationally, people living in tribal areas from 2006 to 2010 had a poverty rate and an unemployment rate that were at least twice as high.
- Compared with the national average, households in large tribal areas were more than 3 times as likely to live in housing that was overcrowded, and 11 times more likely to live in housing that did not have adequate plumbing facilities. [24]

## Education

Much like health and socio-economic disparities, or, perhaps, because of these disparities, AI/ANs also face significant gaps in education and literacy. In addition to deficiencies in the school systems, those living in remote rural areas (which is often the case for people on reservations) have limited access to higher education. In fact, AI/ANs account for less than 1% of those who have earned a college degree, compared to 72% of Whites, 10% of African Americans, 8% of Hispanics and 7% of Asian and Pacific Islanders. [25]

Additional notable statistics are:

- Among 12th grade students, 74% of AI/AN students scored below *proficient* in reading, compared to 53% of Whites and Asian and Pacific Islanders. [26]
- According to the National Indian Education Association, AI/AN students have a 7% drop out rate, compared to 2% for whites and 3% for all others. [27]
- Statistics from the 2003 National Adult Literacy Survey (the most recent national assessment), found that 32% of AI/AN adults failed to attain basic reading levels, compared to only 13% of White adults. This was a decline from 43% from the 1992 assessment. [28]

Table 1: Higher Education Rates and Outcomes for AI/AN students, 2010

| Higher Education Outcomes and Employment | All Students | White Students | AI/AN Students |
|---|---|---|---|
| **Young adults, ages 25–34, who had a bachelor's degree or higher in 2010** | 31% | 37% | 12% |
| **Young adults, ages 25–34, in the labor force with a bachelor's degree or higher who were employed in 2010** | 85% | 87% | 84% |
| **2010 median full-time annual earnings for young adults, ages 25–34, with a bachelor's degree or higher in any field** | $50,300 | $50,000 | $38,100 |
| **2010 median full-time annual earnings for young adults, ages 25–34, with a science, technology, engineering, and math bachelor's degrees or higher** | $58,200 | $56,300 | $44,100 |

*Source: Ross, Kena, Rathbun, et al., 2012* [29]

Closely tied with education and literacy levels is *health literacy*, which is the degree to which individuals have the ability to obtain, process, and understand basic health information and make appropriate decisions. Unfortunately, AI/AN were categorized as *other* for the purposes of assessing health literacy in the last National Adult Literacy Assessment, so no specific analysis exists. However, the study did find that only 12% of adults have proficient health literacy and, while rates varied, all racial and ethnic groups performed significantly worse than their White counterparts.

Notably, the study also found that lower health literacy rates are associated with:

- Poverty
- Less education
- Ages greater than 65
- Medicare or Medicaid enrollment

Taking into consideration the socio-economic and educational disparities faced by AI/ANs, this research reinforces the notion that AI/AN elders likely have greater propensity for health literacy issues. [30]

## Impact of Acculturation

The history of AI/ANs is filled with traumatic events that impact their lives. After living on the North American continent for 30,000 years as separate heterogeneous nations, AI/ANs were confronted with the arrival of European settlers who invaded their ancestral lands through military intrusions, committed mass murders, engaged in massacres of tribal villages, forced persons to be removed from their territories, and broke treaties. When not engaged in warfare, forced attempts were made to acculturate the population to the colonial lifestyle and eliminate Indian culture and religion, in part by the federal policies of the recent past that removed children from their communities to boarding schools and foster homes. Disease epidemics spread, populations were decimated, and their cultures were violated.

The contemporary state of AI/AN health, wellness, and culture is complex and diverse. While seeking to retain their tribal cultures, not all have been successful. [31] A majority of AI/ANs no longer live on reservations and have blended into the American mainstream. The degree of Native American blood lineage varies by individual. Given the hundreds of tribes and nations that constitute AI/ANs, there is broad variation in cultural beliefs and practices. There are no universal language use, spiritual traditions, or ritual activities. However, all tribes have rich cultural traditions; a literature expressed through oral story-telling; and, as in other cultural groups, unique foods, music, and dance. [32] The loss of culture or acculturation has been described as having the greatest effect on AI/AN communities and a lasting impact that is seen in every disparity that exists today.

Socioeconomic status is often measured as a combination of education, income, and occupation. When considering social standing or class, privilege, power, and control are emphasized. Furthermore, it reflects the inequalities in access to and the distribution of resources. The statistics regarding health, education, housing, and others all point to increasing inequalities in wealth and resource distribution, and the quality of life among AI/ANs (as well as other minorities). For many of these communities, elders and those with disabilities are the most vulnerable. They experience increased barriers to services to improve their quality of life, health, and wellness.

# Chapter 2: ITU Health Care Systems

The HHS provides health-related programs to AI/ANs through:

- The IHS;
- Reimbursement for health services provided directly to tribes, urban Indian health centers, and tribal health facilities through the Centers for Medicare and Medicaid Services' (CMS) Medicare and Medicaid programs;
- The Health Resources and Services Administration;
- The Substance Abuse and Mental Health Services Administration; and
- The Administration for Children and Families.

Indian health care services should not simply be viewed as an extension of the mainstream health system in America. As previously discussed, the federal government's responsibility for providing health services to AI/ANs dates back more than 200 years to the assumption of responsibility for Indian education, health care, and housing. Legal responsibility for AI/AN health traces back to many of the treaties enacted between 1776 and 1858. These treaties included medical care as partial compensation for the ceding of land and other resources. The provision of health services is a *federal trust responsibility where,* **in exchange for land, and as compensation for their forced removal, the federal government has a legal responsibility to provide for the health and well-being of AI/ANs.** It is part of the special government-to-government relationship between the United States and federally recognized tribes.

The IHS facilities, tribally operated "638" health programs, and urban Indian health programs provide general health care services for eligible AI/AN, and are known as the ITU health care system.

Congress passed the Indian Health Care Improvement Act of 1976. The goal was to raise "the status of health care for AI/ANs over a 7-year period to a level equal to that enjoyed by other American citizens." [33] More than 25 years later, this goal has not been achieved, while AI/AN health conditions and services remain substandard, as evidenced by the 2010 Census. [34]

## Indian Health History

Over the past 85 years, the federal government's obligation to provide health care services to American Indians and Alaska Natives, explicit in some treaties, has been explicitly set forth in a series of federal laws, executive orders, and court decisions.

The responsibility to provide quality health care to AI/ANs is based on the Indian Commerce Clause of the U.S. Constitution, confirmed through treaties, federal law, and federal court decisions. The Indian Health Care Improvement Act (P.L. 94-437), along with the Snyder Act of 1921 (25 U.S.C. 13), form the statutory basis for the delivery of federally funded health care to AI/ANs.

The IHS delivery system was designed to be an integrated, community-based system that emphasizes prevention and public health. The IHS system delivers and purchases health care services and provides the infrastructure for health improvements by building health facilities and sanitation systems, as well as guaranteeing long-term improvement through the training, recruitment, and retention of health personnel. Inadequate resources create barriers for the IHS to fully achieve its mission.

To fully understand the unique ITU health care system today, it is necessary to understand the different acts passed by Congress that have shaped the current health care environment in Indian Country.

**Snyder Act of 1921.** Congress, for the first time, enacted legislation permanently authorizing appropriations for American Indian health care. The act authorized the BIA to expend federal funds and employ physicians "for the relief of distress and conservation of health."

**Johnson O'Malley Act of 1934.** This act affirmed the federal government's financial responsibility for Indian health services, authorizing the Secretary of the Interior to contract with state and local governments and private organizations to provide educational, medical, and other assistance to American Indians who no longer lived on the reservation.

**Transfer Act of 1954.** Health services for AI/ANs were transferred from the Interior Department to a newly created division of Indian health (retitled the Indian Health Service in 1955) under the U.S. Public Health Service in the Department of Health, Education, and Welfare. Primary motivation for the transfer was to improve the quality of medical services to American Indians through supervision by an agency with more administrative expertise and funding in health care.

**Indian Health Facilities Act of 1957.** This act authorized IHS to contribute to the construction costs of community hospitals in cases where such facilities could provide better access and care than would result from the direct construction of Indian facilities.

**Indian Sanitation Facilities and Services Act of 1959.** This act expanded the scope of IHS programs by authorizing the agency to provide sanitation facilities, including water supplies, drainage, and waste disposal, for American Indian homes, communities, and lands.

**Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638).** This act authorized IHS to turn over full administrative responsibility for IHS programs, through contracts, to tribes, upon request.

**Indian Health Care Improvement Act of 1976 (P.L. 94-437, IHCIA).** This act authorized a series of health programs based on a *community health model,* directed increased appropriations for such programs; included the first specific legislative acknowledgement of the special federal responsibility for American Indian health services, established urban Indian health programs,

and removed the prohibition of Medicaid and Medicare reimbursements to IHS and tribally operated facilities.

**Indian Health Care Improvement Act Amendments of 1992 (P.L. 102-573).** These amendments extended tribal self-governance to the IHS. Self-governance allows tribes to assume responsibility for resource management and service delivery, providing greater flexibility to design and develop programs that better meet the needs of their members, with no abrogation of the federal government's trust responsibility.

**Affordable Care Act/Indian Health Care Improvement Act of 2010.** This act was enacted to improve the quality of health care and make it more accessible and affordable for all Americans—with special provisions for AI/AN populations—as well as permanently reauthorizing the IHCIA, which extends the current law and authorizes new programs and services within IHS.

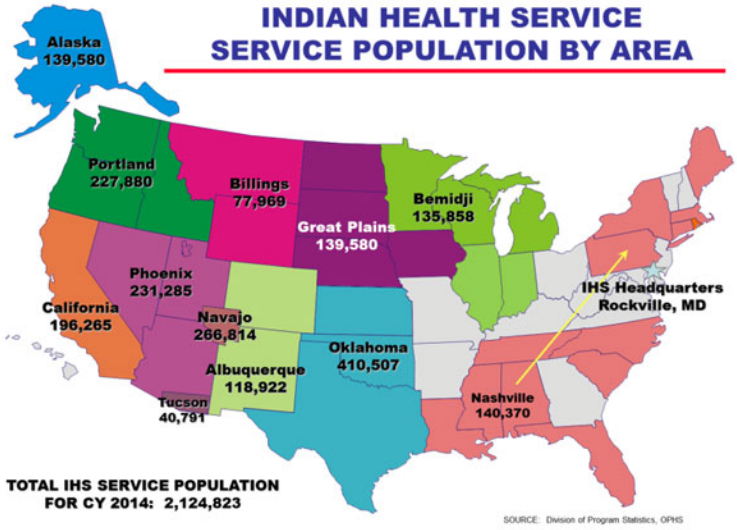
This legislative history demonstrates AI/ANs long history of working with the federal government on health care systems through treaties and acts. Below are some quick facts related to the history of IHS.

- The first federal health assistance for AI/ANs dates back to 1832 when Congress appropriated $12,000 for a health program.
- By 1880, there were four AI/AN hospitals, which were run by the BIA. [35]
- Forty years later, the Snyder Act of 1921 specifically authorized federal funds "for the relief of distress and conservation of health … [and] for the employment of … physicians" for Indian tribes throughout the United States. [36]
- In 1954, the responsibility for health care delivery to AI/ANs was transferred from the Department of the Interior to the agency known today as the Department of Health and Human Services. [37]
- In 1955, the HHS transferred the responsibility for health care delivery to IHS and, to this day, direct services are administered by IHS to tribes across the country.

# Health Care Today

## Indian Health Service

IHS is primarily responsible for providing care to AI/AN people who are members of federally recognized tribes. According to IHS, the agency provides care to an estimated 2.1 million AI/ANs, [38] which encompasses about half of the 5.2 million people classified by the Census as AI/AN. [39] The IHS directly operates 31 hospitals, 52 health centers, 2 school health centers, and 31 health stations throughout Indian Country.




### Contract Health Services (CHS)

The CHS Program is for medical and dental care provided away from an IHS or tribal health care facility. The fund is used in situations where: 1) no IHS direct care facility exists, 2) the direct care element is incapable of providing the required emergency or specialty care, 3) the direct care element has an overflow of medical care workload, and 4) supplementation of alternate resources (i.e., Medicare or private insurance) is required to provide comprehensive care to eligible Indian people.

CHS funds are used to supplement and complement other health care resources available to eligible Indian people. CHS is not an entitlement program, and an IHS referral does not imply that the care will be paid for with IHS funds. If IHS is requested to pay, then a patient must meet the residency, notification, medical priority rating, and the use of alternate resources requirements.

The term *Contract Health Services* originated under BIA when medical health care services were contracted out to health care providers. In 1955, the Transfer Act moved health care from the BIA to the Department of Health Education & Welfare, establishing the IHS.

Because IHS programs are not fully funded, the CHS program must rely on specific regulations relating to eligibility, notification, residency, and the medical priority rating system. IHS is designated as the payer of last resort, meaning that all other available alternate resources, including IHS facilities, must first be used before payment is expected. These mechanisms allow IHS to stretch the limited CHS dollars, and are designed to extend services to more Indians. This renders the CHS program to authorize care at restricted levels and results in a rationed health care system.

## Tribal Health Care

Indian tribes are recognized in law as sovereign entities with the power to govern their internal affairs. The legal authority of tribal governments to determine their own health care delivery systems, whether through IHS or tribally operated programs, must be honored.

The Indian Self-Determination and Education Assistance Act (ISDEAA) of 1975 gave tribes the choice of whether to take over the administration and operation of health services from the U.S. Government or to remain with the government's direct health system. [40]

Tribes and tribal organizations, through contracts and compacts under the ISDEAA, operate almost 50% of the IHS system and provide health care in:

- 15 hospitals,
- 256 health centers,
- 9 school health centers, and
- 282 health stations (including 166 Alaska Native village clinics).

## Urban Indian Health Program

The IHS Urban Indian Health Program supports contracts and grants to 34 urban health programs operating at 41 sites throughout the United States. These programs are funded under Title V of the Indian Health Care Improvement Act. [c] Approximately 100,000 American Indians use 23 Title V urban Indian health programs. These populations are not generally able to access hospitals and health clinics, or contract health services administered by IHS and tribal health programs because they either do not meet IHS eligibility criteria or they reside outside of IHS and tribal service areas. Another 49,000 AI/ANs use 11 Title V programs in cities that are located in IHS or tribal service delivery areas.

Since 1972, IHS has gradually increased its support for health-related activities in off-reservation settings. The aim is to assist access to available health services, and also to develop direct health services when necessary. Though the Urban Indian Health Program still accounts for less than 1% of the total IHS budget.

In its 1992 amendments to the IHCIA, Congress specifically declared the policy of the Nation "in fulfillment of its special responsibilities and legal obligations to the American Indian people [is] to assure the highest possible health status for Indians and urban Indians, and to provide all resources necessary to affect that policy."

**The types of services that are offered by the 34 programs vary from clinic to clinic**. Activities range from the provision of outreach and referral services to the delivery of comprehensive ambulatory health care. Fifteen of the programs are designated as Federally Qualified Health Centers and provide services to Indians and non-Indians.

[c] IHCIA Title V directs the Department of Health and Humans Services Secretary to make contracts with or grants to Urban Indian Organizations for health projects to serve urban Indians, and sets requirement for the contracts and grants.

Services may include medical, dental, and community services; alcohol and drug abuse prevention, education, and treatment; AIDS and sexually transmitted disease education and prevention services (provided by all of the IHS Title V funded, off-reservation Indian health programs); mental health, nutrition education and counseling, pharmaceutical, health education, optometry, and social services; and home health care.

Dental care services, both preventative and restorative, are provided by many programs. Dental education and screenings for children and adults are provided in both clinic and community settings. When needed, referrals are made to specialists for orthodontics, periodontics, selected restorative procedures, and oral surgery.

Community outreach services are provided throughout the urban, off-reservation health programs, including patient and community education, patient advocacy, outreach and referral, and transportation. Outreach workers serve important functions as liaison between the off-reservation health program and the community, and work to make health services more available and accessible to those community members who need them.

Alcohol treatment services are provided at 10 off-reservation Indian sites. These programs were originally funded by the National Institute of Alcohol Abuse and Alcoholism (NIAAA). At least 28 additional NIAAA programs are in the process of being transferred to the Urban Indian Health Program.

Additional services at various off-reservation Indian health programs include health prevention activities, such as diabetes, maternal and child health, women's health, men's health, nutrition education and counseling for prenatal care and chronic health conditions, social services, community health nursing and home health care, and other health promotion and disease prevention activities.

**Notes:**

- The Urban Indian Health Program participates in line-item increases, as appropriated by Congress.
- The contracts and grants are awarded pursuant to a HHS/IHS class Justification for Other than Full and Open Competition (JOFOC) for Title V, Urban Indian Contracts. The applicable statutes are the Snyder Act of 1921 (25 U.S.C., 13) and Title V of the Indian Health Care Improvement Act (PL 94-437), as amended. The JOFOC is also pursuant to Federal Acquisition Regulation 6.302-5 and 41 U.S.C., 253 (c) (5), and the use of set asides under the Buy Indian Act, 25 U.S.C., 47. Full and open competition need not be provided for when a statute expressly authorizes or requires that the acquisition be made from specified sources, as identified by Title V and pursuant to the Buy Indian Act.

- The Urban Indian Health Program line item is distributed through contracts and grants to the individual urban Indian health programs. The distribution is based upon the historical base funding of these programs.
- The funding level is estimated at 22% of the projected need for primary care services, with less than 1% of IHS funding reaching urban Indian centers.
- Eighteen additional cities have been identified as having an urban Indian population large enough to support an urban Indian health program.

## Health System Funding

*"Don't get sick after June," has been incredibly effective [in] describing the problem of what it means for a health care delivery system to run out of money.*
*-- Dr. Yvette Roubideaux, Indian Health Service Director*

The need for additional funding is particularly well supported by advocates for Native American health care, who have developed a variety of measurements to verify the inadequacy of present funding levels. Over the years, they have made the following arguments to the President and Congress when requesting additional funding:

- Annual per-capita health expenditures for Native Americans are only 60% of the amount spent on other Americans under mainstream health plans.
- Annual per-capita expenditures fall below the level for every other federal medical program and standard.
- Annual increases in IHS funding have failed to account for medical inflation rates and increases in population.
- Annual increases in IHS funding are less than those for other HHS components.
- Annual increases have effectively been reduced to reflect increased collection efforts despite express congressional intent that appropriations not be reduced.

### Background

As the primary health care provider for Native Americans, IHS receives the vast majority of funds appropriated for that purpose. For FY 2015, the President's budget request included $4.27 billion for IHS, just 5.5% of a $77.1 billion HHS discretionary budget and an even smaller 0.4% of the overall HHS budget of $1 trillion. [41]

While other HHS components and programs provide limited health-related services for Native Americans, their Native American expenditures are equal to approximately 0.5% of IHS spending on

Native Americans, which is less than $20 million. [42] The FY 2015 budget request includes a $200 million increase from FY 2014. To some extent, at least in the allocation of additional funds, the increase reflects priorities established through tribal consultation, including increases to cover pay raises and inflation, thereby protecting the current level of services and providing greater funding for preventive services. [43]

Another HHS agency, CMS, directly funds health care services for AI/ANs who are enrolled in Medicaid, Medicare, or the state-administered Children's Health Insurance Program when their care is provided through IHS or tribal facilities. When IHS budget appropriations are combined with collections from CMS and private third-party insurers, the total composes the program-level funding for IHS and provides a better picture of the overall federal government spending on Native American health care. Even with program-level funding boosted by third-party collections, the end result is a rationed system. The IHS acknowledges this reality in its budget justification, explaining that its system "explicitly rations care, deferring and denying payment for medical services that are thought to be of lower priority." [44] To what degree rationing is a problem is discussed in detail in the Contract Health Services section.

## Casinos Don't Equal Health Care for All

It is necessary to address the myth surrounding the gaming industry in Indian Country, its contribution to the continued shortfalls in federal funding, and the resulting system of rationed care. Because the Native gaming industry has grown to encompass 220 tribes, 377 facilities, and more than $16 billion per year in revenue, a perception exists that Indians have been given everything they need and that federal "handouts" are no longer necessary. [45] This perception is inaccurate on several levels. First, it ignores the federal trust obligation discussed earlier in this report. Second, it overstates the magnitude and impact of gaming profits. A report prepared for the American Indian Program Council provides a clearer picture of the impact of casinos in Indian Country:

- Only half of all tribes have casinos.
- Thirty-nine casinos produced the majority of casino-generated income.
- More specifically, 39% of casinos accounted for 66% of revenue.
- Casinos in five states, with more than half the total Native American population, accounted for less than 3% of all casino revenue.
- Casinos in three states, with only 3% of the Native American population, accounted for more than 44% of all casino revenue.
- Dozens of casinos barely break even because of inadequate sizes or locations. [46]

The overall effect is that only a relatively small number of tribes have been very successful enough to establish health care systems independent of federal aid. For most tribes, gaming has brought increased administrative, legal, and lobbying expenses, along with impressive gains for non-Indian investors and state governments that have taken as much as 16% of revenue. [47] After other expenses are covered, a small percentage of the successful tribes appropriately apply some portion of their

increased revenue to health care. Nevertheless, the vast majority of tribes and Native people must continue to rely on the inadequate funds appropriated to the IHS.

### Per Capita IHS Expenditures Compared with Other Federal Per Capita Health Care Expenditures

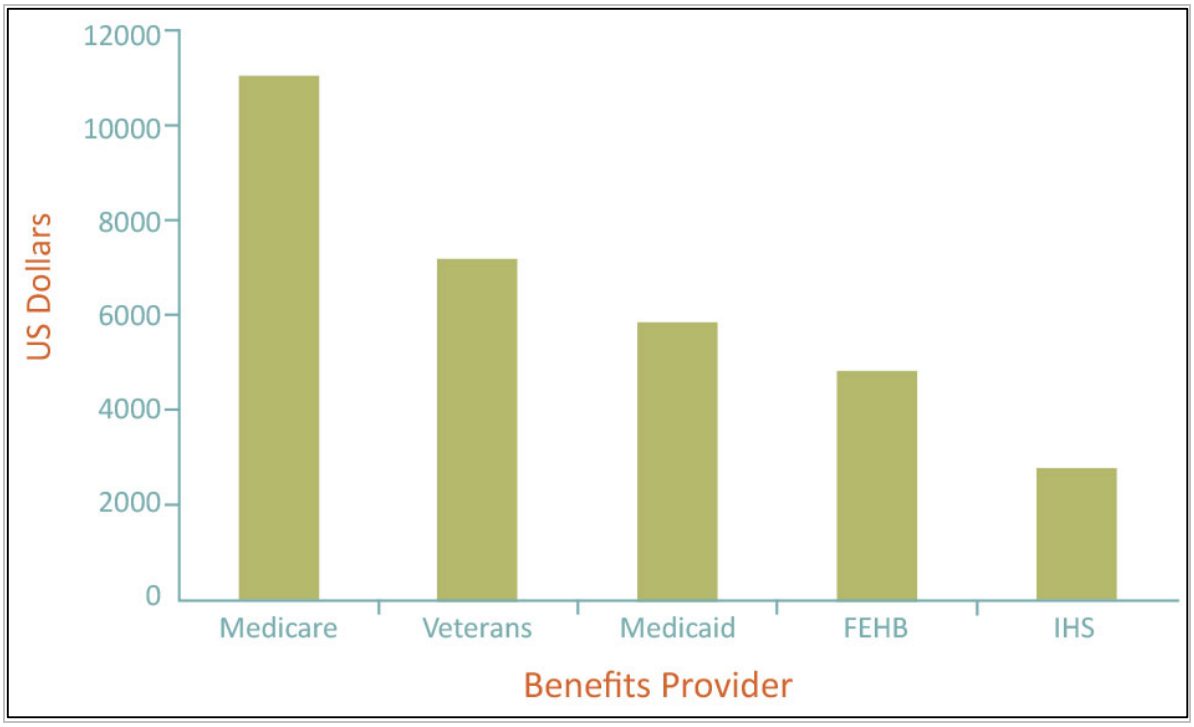



Figure 2. 2009–2010 Indian health expenditures per capita compared with other federal per capita health care expenditures.
*Note: FEHB=Federal Employee Health Benefits; IHS=Indian Health Service.*
Source: National Tribal Budget Formulation Workgroup.[48]

## Relationship of Medicare to ITUs

Amendments to two landmark federal acts—the ISDEAA of 1975 and the IHCIA of 1976—provided new health care delivery options for IHS and tribes. Among other things, the IHCIA included authorization to collect from Medicare, Medicaid, and other third-party insurers for services provided at IHS or tribal facilities. Under the ISDEAA, many tribes assumed roles previously carried out by the federal government. According to IHS, tribes currently administer more than half of IHS resources through contracts and compacts. IHS administers the remaining resources and manages facilities where tribes have elected not to contract or compact their health programs. [49]

## Why Do Elders Need Medicare?

IHS is not health insurance or an entitlement program, and it limits the types of services it covers. Because IHS funding appropriations historically fall short, health care funding often runs out before the end of the year. CMS funding helps supplement the health care programs, which, in turn, help provide greater access to care for elders and can enhance those services and resources.

Medicare and Medicaid payments can be used to offset IHS and tribal health care expenses without a reduction in appropriated funding. The law specifically dictates those reimbursements must then be spent only on health care. Funding by these two programs is a significant source of revenue for tribes and IHS.

Elders can also use Medicare to pay for Medicare-approved services outside of the IHS system. There are certain services that aren't routinely paid for by the ITU system that may be covered by Medicare, including:

- Skilled Nursing Facility Care (Part A);
- Hospice Care (Part A);
- Dialysis (Part B);
- Acute In-patient Mental Health Programs (Part A);
- Mental Health services outside of the IHS System (Part B); and
- Certain DME, such as beds, scooters, lifts (Part B).

Conversely, some tribes may pay for services not provided by Medicare, such as vision, dental, and hearing services.

## Tribes and Medicare

Under the IHCIA, tribes have the authority to pay for Medicare premiums for their tribal members. And, as previously noted, tribes may opt to provide additional services to their members beyond what Medicare covers. Each tribal health entity establishes its priorities, service design, and service line.

Payment of premiums and the provision of additional services is not a practice of all tribes, but it is an option. The benefit to the tribes is knowing that all tribal members have health coverage and that it could bring additional revenue to the tribe from third-party billing. However, there is the obvious challenge of affordability, among others.

## AI/AN Medicare Enrollees

It is a challenge to routinely and accurately identify and classify all AI/ANs receiving, or who are eligible for, Medicare. Medicare, Census, and IHS data often contain significant discrepancies. In a study of 33 of the most AI/AN populated states, an average of 10% of all AI/ANs reported having Medicare coverage, ranging from 6% to 15%. See Figure 2 below for state-by-state percentages. [50]

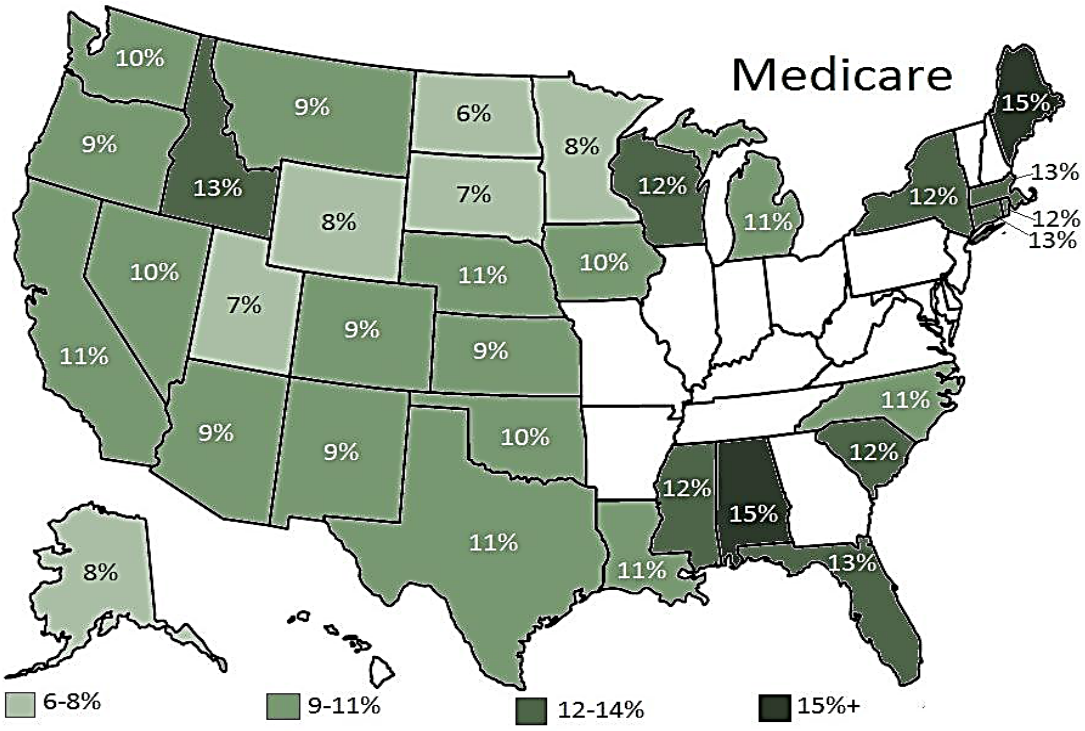



Figure 2: Percentage of AI/ANs Enrolled in Medicare by State

The US Census' 2008 to 2010 American Community Survey estimated that approximately 446,000 AI/ANs had Medicare coverage. However, Medicare's database only identified 385,000 beneficiaries in that same timeframe. When matched with an IHS dataset, the IHS data only uncovered 331,674 beneficiaries. Remaining Medicare enrollees were identified through the Social Security Administration or the Medicare Beneficiary Survey. Differences arise largely as a result of Medicare's inability to identify a large portion of self-declared AI/ANs, alongside classifying them in other racial, other, or unknown group categories. [51]

Population growth has significant implications for Medicare enrollment numbers. According to 2010 Census data, the AI/AN population alone, or in-combination, grew by 27% from 2000. During that same time frame, the total population grew at only 9.7%. [52] Census population projections forecast that the percentage of AI/AN-only who are 65 and older will more than double in the next two decades—a faster growth rate than the both the total population and most other races, including those of Hispanic origin. [53]

## Barriers to Medicare Enrollment

A number of known barriers to enrolling elders in Medicare exist. In some areas, like North Dakota and South Dakota, due to devastatingly poor prevailing socioeconomic conditions, work history requirements keep elders from being eligible. Other barriers include:

- Beliefs that IHS covers all medical needs so they don't feel that they need the service;

- Beliefs that, because they are Native American, they are entitled to free care and shouldn't have to enroll in, or be concerned about, health care insurance or billing;
- Complexity of the health care system;
- Lack of knowledge and awareness about how to enroll;
- Lack of knowledge about health insurance;
- Confusion over the parts of Medicare, coverage options, deductibles, etc.;
- Difficulty signing up: no internet access and limited information and resources available to help in the community; and
- Costs of the programs.

## Medicare Payments for Elders

Difficulties identifying AI/ANs enrolled in Medicare, as well as the complexities of the ITU systems of care, make quantifying the amount of funds spent on AI/AN Medicare beneficiaries extremely challenging.

Essentially, all AI/ANs *enrolled* in Medicare (who can be identified) have Part A (Hospital Insurance), and about 90% have both Part A and Part B. This is surprising, given the common perception that many tribal elders with access to IHS or tribal facilities feel that paying premiums for care is inappropriate due to the federal trust responsibility. However, some state Medicaid programs pay the Medicare Part B premiums for all IHS AI/ANs. There are also tribes who pay premiums for their elders to ensure that they have access to needed care throughout the year. [54]

According to the IHS budget proposal for 2015, payments from CMS to IHS and tribal facilities for 2014 will total just over $1 billion, including approximately $217 million for Medicare. [55] This is a significant increase from approximately $735 million in total 2010 reimbursements. It is important to note that these estimates fail to account for all collections by IHS-funded facilities, as tribal facilities are not required to report reimbursements.

According to Crouch et al (2012), Medicare payments for hospitalizations not covered by managed care, for IHS AI/ANs alone, totaled $604 million in 2009 (the latest dataset available for analysis at the time). Medicare hospital payments typically constitute the largest category of benefit payments—roughly twice as much as payments for physician and other professional services. Medicare prescription drug data were not available at the time of the report. Based upon these estimates, somewhere in the neighborhood of $1 billion may be paid by Medicare annually for AI/AN care.

## Billing Entities

A number of entities are involved in the ITU billing process.

- The Medicare Administrative Contractor for IHS is currently Novitas Solutions, Inc. (formerly Trailblazer Health Enterprises, LLC).
- Tribes, federally qualified health centers, rural health centers, and other non-IHS entities may have other fiscal intermediaries or carriers, can use the Medicare Administrative Contractor designated for their state for Medicare claims, or can elect to file claims through Novitas.
- Blue Cross and Blue Shield of New Mexico currently serves as the fiscal intermediary for the federal IHS Contract Health Services program and 11 tribal programs.

# Chapter 3: Medicare Fraud & Abuse in Indian Country

***Why is it so difficult to quantify the problem of Medicare fraud and abuse for AI/AN seniors?***

- Medicare, Census, and IHS data do not routinely and accurately identify and classify all AI/ANs, and often contain significant discrepancies.
- Medicare, Census, and IHS data systems are not linked.
- The health care and billing systems can be extremely complex.
- IHS estimates of Medicare payments only tell part of the story, as they do not capture data collected by tribal facilities.
- No concrete estimates or methodologies exist for determining fraud, waste, and abuse in the Indian health care system.

## Fraud, Waste, and Abuse

As with any type of fraud, it is nearly impossible to quantify the scope of the problem. The perception exists that potentially less fraud may be impacting AI/AN elders due to:

- Cultural *insulation* or geographical isolation in some tribal communities from typical fraud and abuse scams; and
- Fewer incentives to commit fraud because ITU reimbursements are so complex and program funding is limited.

Findings from an SMP staff survey, interviews with tribal aging and health service providers, and feedback from the Office of the Inspector General (OIG) staff identified a number of factors impacting Medicare fraud for AI/ANs, including:

- Cultural barriers: distrust of the government; close-knit communities may lead to a reluctance to report friends and relatives; the limited number of providers available; a fear of retribution; limited literacy; limited access to phone, internet or other technologies; etc.
- High poverty rates may create susceptibility to induce beneficiary participation in scams
- Lack of interest by elders—"they don't pay their bills, so they don't seem to care"
- Lack of knowledge about Medicare programs and services

### Cultural Barriers to Fraud Detection and Reporting

**Distrust of government**

**Reluctance to report**

**Fear of retribution**

**Limited literacy**

**Limited access to information**

**Limited technological access**

**Lack of Medicare knowledge**

**Lack of interest in health care billing**

**High poverty rates**

- Limited access to information, expertise, and resources on Medicare
- Lack of understanding on the impact of Medicare losses on IHS and tribal programs
- Complex billing system with multiple payers involved
- If services are obtained through IHS or an IHS-funded entity, the Medicare Summary Notice (MSN) is *suppressed* and the elder doesn't receive an MSN

## Where Elders Live and Receive Care

Those living in urban settings, or those who seek care from non-ITU providers, are likely equally exposed and susceptible to the same types of scams as the non-Native population.

Elders who receive care from ITU providers, and thus don't receive MSNs, may be more likely to be disengaged from health care billing practices and activities.

Providers in these facilities may, in fact, be emboldened knowing that elders receiving care from most ITU facilities don't receive MSNs and are, therefore, less likely to detect improper billing.

## Oversight and Scams

The HHS OIG is responsible for providing oversight of HHS programs to help protect against fraud, waste, and abuse. Between 2001 and 2010, the OIG opened 288 investigations involving IHS—many were the result of allegations of Medicare or Medicaid fraud. Of the 223 investigations, 118 investigations led to criminal prosecutions.

The OIG has identified five vulnerabilities within IHS and tribal health systems:

- Employee misconduct;
- Drug diversion by employees, contract providers, and beneficiaries;
- Tribal enrollment fraud;
- Fraud related to tribal 638 programs or ISDEAA, and
- Medicare or Medicaid reimbursement fraud.

Examples of **employee misconduct** include specific schemes to defraud IHS, Medicare, or Medicaid, including embezzlement of funds, kickbacks, and more. In South Dakota, an IHS employee and two others were convicted of improperly directing IHS contracts in return for cash and employment kickbacks.

Rural isolation and the black market value of controlled prescription drugs contribute to the appeal of crimes involving **drug diversion**. In one Montana case, an IHS nurse practitioner wrote unnecessary prescriptions for controlled substances. Patients (including some IHS staff) filled the prescriptions at IHS facilities and then sold the drugs back to the nurse practitioner.

Individuals enticed by the availability of expense-paid health care at IHS facilities, which is available only to members of federally recognized tribes, have falsely claimed enrollment as tribal members. A lawyer in South Dakota was put in jail and required to pay restitution for **tribal enrollment fraud**.

Regulations for the use of ISDEAA or **638 program** funds require that they be used for the provision of health care related services only. In one case, a tribe utilized funding to construct a permanent facility and intentionally misled the IHS during negotiations involving the use of the funds.

Typical **Medicare and Medicaid fraud** scams are also perpetrated within the ITU system. In one successful investigation, an unlicensed physician's assistant illegally billed hundreds of thousands of dollars to Medicaid and Medicare while working at an IHS facility. [56]

At any point in time, tens of thousands (perhaps hundreds of thousands) of elders may be seeking care outside of the ITU system, which means they are exposed to the same types of scams as the general Medicare beneficiary population.

# Chapter 4: Conducting Outreach with AI/AN communities

## Challenges and Barriers

Working with AI/AN communities to address Medicare fraud must be done with cultural sensitivity and collaboratively with the community. Challenges face organizations wishing to work with AI/AN communities in preventing Medicare fraud. These challenges are grouped into three areas:

1. Lack of understanding about Medicare within the communities,
2. Historical underpinnings of working with AI/AN communities, and
3. Cultural competency and health literacy.

It is important to note that great diversity exists in AI/AN cultures. Within communities, differences often exist between those who are more or less traditional in their approach to their Native American identity.

Despite the challenges they face, Native communities usually offer great strength and resiliency. Furthermore, family and community factors—including spirituality, traditional practices, and other cultural strengths—can and do offer opportunities to maximize the health and well-being of AI/ANs. Incorporating these factors will make programs and interventions more culturally relevant and successful.

## Historical Underpinnings of Working with AI/AN Communities

Historical events with lasting repercussions create complex issues that must be acknowledged and understood when working with AI/AN communities. Historical relationships with the federal government and with the U.S. health care system have engendered a large degree of mistrust. Key themes of these historical underpinnings include the trust responsibility of the federal government toward AI/ANs.

The federal trust responsibility stems from sovereign tribes ceding lands to the U.S. government in exchange for certain protections for individuals, including health care, which constitute the trust. This is the basis for federal funding of health care and education programs for Indian Country. Many breaches of this trust responsibility have occurred throughout history, and there are still unresolved issues about tribal sovereignty.

It is a challenge to overcome the historical underpinnings of AI/AN communities. However, some strategies are available to help support the successful implementation of a Medicare fraud prevention program. A key component is seeking to develop a collaborative, trusting, long-term relationship—not

simply to conduct a project that will end in a few years. Experience has shown that interventions, when introduced effectively, tend to continue in the community long after funding and technical assistance ceases.

## Cultural Competency and Health Literacy

Cultural competency based on key audience insights is essential to an effective outreach plan, including its execution and evaluation. Effective delivery of health communications to elders depends on understanding the audience, earning trust, building effective partnerships, and identifying the most effective communications strategies and channels. Strong consideration should be given to:

- Understanding how community members view the world—especially regarding health—from a cultural perspective;
- Considering culture early on and at every subsequent step of outreach and education;
- Seeking guidance and participation from people and experts who share the culture of the target population; and
- Partnering with trusted organizations and individuals who can help positively impact the outreach messages and materials.

**Most racial and ethnic groups face issues of health literacy. It is a major public health factor in eliminating disparities among minority populations, including AI/ANs.** As defined in Healthy People 2020, health literacy is the degree to which individuals have the capacity to obtain, process, and understand the basic health information and services needed to make appropriate health decisions.

Studies show that low health literacy is disproportionately burdensome on AI/AN people and also adversely affects the health care system. These factors make it critical for outreach messaging to remain simple, clear, and culturally relevant. During the message development phase, careful considerations should be given to readability, culture, and patient interaction with U.S. health care systems.

## Tips and Recommendations for Working with AI/AN Communities

While the challenges in addressing Medicare fraud prevention may be complex, some strategies can work well, even in resource-constrained situations. As noted above, building trust and establishing rapport with the tribe's leadership and elders sometimes remains a slow and time-consuming process. Knowing the local history of the community, its experiences with neighboring non-Native communities, and the tribe's experience with both federal and state governments is important. Local variations and unique relationships exist, which are difficult to generalize.

**Confidentiality:** Native Americans, as a whole, have serious concerns about breaches of confidentiality within their communities. In general, many do not trust IHS to protect their confidentiality. In addition,

because communities can be very small, many people have relatives, friends, or acquaintances working in a clinic, which leads to the fear that those people will have access to confidential information and will breach that confidentiality

Following, are a few important tips for working with Native American communities:

- Establish trust with and support from tribal leaders;
- Identify or recruit a community member to serve as the project's advocate within the community and tribe;
- Conduct a needs assessment;
- Meet communities where they are;
- Fund or support agencies or community-based organizations with a proven track record in the community, and ensure that people from the community can provide services;
- Form collaborations with tribal departments and non-tribal agencies working on other health and social issues;
- Address confidentiality;
- Challenge assumptions about the cultural values of the community; and
- Address the concerns around misclassifying data.

The following table compares key difference in communication patterns between Natives and non-Natives:

Table 2: Key Differences in Communication Patterns between Non-Natives and Natives

| Non-Natives | Natives |
|---|---|
| **Demonstrating learning early; seeking to please** | Gaining respect through silence and observation at an early age |
| **Speaking to many people who give perspective to life; not needing to talk to those whom one is close to; companionship** | Conversing at length with those whom one is close to; watching and giving respect to those whom one does not know well |
| **Valuing conversation as a way to get to know others** | Valuing observation as a way of getting to know others |
| **Learning through trial and error** | Children listening and learning; not answering questions or demonstrating skills unless they know the answer or are adept at the skill |

| Non-Natives | Natives |
|---|---|
| **Expecting to demonstrate knowledge** | Difficult meeting expectations of non-Natives due to their way of learning |
| **"Putting your best foot forward." Presenting positive self-image and high hopes for the future**<br><br>**Interpreting Natives who are not boasting or speaking of the future as lacking self-confidence.** | Not accepting boasts, nor speaking of the future (which makes job interviews difficult) |
| **Communicating rapidly** | Thinking before answering, leading to longer pauses |
| **Requiring closure for courtesy** | Not requiring closure (e.g. may hang up at the end of a telephone conversation without saying good-bye) |
| **Preferring direct messages** | Preferring indirect messages |

Collaboration and community engagement compose the basis for conducting outreach in tribal communities. Community-wide participation fosters greater collaboration and coordination of services, engages partners in both the identification of and solutions to important community health concerns, and builds community capacity to improve health outcomes. Consider the tribal public health system, which includes all organizations, stakeholders, and partners responsible for assuring the health of a community. Each tribal public health system is different in terms of partners, their roles, and their levels of engagement. For tribes, Medicare education should not only be collaborative, but tribally driven. Tribal leaders, health professionals, and community members are concerned about particular health conditions, and the availability of resources and services to address them.

Partner engagement will focus on identifying and building mutually rewarding relationships with public and private partners who can help extend the outreach plan and mobilize stakeholders to learn more about Medicare and issues related to fraud and abuse.

The partnership strategy involves connecting with select regional and local organizations, such as nonprofit organizations, urban Indian centers, health care systems, public programs, tribal senior programs, and other community-based organizations. Partnerships that might also include local media outlets, radio stations, and other communication groups that reach the AI/AN community are encouraged.

Grassroots engagement will encourage person-to-person contact at the community level. Research shows that family, friends, community leaders, and providers are trusted messengers who can positively influence audience participation. Grassroots engagement involves working directly with tribes to get the message out through a variety of communication channels and venues, including tribal websites, newspapers, tribal radio stations, newsletters, special events, churches, community health workers, private businesses, employment offices, tribal colleges and universities, and food distribution centers. Where possible, partners may play a role in supporting facilitated education, awareness, and outreach, which has proven to be effective in helping individuals learn more about health care services.

# Chapter 5: Outreach Strategies and Tools

This chapter discusses outreach strategies and tools that can be used when working with AI/AN communities. A vital component of an outreach effort includes a plan that utilizes the current communications environment in a community, profiles the audience, understands the unique health system, and provides strategies, tactics, messages, channels, and evaluation.

The primary goal of the outreach strategy is to form the foundation for a multifaceted, culturally competent education campaign that resonates with AI/AN audiences who vitally need information on Medicare. Successful outreach implementation will help:

- Increase awareness and understanding about Medicare and services;
- Influence individuals to take action in learning more about available Medicare fraud and abuse issues;
- Address barriers to action;
- Forge public and private partners that extend message reach; and
- Measure outreach effectiveness.

## Developing an Outreach Plan

Since every state and tribal community is different, it would be a great start to develop your own outreach plan for working with tribes in your area.

**Remember:** Keep it simple. You don't want to derail your project plans by being overly ambitious. Forging new relationships with AI/AN communities takes time and a hands-on effort.

### Step 1: Develop a Purpose

This is integral to establishing a basis for how your organization will address working with tribes and what is to be implemented through this plan. An example of a purpose is as follows:

> "The purpose of this outreach plan is to identify communications strategies to effectively engage and inform tribal leaders, tribal health directors, and those involved with Medicare around the topic of Medicare fraud and best practices in preventing fraud."

### Step 2: Conduct a Quick Assessment

Take the time to get to a general understanding of the AI/AN population in your state. This will help pinpoint potential priority areas based upon population estimates, tribes, or communities. Utilize the "SMP Native American Project Outreach Assessment Form" in the Appendix to start your research. Conduct an internet search and identify a list of organizations in your state that are well established and that may have common interests or needs. You might start the assessment before identifying your

audience, and then continue after you've identified your audience. This assessment and research is a great task for a volunteer to undertake.

## Step 3: Identify an Audience

Below, is a list of audiences who have been identified as being a part of the Medicare spectrum; however, this list may grow as you reach out to specific communities and find that they have others who may assist in efforts to educate the AI/AN community.

- Beneficiaries who receive MSN (i.e., those who use some tribal facilities or non-ITU providers)
- Beneficiaries who don't receive MSN (i.e., those who use IHS facilities)
- Family
- Tribal Leaders
- Tribal Community
- Community Health Representatives
- Area Indian Health Boards
- National Indian Health Board
- Title VI Directors (ACL grantees working with elders in tribal communities)
- Tribal Health Billing Coordinators
- Tribal Health clinics
- Tribal Senior Care specialists
- Urban Indian health programs

Family and community play larger roles in most tribal communities and should be considered as primary audiences for SMP activities.

## Step 4: Customize the SMP Message

The SMP message and materials utilized when working with AI/AN elders and their communities may need to vary somewhat from traditional messaging. The degree to which this is necessary will vary from one community to the next.

The majority of SMPs and those in the aging community believe the typical Medicare fraud awareness and prevention message will fail to resonate with most elders. Help elders make the connection between Medicare and the ITU system, and help them understand how Medicare losses directly and indirectly impact their local tribal health providers in incredibly complex ways. Further, be aware that the elders may feel antipathy towards Medicare as a Federal government program, given the history of unmet health care trust responsibilities.

Outreach strategies must take into consideration the general lack of understanding and awareness within AI/AN communities about health insurance, as well as Medicare. SMPs who don't have significant knowledge or access to resources about Medicare benefits may want to consider partnering with an entity that can fulfill this function.

Other points to keep in mind when considering the SMP Messaging include:

- Emphasizing Medicare as insurance and the direct connection to the benefits to them individually as well as to their tribe;
- Personalize the implications of fraud and scams to them individually;
- Simplify the message and use plain language;
- Consider minimizing references to federal government programs in some communities, because of their lack of trust or other negative perceptions; and
- Consider methods that are typically less formal (talking circles vs. PowerPoint presentations).

For specific talking points, please refer to the accompanying SMP Brochure.

Be sure to invite your new community partners to review materials and invite their feedback before distributing them within the community or conducting presentations to ensure your message is on-target and will resonate.

## Step 5: Utilize Information from Current SMP Outreach Practices

A number of SMPs have a successful track record of conducting outreach and partnering with tribes in their state. Examples of strategies that have been successfully employed follow.

### North Dakota SMP

The North Dakota SMP has conducted outreach to tribal communities regarding Medicare fraud in various ways. Some of their methods include: hosting an exhibit booth or presenting at a tribal health fair, presentations to Tribal leaders, and attending powwows. These methods have been met with varying degrees of support and interest from the tribe.

#### Results

The health fair was the most favorable event to conduct outreach activities. This was most likely due to the audience's willingness to hear health messages. Also, presenting to the elders was a success. Most outreach events will need to be planned in coordination with the community contact. North Dakota mentioned that conducting outreach at a powwow was not the best venue for educating elders, since most were not willing to participate in the activities. Most powwow events are celebrations related to traditional dances and ceremonies. To plan an outreach event at such an event, you would need the full support and direction of the tribal health care staff. **Be sure to have the full support and buy-in from the tribal health staff before thinking of conducting an outreach event at any tribally affiliated event.**

### Future Plans

The North Dakota SMP has decided to move forward in creating a video on the importance of protecting your Medicare number. This video will be aired on GoodHealth TV in waiting rooms of medical facilities in all North Dakota tribal communities. This video, and the use of GoodHealth TV network in all Indian Health Service facilities, is a great way to reach the AI/AN community in your region.

## North Carolina SMP

The North Carolina SMP has been able to conduct outreach to tribes in various ways. Some of their methods include: trainings for tribal health clinic or elderly care staff in Seniors' Health Insurance Information Program and SMP materials; having "How to read your MSN" events; utilizing Senior expos for AAA region on the reservation; contracting with regional AAA staff to work with local tribal populations.

### Results

The most successful method for the North Carolina SMP outreach occurred at the senior expo which had a large turnout of elders from the Eastern Band of Cherokee Nation. The senior expo was coordinated in conjunction with the states' AAA region. They have also built a relationship with the tribe and the AAA to ensure that SMP materials will be promoted at all the events held on the reservation.

### Future Plans

The North Carolina SMP recognizes the need for educating tribal health staff, community health representatives, elder care staff, and other advocates about Medicare and Medicare fraud. Educating tribal staff about Medicare and fraud issues will assist the tribe in saving money through reimbursements, as well as help prevent any fraud issues.

## Alaska SMP

The Alaska SMP has used many different methods to conduct outreach to elders regarding Medicare fraud. They have met with Alaska Natives in Native communities at health fairs, employee health fairs, and military retiree health fairs. They partner with the Alaska Native Tribal Health Consortium to host Native elder talking circles about health topics including Medicare fraud. Depending on the varying degree of health knowledge, they tailor their efforts to meet each tribal community member on site.

### Results

Depending on the community, each method was met with different levels of participation and acceptance. For their communities, many of the methods are dependent on the season and weather, due to the extreme winters and summers filled with subsistence activities. They have discovered that their outreach is seasonal (April, May, and September), and this should also be considered for other communities in the Lower 48, as well. Many Native communities have certain ceremonies throughout

the year that inhibit any outreach activities or events. It is advisable to contact each tribal community to make sure you are not overlapping any traditional holidays or events.

### Future Plans

The Alaska SMP will continue many of their current outreach activities. They rely heavily on relationships with partners on the reservation or Native village. The messaging for Alaska Medicare issues is similar to other ethnic communities in Alaska (include non-natives, Koreans, Filipinos, Hmong, etc.). The Alaska SMP will continue targeting the best months of the year to conduct outreach to Native elders and other Medicare advocates. Since they continue to struggle with educating rural communities, The Alaska SMP will utilize Native community health advocates to bring the messages to the individual elders.

## Step 6: Consider Outreach Methods

Below is a collection of outreach methods developed in consultation with SMPs who have attempted outreach to tribal communities. Your program might consider one or more of these approaches when developing an outreach plan.

### Media only

Media-only methods are appropriate for states with SMPs who do not have a track record of tribal relationships (which are more cost-effective) or where tribal relationships are already effective to support efforts. Examples of media-only approaches include:

### Information Dissemination

Use a variety of media channels to disseminate information and materials about tribal Medicare fraud issues. For example:

- Mail or deliver fact sheets and brochures on Medicare fraud to key tribal contacts;
- Create a culturally appropriate video with the SMP message and broadcast it in clinic waiting rooms;
- Post new materials online and publicize their availability to media outlets and social media channels, especially those connected to tribes in your region.

### Earned Media and Social Media

- Earned media (in contrast to paid advertising) is outreach to reporters, producers, and bloggers that generates publicity, which advances the goals and objectives of a communications campaign. There is an opportunity to use social media channels such as Facebook, Twitter, and YouTube to publicize Medicare fraud trainings and webinars and draw attention to these issues.
- Assist tribal health departments in writing posts and tweets that can be shared by local tribal organizations.

## Grassroots Outreach Efforts

Identify workshop and presentation opportunities at conferences and events for SMPs and other Medicare advocates to take SMP messaging directly to tribal leaders and other key stakeholders. Some possible venues include:

- Area Indian Health Board conferences,
- Other regional tribal health- or non-health-related conferences,
- Tribal health fairs or local events,
- Title VI Elder Nutrition program events, and
- Tribal senior and elder center events.

### Tribal-specific direct approach

This method encourages a connection with health advocates within the tribe. First, connect with a tribal health advocate. For many tribes, this will include the tribal health care director, community health representative, elder care director, Title VI director, or other health advocates. These contacts will not only be helpful in setting up any outreach events or activities, they will be helpful in connecting you to other tribal leaders who many serve on health committees. Typically, when connecting with a tribal leader who advocates for health issues on the reservation or Native Village, you will have the opportunity to send a "Dear Tribal Leader" letter to address any activities you wish to coordinate with the tribe or tribal health center. This method may be more time intensive and will require a substantial long-term commitment towards building and sustaining relationships within the tribe.

### Regional Area Indian Health Board approach

This method involves connecting with the IHS regional contacts or Area Indian Health boards (nonprofits), which serve that IHS regions tribes. These contacts could be valuable in reaching multiple tribes within your area. You may be able to use these entities as a vehicle to organize webinars or provide in-person training if the location allows.

### Urban Indian Health Center approach

Consider this approach if your state or region has either an Urban Indian Health Center (see the maps) or a large urban Indian population that may be served by cultural, or other types, of urban Indian organizations. Many health centers provide services to people from different tribes around the country. Some cities may have community groups or other entities designed to focus on one tribal population that has relocated in large numbers to the area. Many of these organizations have large populations of elders or sponsor elder-specific activities. Working with urban Indian health organizations or centers will provide an opportunity to have elders or health advocates bring Medicare messaging back to the tribal members on the reservations or Native villages. Refer to the previous urban Indian section in Chapter 1 for background. Because there is not a single tribal entity or issue gaining access to reservations, this option may present a more stream-lined alternative.

### Combination of media and direct approach

This method is appropriate for states where tribal approaches exist, although they may not be effectively established.

### Conference approach

Depending upon the number of tribal communities in your state, you may consider convening a conference specifically for AI/AN advocates in your state. If you already sponsor an annual conference, you might consider extending an invitation to tribal health or elder advocates in your state. If the number of participants warrants, create a conference session or sessions, or invite participants to a working session geared specifically towards AI/AN populations.

### Other large structured entities

Each tribe has multiple departments or agencies that work with elders and disabled tribal members. Be sure to connect with your tribal contacts to identify which agencies might be available to assist in providing outreach and education to Native elders. Some of the agencies that have been instrumental in providing various services to elder populations include title VI: Elder nutrition programs, the tribal housing authority, tribal health consortiums, non-tribal health clinics near reservations, AAA organizations, Human Services Departments, Tribal IHS Billing and Coding agencies, Tribal health organizations, etc. Many Senior Health Insurance Information Program (SHIIP) programs have established relationships within communities and may be able to provide an entrance for your SMP outreach efforts.

### SMP Lessons Learned

Those SMPs who have conducted outreach to AI/ANs offered the following lessons learned on their experiences in forging relationships and attempting to create new partnerships:

- Connection with tribal elders can be challenging as an outsider.
- Building relationships with beneficiaries takes time and consistency.
- Eighteen months of integration grant funding is not enough to get established.
- Elders can be slow to comprehend anti-fraud messages due to complexity.
- It can be difficult to recruit volunteers because of tribal commitments.
- There may be a limited need to translate materials: elders rely on oral, not written, messages. (Check with the community.)
- Developing stand-alone media can be expensive.
- Turnover in tribal staff is frequent and can cause project restarts.
- Tribal events tend to be more informal then regular presentations, and have shorter planning cycles.
- Elders have many Medicare questions.

- Before conducting a presentation, understand tribal billing and health benefits, and be able to differentiate between people who receive MSNs and those who don't.

## Step 7: Select and Implement Outreach Strategies

If outreach to AI/ANs is new to your organization, you might consider testing the implementations of multiple strategies to determine which one is most effective within your state and within different tribes or communities.

There is a broad group of agencies and organizations that share the goal of improving Medicare in Indian Country who can advocate with tribal leadership (see Step 3: Identify and Audience for a list of partners). Utilize this list to connect with tribes or urban Indian programs. It is important to involve the tribe early in any plans. You may have to conduct outreach at the Tribe or urban program.

## Step 8: Consider Emerging Trends in Native American Media

The media today are more fragmented than ever, and people consume media and messages when and where they want. People get their news and information from a variety of sources. There is less control over the message and there is more dialogue. These trends are also true for Native American audiences. Several other significant media trends will impact campaign effectiveness in Indian Country.

## Mobile Indian Country

Many tribal lands, often located in rural and isolated areas, still lag behind in Internet broadband access, although efforts continue to help increase connectivity. Broadband adoption among AI/ANs is lower than other demographic groups at 43%, according to the National Broadband Plan and Telecommunications and Information Administration. Despite this, studies suggest that AI/ANs are adopting social media and other forms of new media at some of the fastest rates of any group. In 2009, Native Public Media and the New America Foundation completed a study on *New Media, Technology, and Internet Use in Indian Country* that found that AI/ANs are not only tech savvy, especially among younger age groups, but utilize digital multi-media and communication technologies at higher rates than normal groups. The study found that:

- 94% of tribes had their own website
- 84% of AI/AN respondents used the Internet several times a day
- 44% have used a social networking site
- 92% owned a cell phone
- 40% had a smart phone

The lack of broadband access has expedited the use of cell phones by Native people. Many Native people have moved straight to mobile Internet, accessing digital content through cell phones that do not require broadband connections (2012 Pew Research Study). While cell phone usage has increased significantly among AI/AN people, outreach strategies focused on engaging text messaging campaigns

is still evolving, as issues of government intrusion and costs (mobile packages often include associated text messaging costs) must be carefully considered. Native American news organizations are increasingly responding to this media trend by concentrating on more mobile applications and digital content, including storytelling.

News organizations in Indian Country are attempting to become more multimedia focused. Several Native American outlets, according to the 2012 Pew Research Study, are building resources and extending audience reach through partnerships, particularly with public television and public radio organizations. This media trend reflects the need to deliver messaging across diverse platforms, including online and through social media to forge partnerships with influential communications partners and broadcast networks in Indian Country.

## Health Center Communication Link

Another potential means of distributing health information exists in IHS or tribal health clinic waiting rooms, where both patients and their families may spend significant amounts of time waiting for appointments. Many clinics now cycle a variety of short, health-related videos on a continual basis, resulting in good saturation among Native viewers. Wide-ranging networks featuring Native health videos already exist, although costs for distribution remain high. Locally, it might be possible to create a low-budget video for use at a single tribal health clinic.

## Radio's Effectiveness

Radio remains a strong medium for reaching Native American audiences, especially elderly populations that reside in AI/AN communities. According to Native Public Media, there were 48 Native radio stations in late 2011, a 45% increase from 22 in 2009. Television, although still popular with AI/AN audiences, can be expensive. Newspapers still have significant influence with AI/AN audiences and several regional and national print and online publications, including *Indian Country Today*, are widely read in AI/AN communities. Outdoor advertising, including billboards, transit, street furniture, and cinema, offers proven channels for effective message dissemination in Indian Country, too.

The current communications environment in Indian Country, similar to national trends, is evolving in our increasingly mobile society. While traditional forms of media—including radio, print, and television—remain influential mediums for reaching AI/AN audiences, digital media forms, including multimedia and social media, present new opportunities to connect with AI/AN audiences.

Even so, AI/AN elders remain, perhaps, the least *wired* of all AI/AN age groups. Many still depend on local or national Native radio broadcasts and television news for information. They are more likely to access and pay attention to their monthly tribal newspaper than an Internet report.

Partnerships at local and national levels can help extend campaign messages and influence the audience at the grassroots level where word-of-mouth plays an important role spreading the

messaging. Clearly, messages received from family, friends, health care providers, and the tribal community are the most credible and trusted sources of information.

# Appendix

## Appendix A: Media Tools

**Note, resource materials created as part of this project may be used in part or as is. We would appreciate attribution when possible, but this is not required. If you do use resource materials created as part this project, please consider sending an email to admin@iasquared.org and let us know you found the materials helpful.**

### A.1 Newsletter Article Templates:

#### A.1.1: Medicare Open Enrollment Scams

#### Medicare Open Enrollment – Make Good Choices & Watch Out for Bad Apples

You get a letter in the mail, telling you about the new law that requires you to get a new health care card. Maybe you get a call offering you big discounts on a new health insurance plan. Or maybe someone comes to your house and says they're from Medicare, and they need your Medicare number to issue you a new card.

Scammers follow the headlines. It's [almost] Medicare open enrollment time. That means if you have Medicare you get new choices. It also means you have to keep an eye out for people trying to rip you off. That might be crooks trying to get your Medicare number, financial information or health insurance number. Their goal? To steal your identity or trick you into buying something you don't need. Or it could be "bad apple" insurance agents trying to sell you a Medicare plan that makes them money and cheats you out of benefits you really need.

Don't let anyone trick you into making a bad decision. Take the time every year for a "check-up" on your Medicare choices during Open Enrollment. Make sure you talk with your Indian health care provider before making changes.

#### About Medicare "Open Enrollment"

Medicare offers "open enrollment" every year from October 15 to December 7. People with Medicare can make changes to Medicare Prescription Drug plans (Part D) or Medicare Advantage plans during open enrollment.

Your situation may have changed after you signed up for Medicare. Maybe you take different medications. Maybe your doctor told you that you now have diabetes—or another new health problem. Maybe you moved to be closer to your family. Whatever the reason, the plan you signed up for last year may not be the best plan for you now.

Or, maybe you didn't sign up for a Part D prescription drug plan when you first could. You can switch plans during open enrollment each year or sign up for a new Part D drug plan or Medicare Advantage plan.

If you get your medicine from an Indian Health Service (IHS) or tribal pharmacy, chances are you have "creditable coverage." That means your prescription drug coverage is as good as Medicare requires.

Even if you get your medicine from your Indian health care pharmacy you might still need a Medicare prescription drug plan. The plan may help pay for medicine your Indian health care pharmacy cannot.

If you didn't sign up for a Part D plan when you were first eligible you may have to pay a penalty to sign up now. But, if you had "creditable coverage" by your IHS or tribal pharmacy that penalty may be waived.

## Part A & B Changes Come Later

Medicare offers another enrollment period between January 1 – March 31 for Part A (hospital) and Part B (outpatient). So, if you didn't sign up for Part A or Part B when you were first eligible there is still another chance. You might have to pay an extra fee for enrolling late. Some people might qualify for special exceptions.

## Things to Consider When Choosing a Plan

1. **The type of coverage you need.** Does the plan let you see the doctors you want and go to the hospital you want? Does the drug plan cover the medicines you now take?
2. **The cost of the plan.** Prices are different. Compare costs. Find out if you can get help paying for the plan from your tribe or other sources.
3. **The location.** If you plan to use providers outside of the Indian Health System, are they close to your home? Can you go to the pharmacy you like?

**You are not alone.** Get help from family, Indian health care providers, from the Medicare website or from your local State Health Insurance Assistance Program (SHIP).

## How to Protect Yourself during Open Season

Take a minute to stop and think: Do you really have to get a new health care card? Is that cheap insurance a good deal? Is that "government official" really from the government? The answer to all three is almost always: No.

Don't let someone push you to make a decision right away. Take your time. Before you share your information, ask people you trust for help. Talk to your friends and family, check with your Indian health benefits coordinator, and do some research.

## Medicare Matters to Elders & Our Communities

Medicare is health insurance for elders that offers peace of mind and protection. **It saves you and your tribe money.**

Signing up for Medicare doesn't take away your right to get care from your Indian health care provider. You can still use your IHS or Tribal provider or go to a non-Indian health care provider who takes Medicare. They will all bill Medicare for you.

When you have Medicare and go to your Indian hospital or clinic, Medicare insurance helps pay. **You help your Indian health provider and your tribe save money.** That money can be used for the health needs of your family and friends.

We need you to help preserve and protect this precious resource. We need you to help protect our communities and your neighbors.

If you think someone is trying to scam you, report it. Then pass it on. Tell your friends and people in your community.

Report scams, or bad agents to your Senior Medicare Patrol. Call us [them] at: [INSERT NUMBER]. SMPs help protect elders and communities and prevent Medicare fraud.

## A.1.2: Medicare Matters- Elders and Family

### Medicare Fraud Matters to Our Elders

Sadly, some people don't care about our elders or their health. They don't care about Medicare. They will call and ask for personal information, like a Medicare or Social Security number. They might try to sell someone medical equipment they don't need. Or offer money, gifts or groceries for a Medicare number. Just because Medicare might pay the bill. Then they try to cheat Medicare, and cheat our elders by using this information for fraud.

Medicare matters to all of us. Especially elders. It's health insurance that gives them peace of mind and protection. Many elders need care they can't get through Indian health care providers. Like medical equipment or referrals to specialists. They can't get it either because it isn't offered or because of budget problems. When you have Medicare you can still use your Indian health provider. You can also go to other non-Indian providers if you need to.

Medicare saves each of us and our tribe money. When a person has Medicare and goes to an Indian hospital or clinic, Medicare insurance helps pay. That money can then be used for other Indian health programs. Using Medicare helps save scarce tribal resources.

#### Scammers and thieves try to take that money away from us.

If this happens to you, stop and take a minute. Don't let someone rush you to make a decision right away. Before you share information, talk to your friends and family, do some research, ask for help from people you trust.

If you think someone is trying to scam you, report it. Then pass it on. Tell your friends and people in your community.

Report scams, or bad agents to your Senior Medicare Patrol. Call us [them] at: [INSERT NUMBER]. SMPs help protect elders and communities and prevent Medicare fraud.

Remember, Medicare matters to you and to our community [tribe].

[Alternative ending for articles for family members after sentence "Scammers and thieves":] Your elders depend upon you. Tell them not so share information with strangers. Let them know you are here to help when they have questions.

If you think someone is trying to scam your elders, report it. Then pass it on. Tell your friends and people in your community.

Report scams, or bad agents to your Senior Medicare Patrol. Call us [them] at: [INSERT NUMBER]. SMPs help protect elders and communities and prevent Medicare fraud.

Remember, Medicare matters to our elders and our community [tribe].

## A.1.3: Medicare Identify Theft

### Medicare Identity (ID) Theft – Cheating our elders and our tribes

### [Stop It. Report It. Pass It On.]

- **On your way to the pharmacy, you stop at a table with a nurse that offers to check your blood pressure for free. The nurse checks your blood pressure and then asks to see your Medicare card.**
- **Your "cousin" from out of town calls you and offers to have someone come clean your home and bill Medicare for it.**
- **Someone stops by your house and says they are from Medicare or Social Security and needs to see your Medicare card to issue you a new one.**
- **You get a letter in the mail telling you about the new law that requires you to get a new health insurance card.**

You give out your Medicare card. What's the price? Someone takes over your identity and you and Medicare get billed for the cost.

All types of people steal medical IDs. Doctors, people who sell medical supplies, even gangsters and thieves from other countries. Sadly, a lot of those who steal IDs are people who know the person, such as their family or caregivers.

Medical identity theft happens every day, everywhere. Scammers are good and can trick anyone into giving out their information. It happens to millions of people.

Medical ID theft costs more than time or money. It can lead to fake claims being filed with Medicare, result in big medical bills, use up your benefits and mess up your medical records. A different blood type, wrong disease or someone else's lab tests- think about what could happen if any of these showed up in your records. Bill collectors may hound you for health care you never got.

When your Medicare information is stolen, you get cheated and so does Medicare. Medicare matters to all of us. To you. To your family. To your tribe. It's health insurance that provides peace of mind and protection. It saves our tribe a lot of money.

When Medicare pays the bill it means your tribe doesn't. When Medicare gets ripped off, so do you and your tribe.

## Tips to avoid identity theft

- Keep your Medicare, Medicaid, and Social Security cards safe.
- Only give your Medicare card to your regular doctors or health care providers.
- Look at your Medicare Summary Notice or Explanation of Benefits and medical bills. Make sure you were not charged for anything you did not get.
- Tear or shred papers with your medical information.
- Rip labels off medicine bottles and packages that have your name. Tear them up before you put them in the trash.
- Never accept things offered for "free" in exchange for your Medicare number.

## Strangers don't care about you.

If someone approaches you, stop and take a minute. Don't let someone rush you to make a decision right away. Before you share information, talk to your friends and family, check it out, and ask for help from people you trust.

If you think someone is trying to scam you, report it to your health care provider. Then pass it on. Tell your friends and people in your community.

If someone tries to steal your Medicare ID, or if you think they already have, contact your Senior Medicare Patrol for help. Call us [them] at: [INSERT NUMBER]. SMPs help protect elders and communities and prevent Medicare fraud and Medicare identity theft.

## A.1.4: Medicare Matters- Health Care Providers

### Medicare Fraud Matters to Our Tribal Health System

Sadly, some people don't care about our elders or their health. They don't care about our tribe. They will call an elder and ask for personal information, like a Medicare or Social Security number. Or offer money, gifts or groceries for a Medicare number. They will contact tribal clinic offices asking for the doctor to approve a special back brace, wheelchair, diabetes testing equipment or scooter without the doctor ever seeing the patient. Just because Medicare might pay the bill.

Then they try to cheat Medicare, and cheat our tribal health care system by using this information for fraud.

Medicare matters to all of us. It's health insurance that gives our elders peace of mind and protection. When a person has Medicare they can still use their tribal health providers. If your clinic or hospital isn't able to provide the care or services they need, they have the option to go to a non-Indian health provider that accepts Medicare.

Medicare saves our tribal health system money. When a person has Medicare and comes to an Indian hospital or clinic, Medicare insurance pays. That money can then be used for other Indian health programs. Using Medicare helps save scarce tribal resources.

**Scammers and thieves try to take those resources away from our elders and health programs every day.** Medicare loses more money to fraud in one year than the entire Indian Health Service budget. Ten times over.

We need to step up and help preserve and protect this precious resource. We need you to help protect our communities and your neighbors.

Elders trust and depend upon you. Tell them not so share information with strangers. Let them know you are here to help when they have questions about Medicare. Learn more about Medicare and how it works. Take the time to share information about preventive health benefits. Help them find legitimate sources of care and services outside of your facility when they need it.

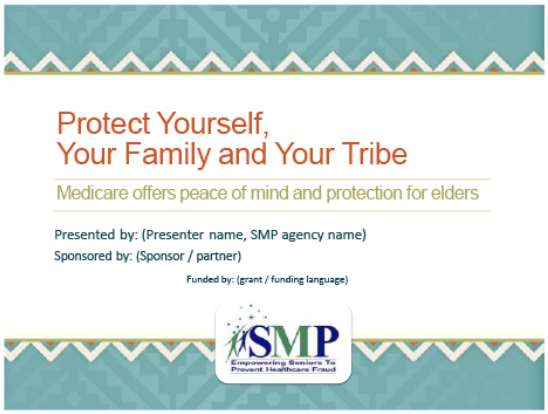
If you think someone is trying to scam an elder, report it. Then pass it on. Tell your colleagues, friends and people in your community.

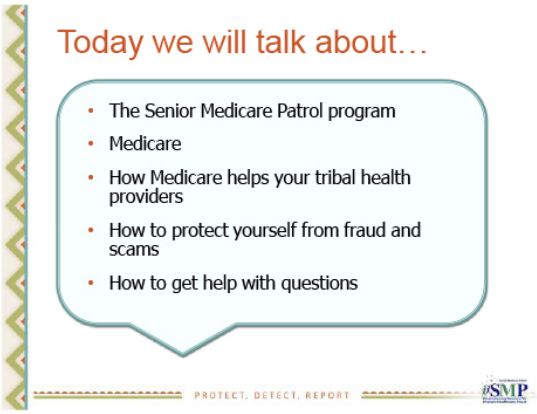
Report scams, or bad agents to your Senior Medicare Patrol. Call us [them] at: [INSERT NUMBER]. SMPs help protect elders and communities and prevent Medicare fraud.

Remember, Medicare matters to our elders and our community [tribe].

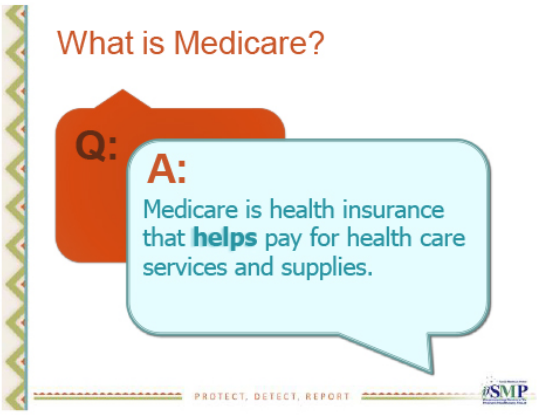
## A.2: PowerPoint Template Preview – 2 Versions Available as Separate Files

*Note: The version previewed below has limited graphics incorporated, a second version is available that has additional graphics. The content on the two versions of the PowerPoint are the same.*









## Medicare vs Medicaid

**Medicare**
- Federal health insurance
- Eligible by age or disability

**Medicaid**
- Health insurance through your state
- Eligible by income

**You can have BOTH!**

PROTECT, DETECT, REPORT

## Who is eligible for Medicare?

**Q:**

**A:**
- Most people 65 or older
- Disabled at any age
- People with end stage kidney disease
- People with Lou Gehrig's disease (ALS)

PROTECT, DETECT, REPORT

**Part A**
Hospital Insurance

**Part B**
Medical Insurance

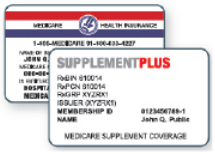
**Part C**
Medical Advantage

**Part D**
Prescription Drugs

Part A + Part B
and sometimes Part D

PROTECT, DETECT, REPORT

## Medigap or Medicare Supplements




- Helps pay some costs after Medicare
- Not required
- Not Medicare plans
- Private insurance
- Must have Part A & B
- Plans have different costs and cover different things

PROTECT, DETECT, REPORT

## Part A: Hospital Insurance

**Helps cover:**
- Inpatient care
- Inpatient skilled nursing
- Hospice care
- Home health services

PROTECT, DETECT, REPORT

## Part B: Medical Insurance

**Helps cover:**
- Doctor visits
- Emergency room visits
- Durable Medical Equipment (DME) i.e. wheelchair, walker
- X-rays, lab tests
- Outpatient services
- Outpatient mental health
- Ambulance
- Preventive health services

PROTECT, DETECT, REPORT

## What's not covered by parts A & B?

**Q:**

**A:**

Original Medicare **doesn't** cover:

- Long-term care
- Routine dental care
- Dentures
- Acupuncture
- Hearing aids
- Cosmetic surgery
- Care not medically necessary

PROTECT, DETECT, REPORT

## Part C: Medicare Advantage

Hospital Insurance | Medical Insurance | Prescription Drugs

**Part A** + **Part B** and sometimes **Part D**

- Replaces A and B
- Don't need Medigap / supplemental insurance
- Some extra benefits
- Compare plans carefully
- Run by private companies – not Medicare

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## Part D: Prescription Drugs

- Must have Part A or Part B
- Run by private companies
- Drugs and costs vary
- No cost to you if IHS approved pharmacy
- Medicare pays the tribal provider

**IHS doesn't pay for all prescriptions**

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## What Does it Cost?

**Q:**

**A:**

**Part A** is free for most.

**Part B, Part C** or **Part D** may have a monthly fee.

If you use a Tribal provider or IHS, you pay no out-of-pocket costs.

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## Things to think about when choosing a plan…


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## Tips for choosing plans

**Take your time, and ask for help!**

- Review and compare
- Ask your family for help
- Find out how your tribal or employer benefits work with Medicare
- Get free help from your local SHIP program
- Take your time, get good info

https://www.medicare.gov/find-a-plan

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## How does Medicare work with IHS, Tribal and Urban Clinics?


- When you use Medicare at an Indian hospital or clinic, Medicare pays them
- That saves your tribe's health care money
- You can also use non-Indian providers and use Medicare to help pay for care - may have costs!

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## More About Tribal Health & Medicare

- Each tribe decides what health care services they offer.
- Medicare may cover services that tribes or IHS do not.
- Indian providers may cover some services Medicare does not: dental, vision, hearing.
- Some tribes may pay Medicare premiums for their members.

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## Preserve your tribal resources…

Protect yourself and your tribe from health care fraud, errors and abuse.

SMP
Empowering Seniors To Prevent Healthcare Fraud

## Health care fraud hurts everyone

- Hurts the tribe by stealing health care dollars
- Steal money
- Reduces quality of care
- Leaves less money for care you need
- Leads to higher health care costs

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## What is fraud & abuse?

**Q:**

**A:**

- Billing for services, supplies, or equipment that were not provided
- Billing for excessive medical supplies
- Obtaining or giving a Medicare number for "free" services
- Improper bill coding to obtain a higher payment
- Unneeded x-rays and lab tests
- Providing services that are not medically necessary
- Using another person's Medicare number, or letting someone else use your number, to obtain medical care, supplies or equipment

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## What about Errors?

**Q:**

**A:** Medicare payment errors are simply mistakes and are not the result of intentional fraud.

Health care billing is complicated, which can lead to simple mistakes.

Must review and investigate.

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## **Real Cases:** Health care fraud & abuse in Indian Country


- South Dakota Man Charged With **Pharmacy** Fraud
- Montana Clinic **Psychologist** Guilty of Bribery and Tax Fraud
- Montana **Home Health** Care Agency Owners Indicted on Conspiracy to Commit Health Care Fraud, Money Laundering and Identity Theft
- Tribal Governor Convicted of 29 Counts of Fraud in **Substance Abuse** and **HIV** Prevention Programs

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## Consequences of fraud and abuse for YOU!

**Fraud with your Medicare number may mean:**

- Errors in medical records
- Medicare won't pay
- You receive the wrong care

**If someone steals your Medicare number they can:**

- Misuse the Social Security number
- Steal your identity
- Get access to banking and credit card info

**Your Medicare number can't be cancelled or changed**

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## Steps to prevent health care fraud


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If you have Medicare, you have a Medicare card.


The Medicare number on that card is a Social Security number.

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## **Step 1: Protect** yourself from Medicare fraud and abuse

| DO | DON'T |
|---|---|
| • Treat your Medicare card and number like your credit cards.<br>• Watch out for identity theft.<br>• Be aware that Medicare doesn't call or visit to sell you anything. | • Give out your Medicare number except to your doctor or other Medicare provider.<br>• Carry your Medicare card unless you will need it. |

*" If it smells like a fish...it probably is! "*

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## **Step 2:** Review to **Detect** signs of fraud & abuse

Use your **Personal Health Care Journal** or a calendar:

- Write doctor visits, tests, and procedures in the journal & take it with you to appointments
- Ask questions about your health care. Write the answers in your journal
- Compare billing statements and Medicare Summary Notices to your journal


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## Contact your State SMP: (Your SMP Name)

**Visit us online: (Your website)**

- For more information

**Call Toll-free: (Your SMP phone #)**

- To report suspected fraud/abuse
- For training, speakers, and/or materials
- To volunteer with the SMP program

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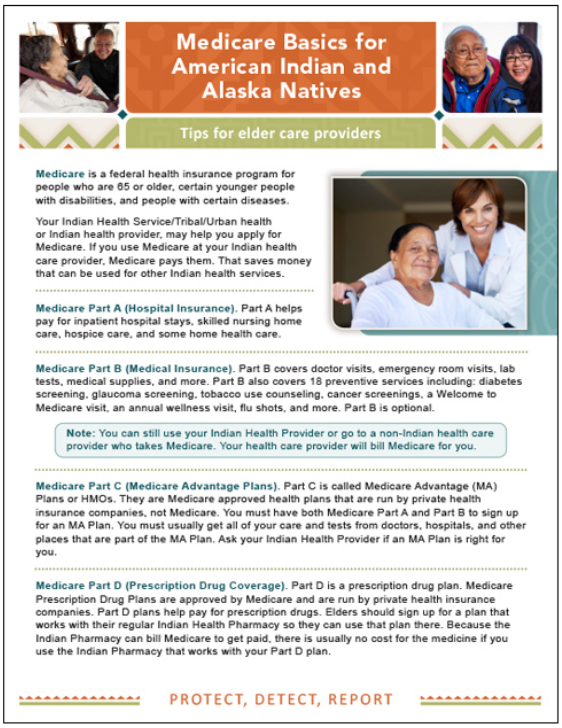
# Appendix B: Preview of Fact Sheets Available as Separate Files

## B.1: Medicare basics for AI/AN



Medicare Basics for American Indian and Alaska Natives

Tips for elder care providers

**Medicare** is a federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with certain diseases.

Your Indian Health Service/Tribal/Urban health or Indian health provider, may help you apply for Medicare. If you use Medicare at your Indian health care provider, Medicare pays them. That saves money that can be used for other Indian health services.

**Medicare Part A (Hospital Insurance).** Part A helps pay for inpatient hospital stays, skilled nursing home care, hospice care, and some home health care.

**Medicare Part B (Medical Insurance).** Part B covers doctor visits, emergency room visits, lab tests, medical supplies, and more. Part B also covers 18 preventive services including: diabetes screening, glaucoma screening, tobacco use counseling, cancer screenings, a Welcome to Medicare visit, an annual wellness visit, flu shots, and more. Part B is optional.

**Note:** You can still use your Indian Health Provider or go to a non-Indian health care provider who takes Medicare. Your health care provider will bill Medicare for you.

**Medicare Part C (Medicare Advantage Plans).** Part C is called Medicare Advantage (MA) Plans or HMOs. They are Medicare approved health plans that are run by private health insurance companies, not Medicare. You must have both Medicare Part A and Part B to sign up for an MA Plan. You must usually get all of your care and tests from doctors, hospitals, and other places that are part of the MA Plan. Ask your Indian Health Provider if an MA Plan is right for you.

**Medicare Part D (Prescription Drug Coverage).** Part D is a prescription drug plan. Medicare Prescription Drug Plans are approved by Medicare and are run by private health insurance companies. Part D plans help pay for prescription drugs. Elders should sign up for a plan that works with their regular Indian Health Pharmacy so they can use that plan there. Because the Indian Pharmacy can bill Medicare to get paid, there is usually no cost for the medicine if you use the Indian Pharmacy that works with your Part D plan.

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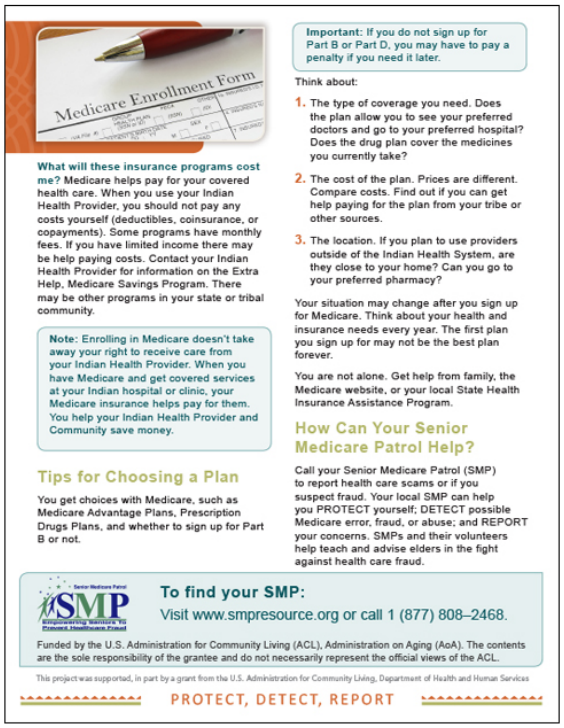

Medicare Enrollment Form

**Important:** If you do not sign up for Part B or Part D, you may have to pay a penalty if you need it later.

Think about:

1. The type of coverage you need. Does the plan allow you to see your preferred doctors and go to your preferred hospital? Does the drug plan cover the medicines you currently take?
2. The cost of the plan. Prices are different. Compare costs. Find out if you can get help paying for the plan from your tribe or other sources.
3. The location. If you plan to use providers outside of the Indian Health System, are they close to your home? Can you go to your preferred pharmacy?

Your situation may change after you sign up for Medicare. Think about your health and insurance needs every year. The first plan you sign up for may not be the best plan forever.

You are not alone. Get help from family, the Medicare website, or your local State Health Insurance Assistance Program.

**What will these insurance programs cost me?** Medicare helps pay for your covered health care. When you use your Indian Health Provider, you should not pay any costs yourself (deductibles, coinsurance, or copayments). Some programs have monthly fees. If you have limited income there may be help paying costs. Contact your Indian Health Provider for information on the Extra Help, Medicare Savings Program. There may be other programs in your state or tribal community.

**Note:** Enrolling in Medicare doesn't take away your right to receive care from your Indian Health Provider. When you have Medicare and get covered services at your Indian hospital or clinic, your Medicare insurance helps pay for them. You help your Indian Health Provider and Community save money.

### Tips for Choosing a Plan

You get choices with Medicare, such as Medicare Advantage Plans, Prescription Drugs Plans, and whether to sign up for Part B or not.

### How Can Your Senior Medicare Patrol Help?

Call your Senior Medicare Patrol (SMP) to report health care scams or if you suspect fraud. Your local SMP can help you PROTECT yourself; DETECT possible Medicare error, fraud, or abuse; and REPORT your concerns. SMPs and their volunteers help teach and advise elders in the fight against health care fraud.

**To find your SMP:**
Visit www.smpresource.org or call 1 (877) 808–2468.

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## B.2: Protecting Elders from Health Care Fraud in Community Settings

Protecting Elders from Health Care Fraud in Community Settings

Tips for elder care providers

The Medicare program and Medicare members lose more money to fraud each year than the entire Indian Health Service budget—10 times over. Older adults are often a target for scam artists.

But there are ways to prevent health care fraud in your tribal health or Indian elder care programs. Your Senior Medicare Patrol (SMP) can also teach you and your staff about local fraud and scams.

Tribal elder care providers include family members or unrelated staff from tribal programs. These providers are in a trusted position. One of their jobs is to help protect clients from dishonest practices that take money out of their pockets and away from much-needed tribal programs.

**Elders trust you.** They believe that any product, service, or activity that your organization directly or indirectly promotes or offers has been properly checked out.

You should know about health care and Medicare fraud schemes that target your community and have practices in place to safeguard your elders.

### What Are Common Health Care Scams that Affect Beneficiaries?

- **Free Health Screenings**—A vendor offers to provide "free" health care screenings, tests, or other services, but asks for a person's Medicare number or personal information.
- **Insurance "Bait & Switch" or Cross-selling**—Licensed agents present information about a Medicare Advantage or Drug plan. They describe benefits and services that the plan does not really offer. Then, they sign people up for plans that are not right for them.
- **Services Not Provided**—People are billed for services they never got, or providers change billing codes or submit fake claims.
- **Medical Equipment Fraud**—Equipment sellers offer "free" products or equipment that a person does not need.

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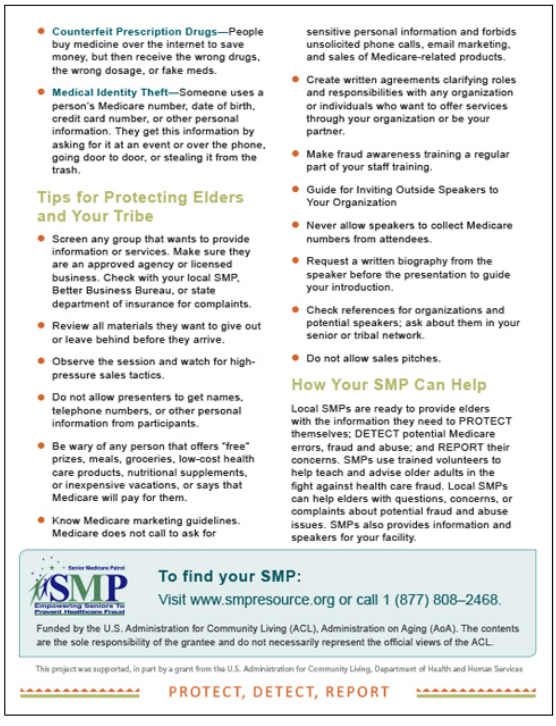

- **Counterfeit Prescription Drugs**—People buy medicine over the internet to save money, but then receive the wrong drugs, the wrong dosage, or fake meds.
- **Medical Identity Theft**—Someone uses a person's Medicare number, date of birth, credit card number, or other personal information. They get this information by asking for it at an event or over the phone, going door to door, or stealing it from the trash.

### Tips for Protecting Elders and Your Tribe

- Screen any group that wants to provide information or services. Make sure they are an approved agency or licensed business. Check with your local SMP, Better Business Bureau, or state department of insurance for complaints.
- Review all materials they want to give out or leave behind before they arrive.
- Observe the session and watch for high-pressure sales tactics.
- Do not allow presenters to get names, telephone numbers, or other personal information from participants.
- Be wary of any person that offers "free" prizes, meals, groceries, low-cost health care products, nutritional supplements, or inexpensive vacations, or says that Medicare will pay for them.
- Know Medicare marketing guidelines. Medicare does not call to ask for sensitive personal information and forbids unsolicited phone calls, email marketing, and sales of Medicare-related products.
- Create written agreements clarifying roles and responsibilities with any organization or individuals who want to offer services through your organization or be your partner.
- Make fraud awareness training a regular part of your staff training.
- Guide for Inviting Outside Speakers to Your Organization
- Never allow speakers to collect Medicare numbers from attendees.
- Request a written biography from the speaker before the presentation to guide your introduction.
- Check references for organizations and potential speakers; ask about them in your senior or tribal network.
- Do not allow sales pitches.

### How Your SMP Can Help

Local SMPs are ready to provide elders with the information they need to PROTECT themselves; DETECT potential Medicare errors, fraud and abuse; and REPORT their concerns. SMPs use trained volunteers to help teach and advise older adults in the fight against health care fraud. Local SMPs can help elders with questions, concerns, or complaints about potential fraud and abuse issues. SMPs also provides information and speakers for your facility.

**To find your SMP:**
Visit www.smpresource.org or call 1 (877) 808–2468.

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## B.3: What is Medicare Fraud

# What Is Medicare Fraud?

Tips for Protecting Yourself and Medicare

**Mrs. Whitecloud had a salesman come to her door.** He sold her an electric scooter she did not need because she could walk well. She could not use it because it was too heavy to go up the stairs and did not fit through the doors in her house. The salesman would not call her back. Medicare got the bill for a scooter she did not need, could not use, and could not return.

**Mr. Lucero signed up for home health care with someone he met at the market.** He had a broken arm and they offered to come clean his home. They said Medicare would pay for all of it. No one ever showed up. He got mail that said Medicare had paid for a nurse and physical therapist. Medicare paid for care he did not need and did not get.

**Ms. Aiylen's medical identity was stolen.** After a "free" blood pressure check, a nurse asked for her Medicare card and had Ms. Aiylen sign a form. She got letters in the mail from hospitals and doctors she never saw. Bill collectors called her. It took a year and a lot of money to fix it.

**Medicare Fraud** happens when doctors, providers, or people trick Medicare into paying bills. They might make Medicare pay more than it should. They might bill for health care they never provided. They do it on purpose to make money.

**Medicare fraud hurts everyone—including you.**

The good news: **YOU can help stop fraud.** When you report fraud to your Senior Medicare Patrol (SMP) they can help. It also saves your tribal providers money and means better health care for you and your community.

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### Why Should You Care About Medicare Fraud?

Health care fraud takes money from you. It hurts tribes and Indian health providers by stealing health care dollars. When they steal, it means less money for care for you, your family, and the community. If a person steals your medical identity, somebody else's information can go in your medical record. You can get the wrong care. You might be denied the tests, care, or equipment you need later. Bad doctors give people tests, medicine, or surgery they do not need.

### How Do People Commit Fraud?

- They bill for visits, tests, supplies, or equipment you do not get or do not need
- They bill for more visits, tests, supplies, or equipment than you received
- They pose as people from Medicare or Social Security to get your Medicare number
- They offer "free" health care but then bill Medicare
- They offer money, groceries, or gifts for your Medicare number
- They pay people to take tests, have surgery, or buy drugs they do not need

Senior Medicare Patrol SMP Empowering Seniors To Prevent Healthcare Fraud

**To find your SMP:**
Visit www.smpresource.org or call 1 (877) 808–2468.

### You Can Stop Medicare Fraud

**Do:**

- Ask questions. It is your right to know everything about your care.
- Write down the date and type of health care you get.
- Protect your Medicare, Medicaid, and Social Security cards.
- Look at your Medicare Summary Notice or Explanation of Benefits for things you did not need, things you did not get, or double charges.

**Don't:**

- Give your Medicare number to just anyone. Only your doctor or other Indian health care providers should need it.
- Give your Medicare number to telephone callers or door to door salesmen.
- Accept "free" tests or services in exchange for your Medicare or Social Security number.

### How Can Your SMP Help?

First, call your doctor or provider with questions about your bill. If you still need help, call your SMP. Call your SMP to report health care scams or suspected fraud. Your local SMP can help you PROTECT yourself; DETECT possible Medicare error, fraud, or abuse; and REPORT your concerns. SMPs and their volunteers help teach and advise elders in the fight against health care fraud.

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## B.4: Home Health Care Fraud

# Home Health Care Fraud

Tips for Protecting Yourself and Medicare

Mr. Lucero broke his arm and had a cast. A lady came up to him while he was in the market. She asked if he needed help at home cleaning and said that Medicare would pay for it. The cast made it hard for him and he lived alone, so he said yes. **She asked for his Medicare card and phone number.** She never called.

Later, he got phone calls from bill collectors. They said he owed a home health company for cleaning his house and were going to take his social security check if he did not pay them. He also received mail showing Medicare had paid for a nurse and physical therapist to come to his home for a month. He tried to call the company but no one answered the phone.

Medicare paid a very big bill for something Mr. Lucero did not need and, more importantly, he did not get.

### Where Is the Fraud in This Story?

- Mr. Lucero did not need home health because he was not homebound.
- He should not have given his Medicare number to a stranger.
- His doctor did not order home health and did not know anything about it.
- The home health company billed Medicare for services he never got.
- The collection agency may have been trying to trick him into paying them.



Medicare has strict rules for home health agencies. This is to help you get the care you need, when you need it, from trusted companies.

Medicare fraud hurts everyone—including you. But YOU can fight back! When you report fraud to your Senior Medicare Patrol (SMP), they can help. It can also save your tribal providers money and mean better care for you and your community.

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### How Could a Company Commit Home Health Fraud?

- It bills for people who are not homebound, as Medicare defines it.
- It bills for home health when it is not needed or not done.
- It offers bribes to doctors to fake your injuries or say you are homebound.
- It will clean your house and then charge for it as nursing care or therapy.
- It offers money, groceries, gifts, or free rides for your Medicare number.
- It offers free things if you change to a new home health agency.
- It makes you pay for home health, which is paid by Medicare.
- It asks you to sign forms saying that home health services were provided, even if they weren't.

### What Can You Do To Stop Home Health Fraud?

- Do not accept services from strangers who call, knock on your door, or approach you outside of your home.
- See your regular doctor in person. Let him order your home health and make sure you meet Medicare's definition of being homebound.
- Always make sure forms are dated. Never sign a blank form.
- Learn about Medicare home health benefits:
  - Contact your local Indian Health Service care provider.
  - Contact 1-800-Medicare or visit www.medicare.gov.
- If you have Medicaid, you may be able to get different services. Contact your Medicaid office for more details.
- Keep your Medicare, Medicaid, and Social Security cards safe.
- Report things offered for "free" in exchange for your Medicare number.
- Report mistakes or possible fraud and abuse.

### When Can Your SMP Help?

First, call your doctor or provider with questions about your bill. Call your SMP if you still need help or to report health care scams and suspected fraud. Your local SMP can help you PROTECT yourself; DETECT possible Medicare error, fraud, or abuse; and REPORT your concerns. SMPs and their volunteers teach and advise elders in the fight against health care fraud.

Senior Medicare Patrol SMP Empowering Seniors To Prevent Healthcare Fraud

**To find your SMP:**
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## B.5: Medical Identity Theft

# Medical Identity Theft

Tips for Protecting Yourself and Medicare

On her way to the market, Ms. Alylen stopped at a table with a nurse who offered to check her blood pressure for free. The nurse checked her blood pressure, **then asked to see her Medicare card and had her sign a form.** Months later, Ms. Alylen got bills from a hospital and doctors in another state. She got mail with results from a blood test she never took.

She called the hospital, but they wanted proof that she did not come to their hospital. She called Medicare. They said her medical identity (ID) might have been stolen. They could not change her Medicare number but tried to help. Soon she started to get letters in the mail and phone calls from bill collectors. It took her more than a year to fix all of the problems.

Medical identity theft happens everywhere every day. It happens to millions of people. It can cost more than $20,000 and take years to fix.

### What Is Medical ID Theft?

Medicare ID theft is fraud! ID theft is when someone steals information—like your name and Medicare number—and uses it to bill Medicare for medical treatment, drugs, surgery, or other services.

All types of people steal medical IDs. Doctors, people who sell medical supplies, even thieves from other countries. Sadly, a lot of those who steal IDs are people who know the person, such as their family or caregivers.




Medical ID theft costs more than time or money. Sometimes people can't get a Medicare service or test because their record shows they already got it. That's because the service was given to someone who used the stolen ID number.

ID theft can cause your medical records to be wrong. When a thief uses your ID for care, a record is created with your name but someone else's information.

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Types of wrong information could include:

- A different blood type
- A fake history of drug or alcohol abuse
- Test results that are not yours
- An illness, allergy, or disease that you do not have

The wrong information could cause doctors to give you the wrong treatment, which can make you sick or hurt you.

### What are Warning Signs?

- You get a bill for medical care you did not receive.
- A debt collector sends you a letter or calls for money you do not owe.
- The insurance company says you've used all of your medical benefits.
- You are denied insurance for a medical condition you do not have.

### How Can I Avoid Medical Identity Theft?

- Look at your Medicare Summary Notice or Explanation of Benefits and medical bills. Make sure you were not charged for anything you did not get.
- Keep your Medicare, Medicaid, and Social Security cards safe.
- Only give your Medicare card to your regular doctors or health care providers.
- Tear or shred papers with your medical information.
- Rip labels off medicine bottles and packages that have your name on them. Tear them up before you put them in the trash.
- Report things offered for "free" in exchange for your Medicare number.
- What Can You Do If Your Medical ID Has Been Stolen?
- Ask your Indian health care provider for your medical records. If anything is wrong, ask your health plan or Indian health care provider to fix it.
- Contact your Senior Medicare Patrol (SMP) for help.

### When Can Your SMP Help?

First call your doctor or provider with questions about your bill. Call your SMP if you still need help or to report health care scams and suspected fraud. Your local SMP can help you PROTECT yourself; DETECT possible Medicare errors, fraud, or abuse; and REPORT your concerns. SMPs and their volunteers teach and advise elders in the fight against health care fraud.

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## B.6: Durable Medical Equipment Fraud

# Medical Equipment Fraud

Tips for Protecting Yourself and Medicare

A friendly salesman came to Mrs. Whitecloud's door one day and said he was from Medicare. He said he could help her get a free electric scooter. She told him she walked okay. He said "Get it now, so you will have it if you ever need it."

He wrote down her Medicare number and placed the order. Later, she received a big scooter that was too heavy to move up her steps and didn't fit through the doors in her house. She tried to send it back, but the salesman would not return her calls. The scooter cost $3,500.

### Where is the fraud in this story?



- Medicare never calls or visits to sell things.
- She didn't need the scooter because she could walk okay without it.
- Her doctor did not order the scooter or know she received it.
- She should not have given her Medicare number to strangers.
- Medicare paid the bill for something she did not need, could not use, and could not return.

Medicare fraud hurts everyone—including you. The good news: You can help stop fraud. When you report fraud to your local Senior Medicare Patrol (SMP) it saves your tribal providers money and means better quality health care. Refuse and report anything offered for "free," like equipment or supplies, in exchange for your Medicare number.

### What Is Durable Medical Equipment?

Durable medical equipment (DME) includes hospital beds, walkers, home oxygen, wheelchairs, scooters, and more. DME must be prescribed by your doctor.

The company must be approved by Medicare. Medicare usually covers only 80% of the cost. You may have to pay the rest.

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### How Would a Doctor or Company Commit Fraud?

- They offer "free" equipment, but bill Medicare.
- They use their doctors (not yours) to prescribe medical equipment that is not needed.
- They give you medical equipment or supplies you never asked for.
- They charge for items you never get.
- They ask for your Medicare number during a meeting, sales pitch, or phone call.
- They offer you money, groceries, or gifts for your Medicare number.
- They deliver a cheap product, but bill Medicare for something that costs more.

### What Can You Do To Stop DME Fraud?

- See your regular doctor in person and let them order your equipment.
- Never sign a blank form for equipment or supplies.
- Always get a dated receipt for equipment or supplies.
- Keep your Medicare, Medicaid, and Social Security cards safe.
- Do not accept equipment from strangers who call or knock on your door.
- Look at your Medicare Summary Notice or Explanation of Benefits for equipment you did not need or did not get, and for double charges.
- Report things offered for "free" in exchange for your Medicare number.
- Report mistakes or possible fraud and abuse.

### How Can Your SMP Help?

First call your doctor or tribal health care provider with questions about your bill. If you still need help, call your SMP. Call your SMP to report health care scams or if you suspect fraud. Your local SMP can help you PROTECT yourself; DETECT possible Medicare errors, fraud, or abuse; and REPORT your concern. SMPs and their volunteers help teach and empower elders in the fight against health care fraud.

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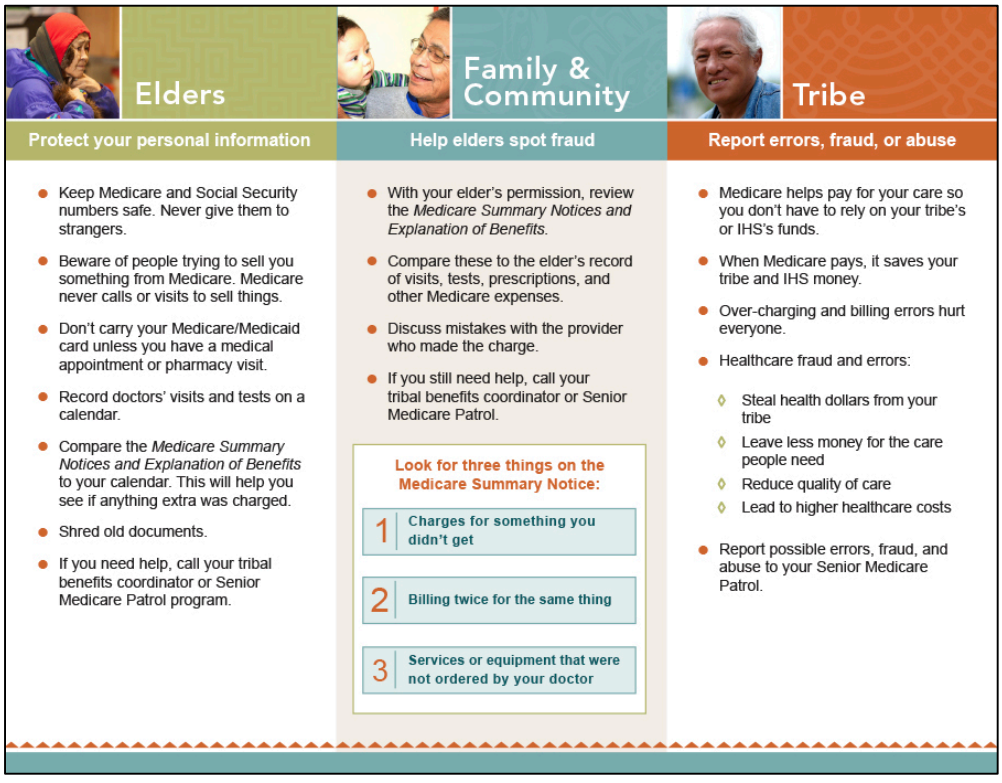
# Appendix C: AI/AN SMP Brochure Available as Separate File

## C.1: Protect Yourself, Your Elders, and Your Tribe Brochure

# Appendix D: SMP AI/AN Assessment Form

## D.1: SMP AI/AN Assessment Form

### SMP Native American Project Outreach Assessment Form

**Gather Background Information**

1. What is your state's AI/AN population and where are they located?
    - Search by state name under "Community Facts" and Select Demographic and Housing Estimates to get total counts of AIAN on this page (may also include tribal groupings if relevant): http://factfinder2.census.gov
    - See Wall Maps on this page: https://www.census.gov/geo/maps-data/maps/aian_wall_maps.html
    - See county level map of AI/AIN alone on this page: http://www.indexmundi.com/facts/united-states/quick-facts/all-counties/american-indian-and-alaskan-native-population-percentage
    - See page 14 of this Bureau of Indian Affairs (BIA) document: http://www.bia.gov/cs/groups/public/documents/text/idc1-024782.pdf
2. Who are the tribes in your state? Who are the Tribal Leader Contacts?
    - See Tribal Directory on this BIA webpage: http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm
3. Are they federally recognized tribes?
4. Where are they located?
5. Are they on reservations, tribal lands or communities?
6. Are there IHS/ Tribal Health/ or Urban Health (I/T/U) facilities in your state? Where?
    - Search Indian Health Service (IHS) health care locator: http://www.ihs.gov/forpatients/index.cfm/findhealthcare/
7. Do you have a tribal health consortium in your state or do you fall under a regional consortium (Indian Health Board?)? Tribal health consortium can point you to the people responsible for "3rd party reimbursement" within your states/tribes.
    - See list of Area Health Boards on this webpage: http://www.nihb.org/about_us/area_health_boards.php
    - See list of national, regional and local health boards on this page: http://www.cdc.gov/omhd/Populations/AIAN/AIANHB.htm

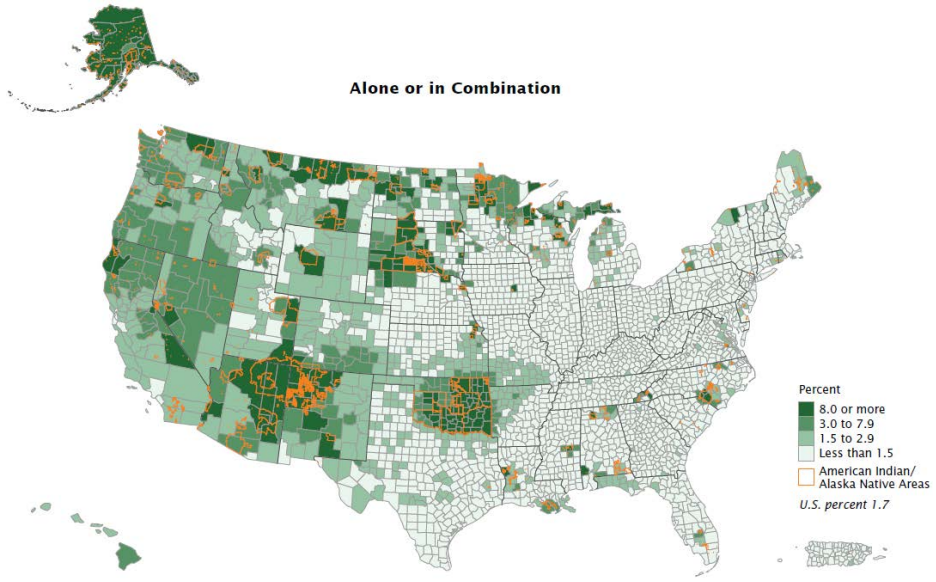
**Sample Questions to Ask of Tribal Leadership/ Contact**

1. How many Medicare beneficiaries, or those Medicare-eligible are there in the tribal community?
2. Where do your elders go to get their care? (I/T/U or other)
3. How is the I/T/U system working for your elders? *Is* it working?
4. Are your elders enrolled in Medicare and/or Medicaid? If not, why?
5. Do you have enrollment problems?
6. Does your tribe have a good understanding of Medicare and Medicare billing?
7. Who handles outreach and billing enrollment in the tribe?
8. Do you utilize Community Health Representatives?
9. Do some/most/all elders receive Medicare Summary Notices? (generally applies if they go outside of I/T/U system, but may be different circumstances if it is tribal health system)
10. How do you conduct outreach to your elders? (media, 1:1)
11. Who conducts outreach to your elders?
12. Do you have places or events where your elders get together? (Title VI, pow wow, regular gatherings, other)
13. Who is/are the leaders of your elder group(s)?
14. How do your elders like to be addressed?
15. Are there local cultural considerations that would be useful for us to be aware of when we are talking with elders?
16. What type of information and resources could we provide that would be useful to your tribal leadership, community and elders?

| | | | |
|---|---|---|---|
| Tribe | | | |
| Federally Recognized? | | | |
| Location | | | |
| Reservation or Community | | | |
| Tribal Leader Contact Information | | | |
| IHS/ Tribal Health/ Urban Facilities Utilized or Identify Other | | | |
| Media Sources (Radio, Newspaper, Newsletter, etc.) | | | |
| Notes | | | |

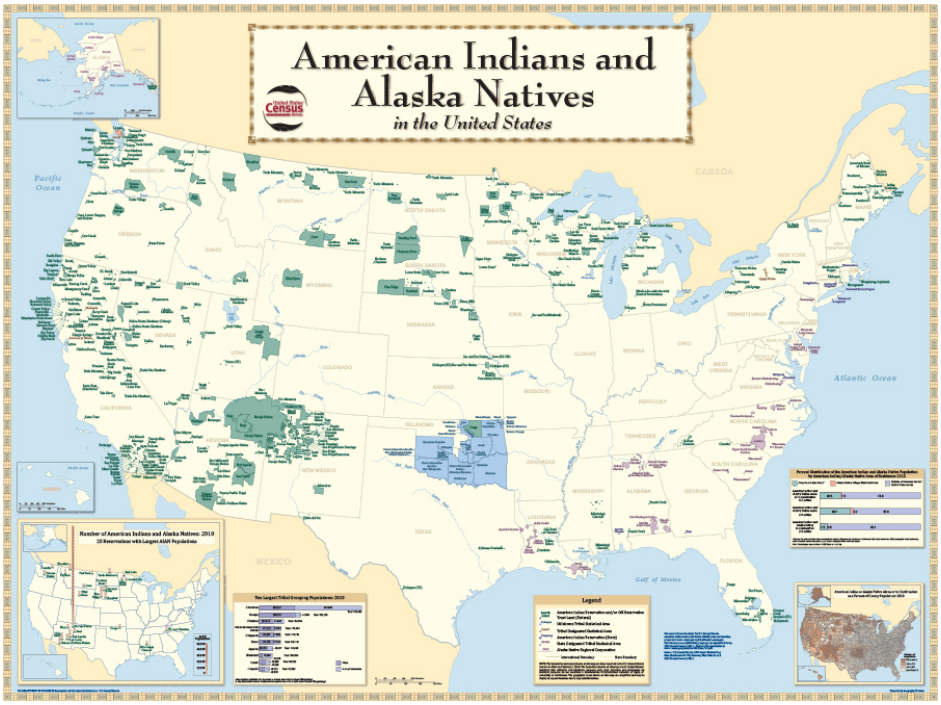
# Appendix E: Maps

## E.1 AI/AN County Level Population



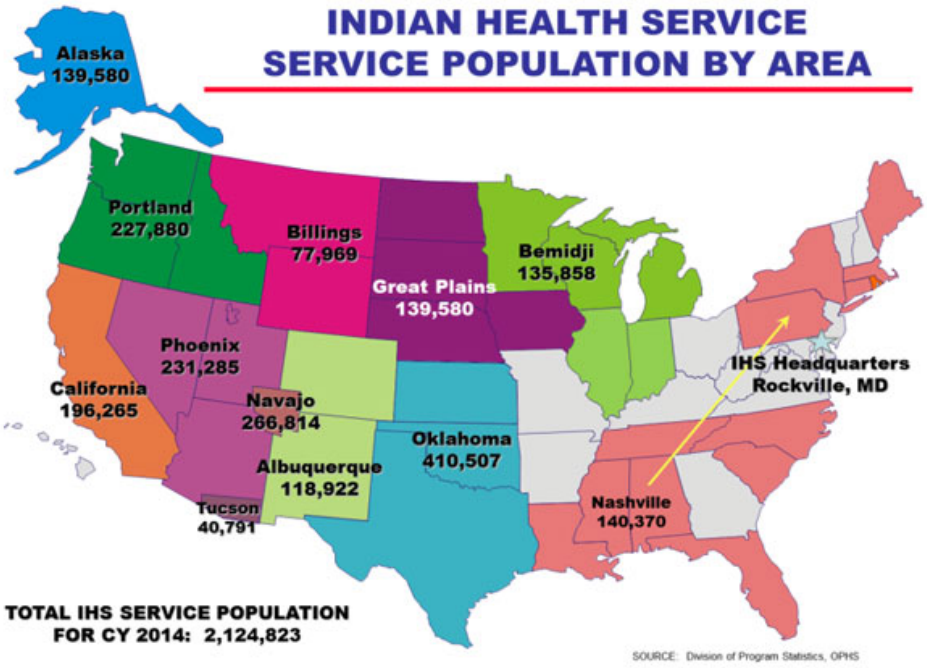

Source: U.S. Census Bureau, *2010 Census Redistricting Data (Public Law 94-171) Summary File*, Table P1.

## E.2 American Indian Map (Lower 48 state)



## E.3 Alaska Native Map (Alaska)


## E.4 Indian Health Service Area Map



# Appendix F: Select Reading/Resource Materials


- California Rural Indian health Board. Medicare Statistics for American Indians & Alaska Natives: Centers for Medicaid and Medicare Services: American Indian & Alaska Native Data Project. Published 2012. Available at: http://www.crihb.org/files/0.MCR_Report_12_31_12.pdf

- Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual – Chapter 19 Indian Health Service. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c19.pdf

- Fox, E., et al. Health Care Coverage and Income of American Indians and Alaska Natives: A Comparative Analysis of 33 States with Indian Health Service Funded Programs. 2012. Available at: http://www.crihb.org/files/Health_care_coverage_and_income_of_aians.pdf

- Government Accountability Office. *Medicare and Medicaid - CMS and State Efforts to Interact with IHS and Indian tribes*. Published: July 11, 2008. Available at: http://www.gao.gov/products/GAO-08-724

- Kaiser Family Foundation. *Health Coverage and Care for American Indians and Alaska Natives*. 2013. Available at: http://kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-american-indians-and-alaska-natives/

- Kaiser Family Foundation. *Race, Ethnicity & Health Care: A Profile of American Indians and Alaska Natives and Their Health Coverage*. 2009. Available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7977.pdf

- Office of Inspector General, Health and Human Services. *White Paper: Summary of OIG IHS Activities*. 2011. Available at: http://oig.hhs.gov/newsroom/spotlight/2011/ihs-whitepaper.pdf

# Appendix G: National Organization Websites

1. Administration on Aging Native American Programs (Title VI): http://olderindians.aoa.gov/index.cfm
2. Bureau of Indian Affairs Tribal Leader Directory: http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm
3. Centers for Medicare and Medicaid Tribal Affairs Group: http://www.cms.gov/Center/Special-Topic/American-Indian-Alaska-Native-Center.html
4. Indian Health Service: http://www.ihs.gov/
5. National Association of Area Agencies on Aging (n4a) list of AAAs/ Title VI Agencies: http://n4a.org/about-n4a/?fa=aaa-title-VI
6. National Congress of American Indians: http://www.ncai.org/
7. National Council of Urban Indian Health: http://www.ncuih.org/
8. National Indian Council on Aging: http://nicoa.org/
9. National Indian Health Board: http://nihb.org/
10. Urban Indian Health Institute: http://www.uihi.org/

# Appendix H: SMP Generated Materials

**Materials Available as Separate Compressed (Zip) File in the SMP Resource Library**

1. **Manual: Delaware SMPI Guide to Cultural Competency and Health Literacy: Learning about the Cultures and Backgrounds of the Medicare Consumers We Serve; Delaware SMP. See Chapter 4: Native American and Delaware Native American**
   ***Filename:***
   ***prior integration grant DE SMPI_Complete_SMPI_CulturalCompetencyManual_5_18_10TDP***

2. **PowerPoint: SMPI Guide to Cultural Competency and Health Literacy: Learning about the Cultures and Backgrounds; Delaware SMP**
   ***Filename:***
   ***prior integration grant DE SMPI_ May 12 2010 The SMPICulturalCompetencyPresentationWithNotes***

3. **PDF of PowerPoint: Delaware Senior Medicare Patrol Integration Grant – Outreach Activity to Rural and Tribal Elders in Delaware September 2008 – 2010**
   ***Filename:***
   ***prior integration DE-SMPI-6-17-10-Webinar-Handout***

4. **PowerPoint: Great Lakes Inter-Tribal Council – Senior Medicare Patrol in Tribal Communities; Wisconsin Great Lakes Inter-Tribal Council SMP Integration Grantee**
   ***Filename:***
   ***prior integration GLITC Great Lakes Intertribal Senior_Medicare_Patrol_in_Tribal_Communities***

5. **Word Document: Fact Sheet – Barriers to Health Care for American Indian Elders; Massachusetts SMP**
   *Filename:*
   *prior integration grant MA Barriers to Health Care IHS SHINE AI AN CC Fact Sheet*

6. **Word Document: Fact Sheet – Indian Health Service - Health Insurance Options; Massachusetts SMP**
   *Filename:*
   *prior integration grant MA Health Insurance Options IHS SHINE Fact Sheet*

7. **Word Document: Fact Sheet – Native American Resources for Massachusetts; Massachusetts SMP**
   *Filename:*
   *prior integration grant MA Native American Resources MA*

8. **PowerPoint: The Health Status of American Indians/Native Americans in Massachusetts; Massachusetts SMP**
   *Filename:*
   *prior integration grant MA native_american_health*

9. **PowerPoint: Promoting Cultural Diversity and Cultural Competency: Working with Native American People; Massachusetts SMP**
   *Filename:*
   *prior integration grant MA Promoting Cultural Diversity and Cultural Competency*

10. **PowerPoint: Understanding Indian People: Cultural Comparisons; Massachusetts SMP**
    *Filename:*
    *prior integration grant MA Understanding Indian People*

11. **PowerPoint: An Overview of Indian Health Service Eligibility, Healthcare Access Issues and Health Disparities for Massachusetts' Native Americans and Native Americans in Massachusetts; Massachusetts SHINE and SMP**
    *Filename:*
    *prior integration grant MA updated EOEA SHINE IHS April 13 In-Service*

12. **PowerPoint: Best practices for reaching out to and engaging Native American Elders and Rural Elders about preventing healthcare errors, fraud and abuse; Massachusetts SMP**
    *Filename:*
    *prior integration grant MA Webinar SMP Roundtable Presentation 2010*

13. **PDF of PowerPoint: Maryland Senior Medicare Patrol Integration Program; Maryland SMP**
    *Filename:*
    *prior integration MD-SMPI-6-17-10-Webinar-Handout_rural and tribal*

14. **PDF of PowerPoint: Wisconsin SMP-I Project: Reaching Rural and Tribal Elders; Wisconsin SMP**
    *Filename:*
    *prior integration WI-SMPI-6-17-10-Webinar-Handout_WI*

15. **Article: American Indian Outreach; Alex Ward**
    *Filename:*
    *SMP outreach document--American_Indian_Outreach_Article from SMP website*

# Appendix I: Regional and Tribal Profiles

## I.1: Regional Profiles

### *Regional Area Profiles*

Following the 12 regional health areas outlined by the Indian Health Service (IHS), we have provided profiles that describe each area, including demographic, tribal, and health care information. The 12 regional areas include Alaska, Albuquerque, Bemidji, Billings, California, Great Plains (formerly Aberdeen), Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson.

### Alaska

As the largest state (in area) of the United States, Alaska was admitted to the union as the 49th state in 1959 and lies at the extreme Northwest of the North American continent. The United States acquired the land from Russia in 1867; the territory was purchased for two cents an acre and was thought to be a bad purchase. However, Alaska holds the greatest number of natural resources in the country. Alaska Natives have inhabited the area since 10,000 BCE. Today, approximately 120,000 Alaska Natives live in the United States.

#### Native People of Alaska

#### The Eskimos

More than half of all Alaska Natives are Eskimo. The two main Eskimo groups, Inupiat and Yupik, differ in their language and geography. The former live in the North and Northwest Alaska and speak Inupiaq; the latter live in Southwest Alaska and speak Yupik. Along the northern coast of Alaska, Eskimos are hunters of bowhead and beluga whales, walruses, and seals. In Northwest Alaska, Eskimos live along the rivers that flow into the area of the Kotzebue Sound. Here, they rely less on sea mammals and more on land animals and river fishing. Most southern Eskimos live along the rivers flowing into the Bering Sea and along the Bering Sea Coast, from Norton Sound to the Bristol Bay region.

#### The Aleuts

Most Aleuts originally lived in coastal villages from Kodiak to the farthest Aleutian Island of Attu. They spoke three distinct dialects, which are remotely related to the Eskimo language. When the Russians came to the Aleutian Islands in the 1740s, Aleuts inhabited almost every island in the chain. Now, only a few islands have permanent Aleut villages. Severe and unpredictable weather conditions in the Aleutian Islands make transportation both expensive and time-consuming. The region is dependent on the fishing industry, which varies from year-to-year.

#### The Interior Indians

The Athabascans inhabit a large area of Central and Southcentral Alaska. Although their language is distinct, they may be linguistically related to the Navajo and Apaches of the Southwest United States.

There are eight Athabascan groups in Alaska. Characteristics of all eight groups include similar languages, customs, and beliefs.

## The Southeast Alaska Indians

The three major Indian tribes inhabiting Southeast Alaska are the Tsimpsians, Haidas, and Tlingits. They reside in the community of Sitka in Southeast Alaska, which was the capitol of Russian America, and the community of Juneau, which is now the capitol city of Alaska.

### Health Care Infrastructure

The Alaska Area Indian Health Service works in conjunction with Alaska Native tribes and tribal organizations (T/TO) to provide comprehensive health services to 143,078 Alaska Natives (Eskimos, Aleuts, and Indians). Approximately 99% of the Alaska Area budget is allocated to T/TOs who operate under the authority of the Indian Self-Determination and Education Assistance Act, Public Law 93-638, as amended. The Alaska Area maintains 13 Title I contracts with Alaska T/TOs, and negotiates one Title V compact [d] with 25 separate tribal funding agreements each year. The Alaska Tribal Health Compact is a comprehensive system of health care that serves all 228 federally recognized tribes in Alaska. IHS-funded, tribally-managed hospitals are located in Anchorage, Barrow, Bethel, Dillingham, Kotzebue, Nome, and Sitka. There are 44 tribal health centers, 160 tribal community health aide clinics, and five residential substance abuse treatment centers. The Alaska Native Medical Center in Anchorage is the statewide referral center and gatekeeper for specialty care. Other health promotion and disease prevention programs that are statewide in scope are operated by the Alaska Native Tribal Health Consortium (ANTHC), which is managed by representatives from all Alaska tribes.

Other federal agencies, such as the Arctic Investigations Laboratory of the Centers for Disease Control, work closely with the Alaska Area IHS and the tribes to improve the health statuses of Alaska Natives. The IHS still holds title to six tribally operated hospitals and three tribally operated health centers in Alaska, and is also responsible for their maintenance.

### Environmental Factors

Alaska encompasses one-fifth of the total land mass of the United States. Within its 586,000 square miles, Alaska has a diverse geography, including deserts, plains, swamps, forests, glaciers, ice fields, fjords, river systems, volcanoes, thousands of islands, and six major mountain ranges. With two oceans and three major seas, Alaska has as many miles of sea coast as the combined Atlantic and Pacific seaboards.

Most communities in Alaska are separated by vast distances. Anchorage is 1,445 miles from Seattle, WA, which is the nearest metropolitan center. Vast mountain ranges and stretches of tundra, glaciers,

[d] Federally recognized tribes or tribal organizations compact with the IHS to assume full funding and control over programs, services, functions, or activities (PSFAs), or portions thereof, that the IHS would otherwise provide for Indians because of their status as Indians. 25 U.S.C. § 458aaa-3-4(b)

impassable river systems, and open waters, separate communities within the state. The distance from many communities to the nearest medical facility is equivalent to the distance from New York to Chicago.

## Alaska Native Medical Center

Located geographically within the boundaries of Southcentral Foundation, the Alaska Native Medical Center (ANMC) operates as the "gatekeeper" for most of the specialty care required by Alaska Natives in all parts of the state. ANMC is managed by two tribal health organizations. The Southcentral Foundation operates the primary care services, and the Alaska Native Tribal Health Consortium (ANTHC) operates the secondary and tertiary services.

## The Alaska Native Tribal Health Consortium

The ANTHC was formed in December 1997 when federal programs, services, functions, and activities previously under the IHS were transferred to Alaska tribes that became owner-consumers of health care. Virtually all statewide Native health services are connected in some manner to the activities of the ANTHC.

ANTHC develops and presents training to village-based community health aide programs including medical, dental, and behavioral health aides. The ANTHC Epidemiology Center is one of 11 tribal epidemiology centers established by the IHS to improve the health of AI/ANs through research. ANTHC operates an HIV/AIDS Early Intervention Program in Bethel, Fairbanks, Juneau, and Sitka. Their clinical team in Anchorage provides HIV case management and coordination of primary care services to clients living in rural areas.

The Alaska Area is made up of dozens of tribal health care organizations, which operate the area health care facilities. Below is a complete list of all the organizations, and links to their respective websites.

## Alaska Native Organizations

- Alaska Native Health Board
- Alaska Native Medical Center
- Alaska Native Tribal Health Consortium
- Alaska Tribal Health System
- Aleutian Pribilof Islands Association
- Annette Island Service Unit
- Arctic Slope Native Association
- Bristol Bay Area Health Corporation
- Chickaloon Native Village
- Chitina Traditional Indian Village Council
- Chugachmiut
- Cook Inlet Tribal Council
- Council of Athabascan Tribal Governments
- Copper River Native Association
- Eastern Aleutian Tribes
- Eklutna Native Village
- Native Village of Eyak
- Fairbanks Native Association
- Kenaitze Indian Tribe
- Ketchikan Indian Community
- Knik Tribe
- Kodiak Area Native Association

- Maniilaq Association
- Mt. Sanford Tribal Consortium
- Ninilchik Traditional Council
- Norton Sound Health Corporation
- Seldovia Village Tribe
- Southcentral Foundation
- Southeast Alaska Regional Health Consortium
- Tanana Chiefs Conference
- Ukpeagvik Inupiat Corporation
- Yukon Kuskokwim Health Corporation

## Alaska Native Village Corporations

- Arctic Slope Regional Corporation
- Bering Straits Native Corporation
- NANA Regional Corporation
- Calista Corporation
- Doyon Limited
- Cook Inlet Region, Inc.
- Bristol Bay Native Corporation
- Aleut Corporation
- Chugach Alaska Corporation
- Sealaska Corporation
- Koniag, Incorporated
- Ahtna, Incorporated

## *Albuquerque (New Mexico, Southern Colorado, and West Texas)*

The Albuquerque Area includes a total of 27 tribes in New Mexico, Southern Colorado, and West Texas. There are approximately 104,000 AI/ANs in the Albuquerque Area. In New Mexico, Colorado, and Texas, the Albuquerque Area serves 20 pueblos, two Apache nations, three Navajo bands (not included in the Navajo Area), two Ute tribes, and the off-reservation population. Additionally, numerous tribal members from throughout the United States who live, work, or go to school in the urban centers of the Albuquerque Area are included in this area.

### Native People of the Albuquerque Area

#### The Pueblo People

The 20 pueblos that are located within this region are primarily located in New Mexico; however, at one time, the pueblo's reached into the Colorado and Arizona. Pueblo people rooted in this region of the Southwest are descendants of indigenous groups that established themselves over many centuries. At the time of the Spanish encounter in the 16th century, they were living in villages that the Spanish called *pueblos*, meaning *towns*.

#### The Ute Indians

Prior to the arrival of Mexican settlers, the Utes occupied significant portions of, what is today, Eastern Utah; Western Colorado, including the San Luis Valley; and parts of New Mexico and Wyoming. The Utes were never a unified group within historic times; instead, they consisted of numerous nomadic bands that maintained close associations with other neighboring groups.

#### Ramah Navajos

The Ramah Navajos, with a population of about 1,700, are considered to be leaders among Native American tribes in asserting political self-determination. An additional 1,500 Navajo, scattered throughout communities between Zuni and Gallup, access their services. Most members of the Ramah Tribe live in traditional hogans. Many maintain a semi-nomadic lifestyle. Health and religious traditions are also important to the Navajo, especially ceremonies for sick persons, known as *Sings*.

#### Zuni Pueblo

It is said that the Zuni Pueblo, its adobe walls gleaming gold when first sighted by Spanish explorers, gave rise to the legend of the "Seven Cities of Cibola." Zuni is one of the oldest, continuously occupied Indian villages, and is also one of the largest of the 19 pueblos. With a young population of about 9,500, most of the Zuni people live at the pueblo itself, at the center of their 400,000 acre reservation.

World-renowned for their fine inlay and needlepoint-style work, 70% of the Zuni still rely on traditional silversmith art for cash income, in addition to farming and livestock management. Most homes are stone, adobe, or concrete block structures housing large multi-family groups. The Zuni are a deeply religious tribe, and nearly all social activities center around traditional ceremonies. Traditional medicine is still very much a part of their lives.

## Health Care Infrastructure

The Albuquerque Area IHS is charged with providing health care to each of the 27 tribes and the urban AI/AN population residing in the Albuquerque area. The administrative headquarters of the Area are located in Albuquerque. Most health facilities are strategically located near population centers and include five hospitals, 11 health centers, and 12 field clinics. These facilities are administratively divided into eight service delivery areas called service units. The Area's extensive network provides the Indian people with a wide-array of inpatient and outpatient services.

### Acoma-Canoncito-Laguna Service Unit

The Acoma-Canoncito-Laguna (ACL) Service Unit serves the three tribal groups in the immediate area: the Acoma Pueblo, the Laguna Pueblo, and the Canoncito Navajos.

The ACL Service Unit consists of the ACL Hospital in Acomita and health centers at Laguna and Canoncito. The hospital provides general medical, pediatric, and obstetric inpatient care with 25 beds. The ACL service unit hospital also houses a dialysis unit and the New Sunrise Regional Treatment Center, which is a residential program for adolescents.

### Albuquerque Service Unit

The Albuquerque Service Unit consists of the Albuquerque Indian Health Center and two field health clinics in the Zia and Santa Ana Pueblos. The Jemez, Alamo Navajo, Isleta, and Sandia Tribes have assumed control over their health care operations under Public Law 93-638, the Indian Self-Determination Act.

### Jicarilla Service Unit

The Jicarilla Service Unit is the youngest and smallest Service Unit in the Albuquerque Area. Designated in 1996, the Jicarilla Service Unit primarily serves the members of the Jicarilla Apache Tribe. The Dulce Health Center provides ambulatory services, including primary care, dental care, optometry services, and urgent care. Special clinics are held for well-child, women's health, and diabetes care.

The Jicarilla Service Unit is located on the Jicarilla Apache Reservation, which spans over 870,566 acres of scenic terrain in North Central New Mexico. The Reservation's geography ranges from high desert, at about 6,400 feet in elevation, to mountainous areas reaching over 10,600 feet. The town of Dulce is the center of the community and the home of most of the population.

### Mescalero Service Unit

The 13-bed Mescalero Indian Hospital provides both inpatient and outpatient services, and is supplemented by a number of field health programs, some of which are conducted by the Mescalero Tribe itself. Inpatient care generally consists of pediatric and medical care.

The Mescalero Service Unit serves the Mescalero Apaches, whose current population of over 3,000 is steadily growing. The Mescalero Apaches mostly reside in Mescalero, NM. The reservation, established by Treaty in 1873, consists of 460,000 acres nestled in the foothills of the Sacramento and Sierra

Mountains. Originally a mountain hunting and fighting people, the Apache were respected for their remarkable hardihood and fighting skills. The Mescalero were the first to offer the U.S. Forest Service a trained and organized unit of fire fighters to put down fires in the Southwest.

### Santa Fe Service Unit

The Santa Fe Service Unit covers an extensive portion of Northern New Mexico, from just north of Albuquerque to the Colorado border. The Service Unit serves nine Pueblos: Cochiti, Nambe, Pojoaque, San Ildefonso, San Felipe, San Juan, Santa Clara, Santo Domingo, and Tesuque.

The Santa Fe Service Unit facilities consist of the Santa Fe Indian Hospital and health clinics located in the Santa Clara, Santo Domingo, San Felipe, and Cochiti Pueblos.

### Southern Colorado Ute Service Unit

The Southern Colorado Ute Service Unit (SCUSU) provides ambulatory care services through two health centers at Towaoc and Ignacio, CO, and a field health station in White Mesa, UT, in conjunction with a diverse contract health services program. SCUSU's service population has grown steadily over the years (to 4,167 in 1990) with strong growth in utilization rates (from 21,701 ambulatory care visits in 1985 to 30,767 in 1990).

Ignacio, 25 miles southeast of Durango, is a major tourist center that offers great restaurants and a surprising variety of cultural events for its size. Also close by, is the smaller town of Bayfield. Towoac is 11 miles south of Cortez, CO. Most staff of this Service Unit live within these four towns.

### Ysleta del Sur Service Unit

The Ysleta del Sur Pueblo is the youngest Pueblo. Though it has been in existence in the El Paso, TX, area since 1680, the tribe was not federally recognized until August 19, 1987. The establishment of the Ysleta del Sur Service Unit was approved on June 7, 1989, in response to the wishes of the Ysleta del Sur Tribe.

There is no IHS direct care medical facility at Ysleta del Sur at this time. Most professional health providers are available to the tribe via the IHS contract health services program.

### Zuni-Ramah Service Unit

The Zuni-Ramah Service Unit serves the people of the Zuni Pueblo and the Ramah Navajo community. There are two facilities in the Zuni-Ramah Service Unit: the Pine Hill Health Center and the Zuni Indian Hospital.

The Zuni Indian Hospital is a 45-bed, general medical hospital, and provides a full range of out-patient services. The hospital has 37 medical, surgical, and pediatric beds, as well as 8 obstetrical beds.

### Pine Hill Health Center

The Zuni-Ramah Service Unit’s relation to the Pine Hill Health Center is due to local initiative and

determination, and is also an important part of the story of the Ramah Navajo leadership, which has turned its community into a model of Indian self-reliance. The Center was **the first community-controlled health care system** in the United States to function under Public Law 93-638, the Indian Self-Determination Act of 1976, which enables Indian peoples to establish and manage their own health care systems, among other service areas, under contract with the U.S. Government.

The Center is supervised and supported by the Ramah Navajo School Board, Inc., who initiated this and many other vital community projects, and the five members of the Ramah Health Board, with continual input from the community. The Center was entirely conceived and executed by the community.

## Bemidji

The Bemidji Area office (BAO) provides service and support to 34 federally-recognized tribes and four urban Indian health programs located in Illinois, Indiana, Michigan, Minnesota, and Wisconsin. Tribal health services are provided through 11 P.L. 93-638 Title V compacts and 23 Title I contracts. Urban Indian health programs are located in Chicago, IL; Detroit, MI; Milwaukee, WI; and Minneapolis, MN. Tribes in the Bemidji Area include Ojibwe (Chippewa), Ho-Chunk, Menominee, Mohican, Oneida, Odawa, Potawatomi, and Sioux.

### Native People of the Bemidji Area

#### Ho-Chunk People

The Ho-Chunk, sometimes called Winnebago, are a Siouan-speaking tribe native to the present-day States of Wisconsin and Minnesota, and parts of Iowa and Illinois. Today, the two federally recognized Ho-Chunk tribes, the Ho-Chunk Nation of Wisconsin and Winnebago Tribe of Nebraska, have territory primarily within the states included in their names.

Ho-Chunk was the dominant tribe in their territory in the 16th century, with a population estimated at several thousand. Their traditions hold that they have always lived in the area. Ethnologists have speculated that, like some other Siouan peoples, the Ho-Chunk originated along the East Coast and migrated west in ancient times.

The Ho-Chunk suffered severe population losses in the 17th century, to a low of, perhaps, as few as 500. This has been attributed to the loss of hundreds of warriors in a lake storm, epidemics of infectious disease, and competition for resources from migrating Algonquian tribes. By the early 1800s, their population had increased to 2,900, but they suffered further losses in the smallpox epidemic of 1836. Today, there are approximately 12,000 Ho-Chunk people split between the two federally recognized tribes.

#### Menominee

The Menominee Indian Tribe's rich culture, history, and residency in what is known in the present day as the State of Wisconsin, and parts of the States of Michigan and Illinois, dates back 10,000 years. The government seat for the Menominee Tribe is located approximately 45 miles northwest of Green Bay, WI, on the Menominee Indian Reservation in the Village of Keshena. The Reservation, sharing nearly coterminous geopolitical boundaries with Menominee County, is situated on the ancestral homelands of its 8,551 tribal members, and includes five main communities: Keshena, Neopit, Middle Village, Zoar, and South Branch. The Reservation is comprised of 235,523 acres, or approximately 357.96 square miles.

#### Mohican

The Mohican are an Eastern Algonquian tribe, originally settled in the Hudson River Valley (around Albany, NY) and Western New England. After 1680, many moved to Stockbridge, MA. In the 1820s and

1830s, most of the Stockbridge Indians moved to Shawano County, WI, where they were promised land by the U.S. government under the policy of Indian removal. In Wisconsin, they settled on reservations with the Lenape (called Munsee after one of their major dialects), who were also speakers of one of the Algonquian languages. Together, the two formed a band and are federally recognized as the Stockbridge-Munsee Community.

Their 22,000-acre reservation is known as the Stockbridge-Munsee Band of Mohican Indians, and is located near the town of Bowler. Since the late 20th century, they have developed the North Star Mohican Resort and Casino on their reservation, which has successfully generated funds for tribal welfare and economic development.

### Ojibwe (Chippewa)

The Chippewa were primarily trappers, traders, entrepreneurs, and guides. As North Dakota's first family, they occupied an extensive territory that extended indefinitely back from the northern and eastern shores of Lakes Superior and Huron. During the three centuries following the discovery of America, they filtered through the Ste. Marie River into what are now Michigan, Wisconsin, and Minnesota. They then moved into the Dakotas, pushing the Sioux southward in many fierce conflicts over the rich hunting grounds.

### Oneida

The Oneida are a Native American and First Nations people who are one of the five founding nations of the Iroquois Confederacy in the area of upstate New York, particularly near the Great Lakes. The Iroquois call themselves *Haudenosaunee* ("The people of the longhouses") in reference to their communal lifestyle and the construction style of their dwellings.

Originally, the Oneida inhabited the area that later became central New York, particularly around Oneida Lake and Oneida County. Today the Oneida have two federally recognized nations in the United States: Oneida Indian Nation in New York and Oneida Nation of Wisconsin, in and around Green Bay, WI.

### Odawa (Ottawa)

The Odawa are a Anishinaabe Native American and First Nations people. They are related to, but distinct from, the Ojibwe and Potawatomi people. Their original homelands are located on Manitoulin Island near the northern shores of Lake Huron on the Bruce Peninsula in the present-day province of Ontario, Canada, and in the State of Michigan, United States. There are approximately 15,000 Odawa living in Ontario, Michigan, and Oklahoma.

The Odawa language is considered a divergent dialect of the Ojibwe, characterized by frequent syncope. The Odawa language, like the Ojibwe language, is part of the Algonquian language family. They also have smaller tribal groups, or bands, commonly called *tribe* in the United States and *First Nation* in Canada. The United States' federally recognized tribes include the Grand Traverse Band of

Ottawa and Chippewa Indians, the Little River Band of Ottawa Indians, the Little Traverse Bay Bands of Odawa Indians, and the Ottawa Tribe of Oklahoma.

## Potawatomi

The Potawatomi are Algonquian-speaking people who originally occupied the Great Lakes region of the United States. Originally, the Potawatomi were part of the Three Fires Council made up of the Potawatomi, Ojibwe, and Odawa, collectively known as the Anishinaabe people. Through a series of treaties beginning in 1789, their tribal estate, equating to more than 89 million acres, was gradually reduced in size. The federal government continued to reduce Potawatomi land holdings by removing them to smaller reserves in Iowa, Missouri, and, finally, Kansas in 1846. In 1861, the Potawatomi in Kansas were officially divided by way of treaty. Currently, there are seven federally recognized Potawatomi tribes, including the Citizen Potawatomi Nation, the Forest County Potawatomi Community, the Hannahville Indian Community, the Gun Lake Band of Potawatomi, the Nottawaseppi Huron Band of Potawatomi, the Pokagon Band of Potawatomi Indians, and the Prairie Band of Potawatomi Nation.

### Health Care Infrastructure

The Bemidji area operates three federal/direct service programs on behalf of the Leech Lake Band of Ojibwe, the Red Lake Band of Chippewa Indians, and the White Earth Band of Chippewa Indians of Minnesota. These federal/direct service programs, Cass Lake Hospital, Red Lake Hospital, and White Earth Health Center, are staffed by approximately 500 federal civil service employees and Public Health Service commissioned officers. These federal employees are composed of physicians, nurse practitioners, physician assistants, nurses, laboratory technicians, radiology technicians, behavioral health practitioners, dentists, dental assistants, dental hygienists, optometrists, optical technicians, dietitians, pharmacists, pharmacy technicians, physical therapists, engineers, sanitarians, equipment technicians, health information managers, and administrators, as well as acquisition, supply, finance, information technology, and clerical staff. In addition, numerous specialty clinics are provided in their federal/direct service programs by local private health care specialists.

Tribal and urban programs directly employ a multitude of health care providers and allied staff, such as mental health counselors, substance abuse counselors, and community health nurses and representatives. Services not available through tribal or BAO federal/direct service programs may be delivered through Contract Health Services (CHS).

According to data from the 2000 Census, the projected 2010 service population for the Bemidji Area service delivery counties exceeded 125,000. The service populations are estimated based on the official census data of self-identified Indians, who may or may not use IHS services, and on vital statistics received by the National Center for Health Statistics from state departments of health.

The Bemidji Area is unique in that 97.0% (as of fiscal year 2011) of the allocated annual funding is distributed among the 34 tribes through contracts and self-governance compacts. Each tribe contracts

or compacts with IHS for health services ranging from outreach and contract health care to fully comprehensive health delivery systems, including environmental health services and sanitation facilities, as well as health facilities construction.

The major role of the IHS Area office staff, and the field office in Rhinelander, WI, has evolved primarily to advocacy, policy development, budget formulation, and strengthened partnership role with tribes and urban programs. Both tribal and IHS locations use a health team approach for successful program design, implementation, and evaluation. The growth of community-based services results from tribes becoming more involved with the management of health care delivery to their own people, and in response to the need to get services into the community, rather than providing services at a central location. This is particularly important in the Bemidji Area, as many tribal members are geographically isolated from the town and community centers where most health care is available.

## Billings

The Billings Area IHS provides health services to more than 70,000 AI/AN people in Montana and Wyoming. The health services are delivered by six IHS-operated service units, two tribally operated health departments, and five urban health programs, which are supported administratively by the Area Office in Billings, MT.

The Billings area is made up of eight different service units, including Blackfeet, Crow, Flathead, Fort Belknap, Fort Peck, Northern Cheyenne, Rocky Boy, and Wind River.

### Native people of the Billings Area

#### Blackfeet (Pikuni)

Blackfeet Country is located in Northwestern Montana, which includes most of Glacier County. On the north, it borders the Canadian Province of Alberta. The Blackfeet belong to the Blackfoot Confederacy along with three other tribes residing in Canada. On the west, it shares a border with Glacier National Park and elevation varies from a low of 3,400 feet in the southwest to a high of over 9,000 feet at Chief Mountain on the northwest boundary.

#### Crow Nation (Apsaalooké or Biiluuke)

The Crow Nation has lived in Crow Country around the base of the sacred Big Horn Mountains from time immemorial. The Crow Nation was traditionally organized into three bands: the Mountain Crow, the River Crow, and the Kick in the Bellies.

The Apsaalooké chiefs entered into their first treaty, a friendship treaty, with the United States in 1825. In 1851, Crow Nation entered into the first Fort Laramie Treaty, allocating 33 million acres of land to the Crow people. That land was located in the Montana, Wyoming, and Dakota Territories. The second Fort Laramie Treaty of 1868 reduced the Crow Indian Reservation to eight million acres in South-Central Montana Territory.

The current Crow Indian Reservation is two million acres, and is home to three mountain ranges and two river basins, as well as substantial natural resources including grazing lands, dry lands and irrigated farms, coal, oil, and gas among others. The Crow Nation currently boasts an enrollment of over 13,000 members.

Crow Nation is organized as a general council with three distinct branches of government: executive, legislative, and judicial.

#### Confederated Salish and Kootenai Tribes

The Confederated Salish and Kootenai Tribes are comprised of the Bitterroot Salish, the Pend d'Oreille, and the Kootenai Tribes. *Confederated Salish* refers to both the Salish and Pend d'Oreille Tribes. The territories of these three tribes covered all of western Montana and extended into parts of Idaho,

British Columbia, and Wyoming. The Hellgate Treaty of 1855 established the Flathead Reservation, but over half-a-million acres passed out of tribal ownership during land allotment that began in 1904.

### Fort Belknap Reservation (Gros Ventre and Assiniboine)

Fort Belknap Indian Reservation is homeland to the Gros Ventre (Aaniiih) and the Assiniboine (Nakoda) Tribes. Fort Belknap Indian Reservation is located 40 miles south of the Canadian border and 20 miles north of the Missouri River, which is the route of the Lewis and Clark Expedition. Fort Belknap Indian Reservation is the fourth largest Indian reservation in Montana.

The Fort Belknap Indian Community Council is recognized as the governing body on the Fort Belknap Reservation. They are charged with the duty of protecting the health, security, and general welfare of the Fort Belknap Indian Community.

The Fort Belknap Indian Community Council consists of the president and the vice president, who are elected to serve a four year term. Eight council members, consisting of four Gros Ventres and four Assiniboine members, are elected every two years. The president and vice president appoint a secretary/treasurer who serves four years.

The Fort Belknap Indian Reservation encompasses an area consisting of 675,147 acres, which extends approximately 28 miles from east to west, and 35 miles from north to south. Fort Belknap has a tribal membership of 7,000 enrolled members.

### Fort Peck Reservation (Assiniboine and Sioux)

The Fort Peck Reservation is home to two separate American Indian nations, each composed of numerous bands and divisions. The Sioux divisions of the Sisseton, Wahpetons, Yanktonais, and the Teton Hunkpapa, are all represented. The Assiniboine Bands of Canoe Paddler and Red Bottom are also represented. The Reservation is located in the extreme northeast corner of Montana, on the north side of the Missouri River.

In 1878, the Fort Peck Agency was relocated to its present day location in Poplar because the original agency was located on a flood plain, suffering floods each spring. The Reservation is 110 miles long and 40 miles wide, encompassing 2,093,318 acres (approximately 3,200 square miles). Of this, approximately 378,000 acres are tribally owned and 548,000 acres are individually allotted Indian lands. The total of Indian-owned lands is about 926,000 acres. There are an estimated 10,000 enrolled tribal members, of whom approximately 6,000 reside on or near the Reservation. The population density is greatest along the southern border of the Reservation near the Missouri River and major transportation routes.

The Fort Peck tribes adopted their first written constitution in 1927. The tribes voted to reject a new constitution under the Indian Reorganization Act in 1934. The original constitution was amended in 1952, and completely rewritten and adopted in 1960. The present constitution remains one of the few modern tribal constitutions that still include provisions for general councils—traditional tribal types of

government. The official governing body of the Fort Peck tribes is the tribal executive board, composed of 12 voting members, a chairman, a vice-chairman, a secretary/accountant, and a sergeant-at-arms.

## Health Care Infrastructure

### Blackfeet Service Unit

First opened in Browning, MT, in1937, the Blackfeet Community Hospital has since been transformed into an expansive modern day; 110,000 square foot; 28-bed; comprehensive health care facility complete with a 64-slice, state-of-the-art computer tomography unit within a fully digitized radiology and lab service department.

Located in the western portion of the 1.5 million acre Blackfeet Indian Reservation, where Browning is home to over 7,000 descendants of the Ampska Pikuni Nation, and bordering Glacier National Park, the hospital sits in the shadows of the "Backbone of Mother Earth," or what is more commonly known as the Shining Mountains of the rugged Northern Rockies.

### Crow Service Unit

Within the valley of Little Big Horn, below the Little Big Horn Battlefield Monument (the site of Custer's last stand) is the Crow Service Unit. This hospital provides health care for the Crow and the Northern Cheyenne, and employs 200 plus doctors, nurses, LPN's, lab technicians, and service personnel necessary to adequately staff a 24-bed health facility.

Sixty miles from Crow Agency is Billings, the largest city in Montana, Interstate 90 connects Crow Agency to Hardin, Billings, and Sheridan, WY, 75 miles south of the Crow Agency.

### Flathead Service Unit

Numerous small communities exist within the Flathead Reservation of 1.3 million acres in Northwest Montana, and several large towns near the reservation provide shopping, housing, and other consumer needs that might not be met by the smaller towns. Pablo, St. Ignatius, Polson and Ronan all lie on the reservation, and the larger cities of Missoula and Kalispell are no more than an hour's drive away. Tribal government headquarters are located in Pablo, while the Tribal Health and Human Services is located in St. Ignatius.

### Fort Belknap Service Unit

Fort Belknap Service Unit operates a six-bed, critical access hospital (CAH) located at the Fort Belknap Agency in Harlem, MT, with a satellite health clinic in Hays approximately 35 miles away. The Fort Belknap CAH outpatient visits average 39,000 per year. The new clinic in Hays, Eagle Child Health Center, can adequately serve 13,000 per year.

## Fort Peck

The Fort Peck Reservation is located in Northeastern Montana and includes Daniels, Richland, Roosevelt, Sheridan, and Valley Counties with 89% of the Indian people residing in Roosevelt County. The estimated *User Population* is comprised of 8,427 Indian people.

Direct ambulatory and preventative health services are provided through the IHS programs, with all inpatient services provided through contractual agreements with the 22-bed community hospital in Poplar and the 32-bed community hospital in Wolf Point.

## California

The California Area IHS provides the health care delivery system to the State of California, the home of the largest AI/ANs population in the country. According to the 2010 Census, California's Indian population was 362,801. California is home to 107 federally recognized tribes. Below, the California Indian tribes are categorized by region to show their diversity, as well as their similarities, due to the regional differences in California.

### Native people of California

#### Northwest

This area includes the Tolowa, Shasta, Karok, Yurok Hupa Whilikut, Chilula, Chimarike, and Wiyot Tribes. The distinctive northern rainforest environment encouraged these tribes to establish their villages along the many rivers, lagoons, and coastal bays that dot their landscape. While this territory is crisscrossed with thousands of trails, the most efficient form of transportation was the dugout canoe used to travel up and down rivers and to cross the wider and deeper ones, such as the Klamath. These tribes used the great coast Redwood trees to manufacture their boats and houses. Redwoods were cleverly felled by burning them at the base and then splitting them with Elkhorn wedges. Redwood, and sometimes cedar, planks were used to construct rectangular gabled homes. Baskets, in a variety of designs, were only manufactured with the twined technique.

#### Northeast

This region includes the Modoc, Achumawi, and Atsugewi Tribes. The western portion of this territory was rich in acorn and salmon. Further to the east, the topography changes from mountainous to a high desert. Food resources were grass seeds and tuber berries, along with rabbit and deer.

These Indians found tule to be a useful source of both food (by consuming the root bulb) and a convenient material, when laced together, to form floor mats and structure coverings. The social-political organization of these peoples was independent of, but connected to, their neighbors by marriage ties. The Modoc's 1872 resistance to removal to the Oregon territory was the last heroic military defense of native sovereignty in 19th century California Indian history.

#### Central California

This vast territory includes: Bear River, Mattale, Lassick, Nogatl, Wintun, Yana, Yahi, Maidu, Wintun, Sinkyone, Wailaki, Kato, Yuki, Pomo, Lake Miwok, Wappo, Coast Miwok, Interior Miwok, Wappo, Coast Miwok, Interior Miwok, Monache, Yokuts, Costanoan, Esselen, Salinan and Tubatulabal Tribes.

Vast differences exist between the coastal peoples and nearby mountain range territories, from those living in the vast central valleys and on the slopes of the Sierra Nevada. Nevertheless, all of these tribes enjoyed an abundance of acorn and salmon that could be readily obtained in the waterways north of Monterey Bay.

Common in this area was the semi-subterranean roundhouse where elaborate Kuksu dances were held in the past and continue to this day. These rituals assure the renewal of the world's natural foods for both plants and animals. Despite differences between tribes, these rituals share similar purposes.

## Southern California

Southern California presents a varied and somewhat unique region of the State. Beginning in the north, tribes found in this area are the Chumash, Alliklik, Kitanemuk, Serrano, Gabrielino Luiseno Cahuilla, and the Kumeyaay. The landmass and climate vary considerably in the windswept, offshore Channel Islands that were principally inhabited by Chumash speaking peoples. Communications with their mainland neighbors was by large and graceful planked canoes powered by double paddle ores. These vessels were called *Tomols,* and manufactured by a secretive guild of craftsmen. They could carry hundreds of pounds of trade goods and up to a dozen passengers. Like their northern neighbors, the Tactic-speaking peoples of San Nicholas and Santa Catalina Islands built planked canoes and actively traded rich marine resources with mainland villages and tribes. Shoreline communities enjoyed the rich animal and faunal life of the ocean, bay, and wetland environments. Interior tribes, like the Serrano, Luiseno, Cahuilla, and Kumeyaay, shared an environment rich in the Sonoran life zone, featuring vast quantities of rabbit, deer, acorn, seeds, and native grasses. At the higher elevations, Desert Bighorn sheep were hunted.

## Brief History of California Indians

The population of Native Californians was reduced by 90% during the 19th century—from more than 200,000 in the early 19th century to approximately 15,000 at the end of the century, mostly due to disease. Epidemics, such as the 1833 malaria epidemic, swept through California Indian Country.

With Mexican independence in 1834, the Spanish missions were taken under Mexican control and secularized, but the new government did not return their lands to the tribes. Many landless Indian peoples found wage labor on ranches. Following its victory in the Mexican-American War, the United States took control of California in 1848 with the signing of the Treaty of Guadalupe Hidalgo, which did not honor aboriginal land titles.

### Health Care Infrastructure

There are presently 31 California tribal health programs operating 57 ambulatory clinics under the authority of the Indian Self Determination Act. IHS funds eight urban health programs that operate under the authority of the Indian Health Care Improvement Act. In fiscal year 2011, California tribal health programs had 140,386 registered users and 80,438 active users. Registered users are a cumulative total for all Indian patients ever seen at tribal facilities, and active users are those who have accessed care during the past 3 years.

None of the tribal facilities and programs currently operating in California originated as IHS facilities. Population sizes and the dispersion of tribal groups in the California area make it unlikely that a hospital-based service program will develop within the area, similar to other IHS areas where the

federal government has built, staffed, and maintained hospitals and satellite clinics on Indian reservations.

Tribal programs will continue to rely on private and public hospitals to meet inpatient and emergency needs. Some tribal health program physicians have privileges at local hospitals and follow their patients through the local hospital system. Otherwise, the patients are referred to private physicians using CHS funding, as well as other alternate resources. Most programs have not developed laboratory, pharmaceutical, or x-ray specialties, so these services are purchased from the private sector through CHS funding or other tribal resources.

## Great Plains (formerly Aberdeen)

The Great Plains Area Office in Aberdeen, SD, works in conjunction with its 19 Indian health service units and tribally-managed service units to provide health care to approximately 122,000 Native Americans located in North Dakota, South Dakota, Nebraska, and Iowa. The Area office's service units include seven hospitals, eight health centers, and several smaller health stations and satellite clinics.

Each facility incorporates a comprehensive health care delivery system. The hospitals, health centers, and satellite clinics provide inpatient and outpatient care, and conduct preventive and curative clinics. The Great Plains Area also operates an active research effort through its Area Epidemiology Program. Research projects deal with diabetes, cardiovascular disease, cancer, and the application of health risk appraisals in all communities.

Tribal involvement is a major objective of the program, and several tribes have assumed management for their own health care programs through contractual arrangements with the IHS.

### Native people of the Great Plains Area

#### *The Three Affiliated Tribes*

Both archeologists and scholars have written extensively about the area, which was originally inhabited by a people called Village Dwellers. These people have also been referred to as the Mound Builders because of the shape of their earthen homes. Their descendants are the Mandans, Hidatsas, and Arikaras. Prior to the 17th century, each tribe had achieved a self-sufficient, agricultural way of life. The Arikaras had originally settled in the Platte Valley in Nebraska. The Hidatsas lived along the Knife River in North Dakota. The Mandans inhabited the area that is now Minneapolis. Today, the Three Affiliated Tribes reside along the banks of the Missouri River on the Fort Berthold Reservation in Central North Dakota.

#### The Winnebago Tribe

The Winnebago were originally woodland people from Northern Wisconsin. The expansion and migration of other tribes and the White men pushed them west until 1865, when they settled in their present location in Northeastern Nebraska.

#### The Omaha Tribe

The original home of the Omahas was east of the Missouri River on what is today the Nebraska-Iowa border. The Omahas were farmers and hunters with strict moral codes and a complex social structure. Non-nomadic by nature, they were builders of permanent earthen homes. The Tribe eventually settled in the Blackbird Hills above the Missouri River in Northeastern Nebraska.

#### The Sioux Tribe

Originally from the eastern woodlands, the Sioux Tribe was actually comprised of a loose confederation of seven bands of common ancestry known as The Seven Council Fires. The word *Sioux* was a name

given by the Chippewa meaning enemy or snake. The Sioux manifested three tribal divisions based on kinship, dialect, and geographic proximity. The eastern division was originally called Isanyeti, meaning Knife Makers. Today they are known as the Santees and are comprised of four Bands: Mdewakanton (Spirit Lake Dwellers), Wahpkute (Shooter among Leaves), Wahpeton (Dwellers among the Leaves), and Sisseton (Fish Scales in the Village). They speak the distinctive "D" Dakota dialect, and have been known as powerful healers and spiritual advocates. The middle division consisted of the Yanktons and Yanktonnais (Village at the End) who speak a distinctive "N" Nakota dialect, and are the acknowledged Keepers of the Sacred Pipestone located in Western Minnesota. The western division is the Tetons (Dwellers on the Prairies). They are the largest band and speak the "L" Lakota dialect. The Tetons moved westward to the plains and west of the Missouri River, spreading out and settling in the sacred lands of Paha Sapa, or the Black Hills.

### Health Care Infrastructure

The Aberdeen Area IHS provides health services to approximately 122,000 Indian people who reside within 19 service units. There are 16 reservations: eight in South Dakota, four in North Dakota, three in Nebraska, and one in Iowa. There are also three non-reservation service units: Rapid City, South Dakota; Trenton Service Unit, North Dakota; and Northern Ponca Service Unit, Nebraska. The Aberdeen Area IHS also provides health services to approximately 6,000 Native Americans who are not counted in the user population of the Area. This population does not reside within any service unit; however, they meet the IHS eligibility criteria for health services provided at IHS or tribally operated direct care facilities. The largest concentrations of the non-service unit eligible are found in Aberdeen and Sioux Falls, SD, and Bismarck and Grand Forks, ND.

## Nashville

In 1970, tribal leaders from the Eastern Band of Cherokee Indians, the Mississippi Band of Choctaw Indians, the Seminole Tribe of Florida, and the Miccosukee Tribe of Florida advocated for a higher level of service and IHS presence in the Southeastern United States, in closer proximity to their respective reservations and tribal members. The answer to this request came with the establishment of a Program Office, located in Sarasota, FL. The new Program Office provided the tribes in the Southeast region with staff solely dedicated to their needs and services. As more tribes across the South and into the Northeast began to gain federal recognition, the IHS recognized the need for an increase in staff and service levels. In 1975, the Program Office was relocated to Nashville, TN, and officially established as the Nashville Area Office.

Today, the Nashville Area IHS serves 29 tribes or nations with 16 Title I (contracted) tribally administered programs, nine Title V (compacted) tribally administered programs, four IHS federal direct care service unit programs, and three urban Indian health programs. These tribes and nations are dispersed across 14 states, although the Nashville Area also assists patients in a total of 24 states in Eastern, Southeastern, and mid United States.

Due to their geographic diversity, the Nashville Area health programs rely on a combination of long-distance communications and on-site meetings, conferences, site visits, trainings, and tribal consultation sessions to share information with one another. To learn more about each of the tribes located within the Nashville IHS area, visit: http://www.ihs.gov/nashville/index.cfm?module=about

### Health Care Infrastructure

Health care services in the Nashville Area are available to eligible beneficiaries through four federal direct care service programs, 26 tribally-administered programs, and three urban Indian health programs. Tribally administered and urban Indian health programs operate largely independent of the IHS and may have different eligibility requirements.

## Navajo Nation

The vast Navajo Nation, comparable in size to the State of West Virginia, has the largest land base of a federal recognized tribe in the United States. Approximately 170,000 tribal members live on the reservation, which is located in the Four Corners region where the States of Arizona, New Mexico, Colorado, and Utah border one another. According to the 2010 Census, the Navajo Nation has a population of 332,129. The largest portion of the reservation is in Arizona, with additional lands in New Mexico and Utah. (There are no Navajo lands in Colorado.) The Navajos (Ni'hookaa Diyan Diné, Holy Earth People, or Lords of the Earth) have been in the Southwest since at least 1300 A.D., after migrating southward from Western Canada over 1,000 years ago.

### Health Care Infrastructure

#### Navajo Division of Health

In 1977, the Navajo Nation Council established the Navajo Division of Health Improvement Services. In 1995, the Council renamed it as the Navajo Division of Health (NDOH) under NTC Resolution CJY 70-95. The plan of operation was also revised in 1995 to plan, develop, promote, maintain, preserve, and regulate the overall health, wellness, and fitness programs for the Navajo population. The target population for the division includes Navajo individuals and families residing on Navajo Nation and surrounding areas. For fiscal year 2003, the division's operative budget totaled 78.8 million, of which 72% constitutes federal funds, 8% is state funds, 17% is tribal funds, and 2% is tribal trust funds. NDOH employs over 1,100 health care professional, paraprofessional, and technical personnel stationed throughout the Tribe's lands.

In addition to the provision of health care services to the Navajo people, the NDOH has taken a lead in advocating for increasing its capacity and improving many public health categories, such as health promotion and disease prevention, alcohol and substance abuse prevention, elder care, and diabetes prevention. The NDOH is committed to improving the level and quality of the health, wellness, and fitness of the Navajo people.

The eight-member Health and Social Services Committee of the Navajo Nation Council serves as the oversight committee for NDOH. In June 2003, the NDOH, in coordination with other tribal divisions and the Navajo Area IHS, identified eight strategic goals to address health care disparities. The goals were developed to guide improvement of the health status of tribal members, cost containment, and quality of care. Each goal requires partnering with federal agencies, states, and counties in Arizona, New Mexico, and Utah.

#### Navajo Area Indian Health Service

The Navajo Area Indian Health Service (NAIHS) is responsible for the delivery of health services to AI/ANs in the Four Corners region of the United States (Arizona, New Mexico, Utah, and Colorado). Comprehensive health care is provided by NAIHS through inpatient care, outpatient contracts, and community health programs centered around six hospitals, seven health centers, 15 health stations,

and 22 dental stations. IHS employs 3,931 staff at six IHS service units and the Area Office, and under three 638 self-determination contracts. NAIHS is responsible for providing health care services to more than 200,000 patients, covering parts of Arizona, New Mexico, and Utah. In fiscal year 2003, the NAIHS budget amounted to $534.6 million, the majority of which are federally appropriated funds totaling $391.1 million. The remaining $143.5 million was generated in revenues from Medicaid, Medicare, and private insurance.

### P.L. 93–638 Health Providers and Tribal Programs

In 2002, three 638 Indian self-determination contracts were approved by the Navajo Nation Council. The contracts' three providers are located in Tuba City, AZ; Winslow, AZ; and Montezuma Creek, UT.

## Oklahoma City

### Brief History

The tribes usually described as indigenous to Oklahoma at the time of European contact include the Wichitas, Caddos, Plains Apaches (currently the Apache Tribe), and the Quapaws. Following European arrival in America and consequent cultural changes, Osages, Pawnees, Kiowas, and Comanches migrated into Oklahoma, displacing most of the earlier peoples. Anglo-American pressures in the Trans Apalachian West forced native peoples across the Mississippi River; many—including Delawares, Shawnees, and Kickapoos—found refuge or economic opportunities in present-day Oklahoma before 1830. However, some of those tribes split in the process.

The Indian Removal Act of 1830 culminated in federal policy aimed at forcing all Eastern Indians west of the Mississippi River. The Choctaws, Cherokees, Creeks, Chickasaws, and Seminoles—the *Five Civilized Tribes*—purchased present-day Oklahoma in fee simple from the federal government, while other immigrant tribes were resettled on reservations in the unorganized territories of Kansas and Nebraska. Passage of the Kansas-Nebraska Act in 1854 precipitated further Anglo-American settlement of these territories, setting off a second wave of removals into present-day Oklahoma, which became known as *Indian Territory*. In 1859, with the State of Texas threatening genocide toward Indians, several tribes found refuge in the Leased District in Western Indian Territory.

The Civil War (1861 to 1865) temporarily curtailed frontier settlement and removals, but postwar railroad building across the Great Plains renewed the Anglo-American homesteading of Kansas and Nebraska. In 1867, to protect newcomers and provide safe passage to the developing West, the federal government once again removed the Eastern immigrant Indians from the Kansas and Nebraska reservations and relocated them on Indian Territory lands recently ceded by the Five Civilized Tribes. The same year, the Medicine Lodge Council attempted to gather the Plains tribes onto Western Indian Territory reservations. Resistance among some resulted in periodic warfare until 1874. Meanwhile, the last of the Kansas and Nebraska tribes were resettled peacefully in present-day Oklahoma. Geronimo's Apache followers, the last to be defeated, were established near Ft. Sill as prisoners of war.

### Present Day

Since the decline of the early 1900s, many of Oklahoma's Indian peoples have taken advantage of changing federal policy to assert their sovereignty and assume responsibility for their own welfare. Constitutions have been written and tribal governments have been established to provide social services for the people including health care, housing, and jobs. Culture and language preservation continue to be a priority amongst the nations.

Many of these endeavors are funded through tribal enterprises. Currently, there are 39 tribal governments of which 38 are federally recognized tribes and tribal towns in Oklahoma. According

to an analysis by the Steven C. Agee Economic Research & Policy Institute at Oklahoma City University, Oklahoma's 38 federally recognized Indian tribes produce an estimated $10.8 billion impact on Oklahoma's economic output.

American Indians contribute to the diverse cultural fabric in Oklahoma today in significant ways. Amongst the distinct tribes, there are 12 linguistic families. In fact, there are more languages spoken in the State of Oklahoma than in all of Europe.

### Health Care Infrastructure

The Oklahoma City Area IHS serves the states of Oklahoma and Kansas, and portions of Texas. Oklahoma is home to more than 39 T/TOs, which is a unique characteristic of the Oklahoma City Area because a large number of tribes have opted to operate their own health programs, from large-scale hospitals to smaller preventive care and behavioral health programs. The Area consists of eight service units with federally operated hospitals, clinics, and smaller health stations.

The Oklahoma City Area is also home to urban clinics and urban demonstration projects, which operate similarly to service units. All of the urban clinic facilities are federally qualified health centers, which provide ambulatory outpatient health care to the urban communities. To learn more about each of the Tribal and IHS health systems, please visit the Oklahoma City Area IHS website.

## Phoenix

The Phoenix Area includes 44 tribes in the tri-state area of Arizona, Nevada, and Utah. Working among the Indian tribes offers the unique opportunity to develop one's skills and to apply those skills in an exciting environment. Each tribe is unique, with distinct languages, governments, and cultures. To find out more about each community, please visit the Phoenix Area IHS website: http://www.ihs.gov/phoenix/index.cfm?module=dsp_phx_tribes.

### Health Care Infrastructure

The Phoenix Area Indian Health Service (PAIHS) Office in Phoenix, AZ, oversees the delivery of health care to approximately 140,000 Native American users, serving 44 tribes, in the tri-state area of Arizona, Nevada, and Utah.

Services are comprehensive and range from primary care services (inpatient and outpatient) to tertiary care and specialty services. In addition, dental, behavioral health, public health nursing, health education, and environmental health services are provided. These services are provided through nine service units located throughout the tri-state area. The Phoenix Area works closely with the 40 tribes within the tri-state area to provide health care services.

The PAIHS works closely with the three urban programs in the Area: Reno, Salt Lake City, and Phoenix; and two tribal organizations: the Inter Tribal Council of Arizona and the Inter Tribal Council of Nevada.

## PORTLAND

Within the Portland IHS area, which includes Oregon, Washington, and Idaho, reside 43 federally recognized tribes. Northwest Coast Indians were found in Oregon, Washington, Idaho, and even as far north as Alaska. Some of the tribes that inhabited those states were the Bella Coola, Haida, Kwakiuts, Makah, Nez Perce, Nisqualli, Nootka, Quinault, Puyallup, Salish, Snohomish, Spokane, Shuswap, Swinomish, Tlingit, and Tsimshian.

The Northwest Coast Indians were considered rich because they had both an abundance of food and sturdy shelters. As with most tribes, the women did chores each day. This includes weaving baskets and mats, collecting berries, making clothing, and cleaning house. The men's day consisted of hunting and fishing. The Northwest Coast Indians built canoes from cedar trees. The Tribe split trees in two, which was perfect for making canoes. The canoes were 50 feet long and could hold up to 20 warriors and 10,000 pounds of fish.

The Northwest Coast Indians did not live in teepees like other tribes, but built longhouses out of wide cedar planks. These longhouses could be very large and, if built by the Tribe, the chief was in charge of assigning who lived in each of them. If it was built by an individual, he and his family lived in that longhouse. However, if the owner of the house died, it was often burned to the ground for fear of the owner's spirit haunting the family if they remained in the house.

The Northwest Coast Indians used totem poles to tell stories, but they did not create the first totem poles. Totem poles were brought to them through trade and they loved them so they started creating their own. Because the Northwest Coast Indians had no written language, the totem poles were very important parts of their culture. The totem poles allowed them to record stories, legends, and myths through images.

To learn more about each of the tribes located in this region, please visit the Portland IHS area page at http://www.ihs.gov/portland/tribesandnations/ or refer to the Appendix of Tribes and Tribal Nations.

### HEALTH CARE INFRASTRUCTURE

The Portland Area Office (PAO) IHS provides access to health care for an estimated 150,000 AI/AN residents of Oregon, Washington, and Idaho. Health delivery services are provided by a mix of health centers, health stations, preventative health programs, and urban programs. Health stations provide a limited range of clinical services and usually operate less than 40 hours per week. Preventive programs offer counselor and referral services.

The Portland Area IHS operates six federal health facilities in five tribal communities and at the Chemawa Indian School. Tribes operate health facilities under the authority of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended), Titles I and V. There are 23 tribes with Title V compacts and 24 T/TOs that contract under Title I. Overall, tribes

administer more than 74% of the Portland Area budget authority appropriation through Self-Determination contracts or Self-Governance compacts. There are also three Urban programs with services ranging from community health to comprehensive primary health care services.

The PAO encompasses a rich diversity of Native cultures and traditions in Washington, Oregon, and Idaho. Meeting the needs of its unique population requires an equally diverse health care delivery system. With direct service health centers operated by a combination of tribal facilities, urban Indian organizations, and the IHS, the PAO provides and coordinates care for over 40 tribes in the Pacific Northwest with a goal of ensuring that comprehensive, culturally acceptable, personal, and public health services are available and accessible to AI/AN people.

The disparity of health status disproportionately affecting Northwest AI/ANs is a primary concern for the PAO. Each year, specific, measurable clinical objectives are used to assess and improve the quality of care at its facilities.

In addition, the Northwest Portland Area Indian Health Board works closely with the PAO, operating a variety of important health-related programs on behalf of their member tribes, including the Northwest Tribal Epidemiology Center.

Major health problems include hypertension, diabetes mellitus, obesity, and otitis media. Accidental injuries account for mortality and morbidity at several times the national average. Substance abuse issues are also a major concern. With a health care team approach, the PAO endeavors to utilize Indian communities and families as primary resources to affect ongoing improvements in of AI/AN health.

## TUCSON

This area serves two tribes, the Tohono O'odham Tribe and the Pascua Yaqui Tribe, and a growing urban Indian population in Tucson and surrounding areas.

### Tohono O'odham Tribe

Historically, the O'odham inhabited an enormous area of land in the Southwest, extending south to Sonora, Mexico, north to Central Arizona (just north of Phoenix, AZ), west to the Gulf of California, and east to the San Pedro River. This land base was known as the Papagueria, and it had been home to the O'odham for thousands of years.

From the early 18th century to the present day, the O'odham land was occupied by foreign governments. With the independence of the Republic of Mexico, O'odham fell under Mexican rule. Then, in 1853, through the Gadsden Purchase or Treaty of La Mesilla, O'odham land was divided almost in half, between the United States of America and Mexico.

According to the terms of the Gadsden Purchase, the United States agreed to honor all land rights of the area held by Mexican citizens, which included the O'odham, and O'odham would have the

same constitutional rights as any other United States citizen. However, the demand for settlement land escalated with the development of mining and the transcontinental railroad. This demand resulted in the loss of O'odham land on both sides of the border.

Today, approximately nine O'odham communities in Mexico lie proximate to the southern edge of the Tohono O'odham Nation, a number of which are separated only by the United States-Mexico border.

On the U.S. side of the border, the Gadsden Purchase had little effect on the O'odham, initially because they were not informed that a purchase of their land had been made, and the new border between the United States and Mexico was not strictly enforced. In recent years, however, the border has come to affect the O'odham in many ways, because immigration laws prevent the O'odham from crossing it freely. O'odham members must produce passports and border identification cards to enter into the United States.

On countless occasions, the U.S. Border Patrol has detained and deported members of the Tohono O'odham Nation who were simply traveling through their own traditional lands, practicing migratory traditions essential to their religion, economy, and culture. Similarly, on many occasions, U.S. customs agents have prevented Tohono O'odham from transporting raw materials and goods essential for their spirituality, economy, and traditional culture. Border officials are also reported to have confiscated cultural and religious items, such as feathers of common birds, pine leaves, or sweet grass.

The division of O'odham lands has resulted in an artificial division of O'odham society. O'odham bands are now broken up into four federally recognized tribes: the Tohono O'odham Nation, the Gila River Indian Community, the Ak-Chin Indian Community, and the Salt River (Pima Maricopa) Indian Community. Each band is now politically and geographically distinct and separate. The remaining band, the Hia-C'ed O'odham, are not federally recognized, but reside throughout Southwestern Arizona. All of the groups still speak the O'odham language, which derives from the Uto-Aztecan language group, although each group has varying dialects.

### Pascua Yaqui Tribe

In 1964, Congressman Morris K. Udall introduced a bill in Congress for the transfer to the Tribe of 202 acres southwest of Tucson. The bill was approved in August 1964, and the Pascua Yaqui Association, a nonprofit Arizona corporation, was formed to receive the deed for the land from the federal government. On September 18, 1978, the Pascua Yaqui Tribe of Arizona became federally recognized, when they achieved status as a created tribe, a designation that was finally converted to that of a historical tribe in 1994. In 1988, the Tribe's first constitution was approved. The Pascua Yaqui Indian Reservation is located in Pima County, in the southwestern part of the Tucson metropolitan area, amidst the suburban communities of Drexel Heights and Valencia West, and adjacent to the eastern section of the Tohono O'odham Indian Reservation, known as the San

Xavier Indian Reservation. The community is governed by a chairman, a vice chairman, and nine tribal council members. Police protection is provided by the Tribal Police Department, and fire protection is provided by six full-time and four reserve firefighters.

For non-Yaquis, it is difficult to fully grasp the blend of ancient Yaqui beliefs and the religion taught to them by Jesuit priests in the 1500s, but they successfully melded the two into a unique belief system that includes their beloved deer dancer. The Yaquis may be best known for these men highly trained in an ancient religious ceremony, in which the dancer wears a headdress depicting a deer's head and whose steps imitate movements of a deer.

The deer dancer is prominent in the Pascua Yaqui logo and tribal symbol. The successful merger of ancient Yaqui traditions with Catholicism allows the deer dancer to remain a central feature of the spiritual lives of today's Pascua Yaqui Tribe of Arizona. Pascua is Spanish for Easter, and it is during the Easter season that the deer dancer is most prominent, participating in ceremonies that depict events of this holy period.

Flowers are important to the Yaquis' daily lives and ceremonies. They combine the ancient belief that the deer dancer is from a flower-filled spiritual world of natural beauty with the belief that Christ's grace is symbolized by flowers that grew from blood that fell from Jesus' wounds during the crucifixion. Flowers are believed to be powerful weapons against evil, and are prevailing symbols seen in elaborately embroidered floral designs on traditional Yaqui clothing.

### Health Care Infrastructure

The Tucson Area IHS provides primary health care and community outreach services to members of the Tohono O'odham Nation (formerly known as the Papago), the Pascua Yaqui tribe of Arizona, and a growing and diverse urban Indian population. The Tucson Area's Sells Service Unit (SSU) operates a 14-bed hospital in Sells, AZ, and 3 outpatient health centers in the Tohono O'odham Nation, treating approximately 20,000 patients annually. Health care services for the Pascua Yaqui tribal members of Pima County are provided through a tribal Self-Determination PL 93-638 contract with approximately 7,000 users.

## E.2: Ten Largest Tribal Grouping Profiles

*Largest Tribal Groupings in the United States, 2010*

Cultural and regional diversity, differences between urban and rural settings and varying levels of access to electronic connections within the AI/AN population present a challenge to any communications campaign. Table 3 lists the largest AI/AN populations that may be potential target audiences based on their size, cultural influence, and regional diversity. These audiences cover urban centers and reservations throughout the United States, including Alaska.

Table 3: Largest Tribal Groupings in the United States

| Tribe | Population |
|---|---|
| Navajo | 332,129 |
| Cherokee | 284,247 |
| Chippewa | 170,742 |
| Sioux | 170,110 |
| Apache | 111,810 |
| Choctaw | 103,910 |
| Creek | 88,332 |
| Iroquois | 81,002 |
| Pueblo | 62,540 |
| Blackfeet | 27,279 |

*Source: U.S. Census Bureau, Census 2010*

## NAVAJO

See the tribal profile on Navajo Nation under Regional Area Profiles. Navajo Nation is so large that it is often considered a separate Regional Area, unlike the other tribes in New Mexico, Arizona, and Utah.

# Cherokee

### History

Since their earliest contact with European explorers in the 16th century, the Cherokee people have been consistently identified as one of the most socially and culturally advanced of the Native American tribes. Cherokee culture thrived many hundreds of years before initial European contact in the Southeastern area of what is now the United States. Cherokee society and culture continued to develop, progressing and embracing cultural elements from European settlers. The Cherokee shaped both a government and a society matching the most civilized cultures of the day.

Gold was discovered in Georgia in the 1830s. Outsiders were already coveting Cherokee homelands and a period of *Indian removals* made way for encroachment by settlers, prospectors, and others. Ultimately, thousands of Cherokee men, women, and children were rounded up in preparation for their removal at the order of President Andrew Jackson.

The Cherokee were herded at bayonet point in a forced march of 1,000 miles, ending with their arrival in Indian Territory, which is, today, part of the State of Oklahoma. Thousands died in the internment camps, along the trail itself, and after their arrival due to the effects of the journey.

### Rebuilding

The Cherokee soon re-established themselves in their new home with communities, churches, schools, newspapers, and businesses. The new Cherokee capital of Tahlequah, along with nearby Park Hill, became a major hub of regional business activity and the center of cultural activity. The Cherokee adopted a new constitution in September of 1839, and, in 1844, the *Cherokee Advocate*, printed in both Cherokee and English, became the first newspaper in Indian Territory and the first-ever published in a Native American language. The *Cherokee Messenger* was their first published periodical.

The Tribe's educational system of 144 elementary schools and two higher education institutions, the Cherokee Male and Female Seminaries, rivaled, if not surpassed, all other schools in the region. Many White settlements bordering the Cherokee Nation took advantage of their superior school system, and actually paid tuition to have their children attend Cherokee schools.

Reading materials, made possible by Sequoyah's 1821 creation of the Cherokee syllabary, led the Cherokee people to a level of literacy significantly higher than their White counterparts well before Oklahoma became the country's 46th state in 1907.

The Cherokee rebuilt a progressive lifestyle from remnants of the society and the culture left behind in Georgia. The years between their removal and the 1860s have often been referred to as the Cherokee's Golden Age, a period of prosperity that ended in tribal division over loyalties in the Civil War. Unfortunately, even more Cherokee lands and rights were taken by the federal government after the war to reprimand the Cherokees who chose to side with the Confederacy. What remained of Cherokee tribal land was eventually divided into individual allotments to Cherokees listed in the census compiled by the Dawes Commission in the late 1890s. It is the descendants of those original enrollees who make up today's Cherokee Nation tribal citizenship.

## The Cherokee Nation Today

Today, the Cherokee Nation is an active leader in education, housing, vocational training, and business and economic development. They are the largest Indian tribe in the United States, with well over 300,000 tribal citizens. Over 70,000 Cherokees reside within a 7,000 square mile geographical area, which is a truly sovereign nation covering most of Northeast Oklahoma. Its jurisdictional service area encompasses eight entire counties along with portions of six others. As one of only three such federally-recognized Cherokee tribes, the Cherokee Nation has both the sovereign right and the responsibility to exercise control and development over their tribal assets, including more than 66,000 acres of land and 96 miles of the Arkansas Riverbed.

## Tribal Government

The Cherokee Nation operates under a three-part government including judicial, executive, and legislative branches. A revised constitution of the Cherokee Nation was ratified by the Cherokee people in June of 1976, and approved by the Commissioner of Indian Affairs on September 5, 1976.

Executive power is vested in the principal chief, the legislative power in the tribal council, and judicial power in the Cherokee Nation Judicial Appeals Tribunal.

The position of deputy principal chief is also part of the executive branch. The deputy principal chief presides over the tribal council during their monthly meetings. The principal chief, deputy principal chief, and council members are elected to 4-year terms by registered tribal voters. Council members represent the 5 districts of the Cherokee Nation within its 14-county jurisdictional area.

The judicial branch of tribal government includes the District Court and Judicial Appeals Tribunal, which is directly comparable to the U.S. Supreme Court. The tribunal consists of three members who are appointed by the principal chief and confirmed by the council. It is the

highest court of the Cherokee Nation and oversees internal legal disputes, alongside the District Court. The district judge and an associate district judge preside over the Tribe's District Court and hear all cases brought before it under jurisdiction of the Cherokee Nation Judicial Code.

## Self-Governance Agreement

The Cherokee Nation authorized the negotiation of a tribal self-governance agreement for direct funding from the U.S. Congress on February 10, 1990. This agreement authorizes the Tribe to plan, conduct, consolidate, and administer programs and receive direct funding to deliver services to tribal members. Self-governance is a change from the paternalistic control that the federal government has exercised in the past, to the full tribal responsibility for self-government and independence, as was initially intended by treaties with sovereign Indian nations.

## Sioux

Great Plains Indians were deemed *Sioux* by French trappers who abbreviated a Chippewa term. The Chippewa were not allies of the Plains people, and the term *Sioux* translates to enemy or little snakes. To properly acknowledge and understand today's Sioux people, the true definition of their culture must first be understood.

The Seven Council Fires properly refers to the entire Great Plains tribal system. Within the Seven Council Fires, there are three tribal divisions and each division is comprised of bands, described below, who all speak different and distinct dialects.

### Eastern division—Isanti/Santee (Dakota)

Originally called *Isanti*, or Knife Makers, they were also known as the *Santee*. Members of this division spoke the distinct Dakota dialect. The Eastern division consists of four bands:

- Mdewankanton: Dwellers by the Sacred Lake,
- Wahpekute: Shooters Among the Leaves,
- Wahpetonwan: Dwellers Among the Leaves, and
- Sisitonwan or Sisseton: People of the Marsh.

### Middle division—Ihanktonwan-Ihanktowana (Nakota)

The smallest division, these Native Americans moved into Eastern South Dakota and Northwestern Minnesota. In addition to speaking the Nakota dialect, they are known as the Keepers of the Sacred Pipestone. This division consists of two bands:

- Ihanktonwan (Lower Yanktonai or Hunkpatina): End of the Camp Circle and
- Ihanktowana (Upper Yanktonai): Little End Village.

### Western division—Tetonwan/Teton (Lakota)

The western division is the largest division. All members of these bands speak the Lakota dialect. Tetonwans, or Dwellers on the Plains, traditionally occupied the area west of the Missouri River. Later, they spread out and settled the sacred lands of the Black Hills. This division is made up of seven bands:

- Oglala—Scatter Their Own
- Sicangu/Brulé—Burnt Thigh
- Mnicoujou—Planters by the River
- Hunkpapa—Campers at the Horn
- Itazipo or Sans Arc—Without Bows
- Oohenumpa—Two Kettles
- Sihasapa—Blackfeet

Each of the three divisions has always been distinguishable because of their individual dialects, lifestyles, and means of sustaining themselves. Additionally, all members of the Seven Council Fires hunted from Northern Canada south to the Republican River in Kansas, and from the Mississippi River to the Bighorn Mountains in the West.

## History

Living in separate bands made up of extended families, the Seven Council Fires came together at least once a year, usually midsummer, during the season of the Sundance ceremony. During this time, vows were made and fulfilled. This was also a time for celebrating each other's victories, socializing, horseracing, and competing in contests. While the adults discussed and planned issues of national interest, the youth courted and enjoyed each other's company. Everyone traded goods at this annual event.

Cultural change began in 1803 when the United States completed the Louisiana Purchase from France. The land purchased was home to thousands of Native Americans; however, the act did not give the government the right of possession of the land.

The Supreme Court declared that the government had to honor Indian land holdings by entering into nation-to-nation treaties, which were the first law of the land, according to Article Six of the Constitution, and by purchasing land from the Indian people for White settlement.

Numerous violations of these land rights by the government and White settlers caused much dissent. White hunters, encouraged by government bounties, killed millions of buffalo, which were the Sioux people's primary source for food, clothing, and shelter. After this sacred animal was destroyed, the Great Plains Indians had no choice but to negotiate.

The Treaty of 1868 was established between the Sioux Nation and the U.S. Government to maintain peace and to establish reservations where Indian people would live protected by the U.S. Constitution. In exchange for the land given to the United States for White settlement, the government agreed to protect the Sioux people's right to hunt, and to provide them with health care, education, and personal livelihoods. After thousands of years of roaming their vast, buffalo-hunting land, the Lakota people were required to settle on 11 reservations, nine of which are in South Dakota that, today, encompass the Great Sioux Nation.

The Great Sioux Reservation included the whole of South Dakota west of the Missouri River. During the 1800s, several treaties were entered into between the Sioux and the U.S. Government. With each new treaty, the Sioux lost more land until finally, in 1889, the Great Sioux Reservation was reduced to five separate reservations. The Act of March 2, 1889, by the U.S. Congress, which identified all the Lakota and Dakota reservations, is known as the Great Sioux Settlement.

## Chippewa (Ojibwe)

Today, most of the Ojibwe people still live on the land their ancestors settled before the coming of Europeans, although that land base has been drastically reduced. The original homeland of the Ojibwe was immense, stretching from the northern reaches of the plains to the southeastern shores of the Great Lakes. In Canada, it extended from Central Saskatchewan to Southern Ontario, and in the United States, it included the northern corner of North Dakota, Northern Minnesota, Wisconsin, most of Michigan, and part of Northern Ohio. The Ojibwe regarded their land as a gift from the Great Spirit to their people, and it belonged to everyone in the Tribe. They lived upon it, loved it, and resisted any who tried to drive them from it.

Today, four main groups of Ojibwe people have been distinguished by location and their adaption to varying conditions. They are the Plains Ojibwe, the Northern Ojibwe, the Southeastern Ojibwe, and the Southwestern Ojibwe or Chippewa.

### The Plains Ojibwe

The Plains Ojibwe live in Saskatchewan, Western Manitoba, North Dakota, and Montana. Although they were originally a woodland people, this group of Ojibwe changed their way of life when they moved into the open lands and borrowed many of the customs of other Plains peoples. Today, most of them work at farming and ranching. Many live in reservation communities, known in Canada as *reserves*, and some have moved to the city of Winnipeg.

### Northern Ojibwe

The Northern Ojibwe live in the remote forest country between the Great Lakes and Hudson Bay. This area is also inhabited by the Cree people. The term *Oji-Cree* actually refers to a distinct mix of Ojibwe and Cree people living in that area. From their earliest times, the Ojibwe in that region have depended on hunting for a living, and have separated into small family communities or clans because the land could not sustain large groups living together. A few still earn income by hunting and fur trapping. Some are now guides or work in the timber industry, and a number of Northern Ontario reserves now have provincially chartered business corporations.

### Southeastern Ojibwe

The Southeastern Ojibwe often mingled with related peoples like the Ottawa and Potawatomi who, according to Anishinabe Oral Tradition, along with other Michigan and Ohio Indian people, were forced out of their homeland by the United States military and resettled on reservations in Kansas. However, there remains a large number of Ojibwe people in Michigan's Upper Peninsula, as well as smaller reserves in Central Michigan. There are no longer any organized Ojibwe communities in Ohio. Today, the majority of the Southeastern Ojibwe are in Southern Ontario, particularly around some of the shores and islands of Georgian Bay in Lake Huron.

## Southwestern Ojibwe

In Minnesota, Wisconsin, and upper Michigan reside the Southwestern Ojibwe, where they are generally referred to as *Chippewa*. They traditionally lived by hunting, trapping, fishing, gathering wild rice, and making maple sugar. Today, some Ojibwe in these areas still earn a living from these activities. The Chippewa in the United States form the largest group among the Ojibwe, and they have the most highly organized community and tribal life. Most of them live on reservations in Northern Minnesota and Wisconsin, or in the cities of Milwaukee, Minneapolis, St. Paul, and Duluth.

## History

The Ojibwe were the largest and most powerful Great Lakes tribe, perhaps even the most powerful tribe east of the Mississippi, and quite possibly the most powerful tribe in North America. Very few Americans realize that the Ojibwe were a major power. Their location was well north of the main flow of settlement, and their victories over native enemies have never received proper credit. A variety of names (Ojibwe, Chippewa, Bungee, Mississauga, and Saulteaux) and the division of their population between Canada and United States has masked their true size. As the Chippewa, they signed 51 treaties with the United States, which is more than any other tribe.

Before European contact, Ojibwe religion was similar to their political organization. There was little formal ceremony. For healing, they relied on medicinal herbs gathered by the women and shamans. These were overwhelmed by the new diseases which were deadly beyond anything they had seen. The Midewiwin, or Grand Medicine Society, was a secret religious society that evolved from the Ojibwe's original religion. Open to both men and women, its members performed elaborate healing ceremonies to deal with sickness. Among the Ojibwe, the Midewiwin kept records on birch bark scrolls. Actual written records were unique among the Great Lakes tribes. Beyond its healing and religious functions, Midewiwin membership crossed band lines and provided an additional element of political leadership, binding the different Ojibwe groups to each other. Within 50 years of their first meeting with a European, the Ojibwe had united to become one of the most powerful tribes in North America.

## Choctaw

The Choctaw are native to the Southeastern United States and members of the Muskogean linguistic family, which traces its roots to a mound-building, maize-based society that flourished in the Mississippi River Valley for more than a thousand years before European contact.

Although their first encounter with Europeans ended in a bloody battle with Hernando de Soto's fortune-hunting expedition in 1540, the Choctaw would come to embrace European traders who arrived in their homeland nearly 2 centuries later. By the time President George Washington initiated a program to integrate Southeastern Indians into European American culture following the Revolutionary War, many Choctaw had already intermarried, converted to Christianity, and adopted other White customs. The Choctaw became known as one of America's Five Civilized Tribes, which also included the Chickasaw, Cherokee, Creek, and Seminole.

### Trail of Tears

The Choctaw signed nine treaties with the United States before the Civil War, beginning with the Treaty of Hopewell in 1786, which set boundaries and established universal peace between the two nations. Subsequent treaties, however, reshaped those borders and forced the Choctaw to cede millions of acres of land. In 1830, the United States seized the last of the Choctaw's ancestral territory and relocated the Tribe to Indian Territory west of the Mississippi River. The Choctaw were the first to walk the Trail of Tears. Nearly 2,500 members perished along the way.

Despite the many lives lost, the Choctaw remained a hopeful and generous people. The first order of business upon arriving in their new homeland was to start a school and a church. They drafted a new constitution. And, when the great potato famine befell the people of Ireland, the Choctaws collected money to help alleviate the country's suffering.

### Oklahoma

The Choctaw entered a new post-Civil War era when the United States ceded 2 million acres of Indian land, abolished commonly held tribal lands, and created the Oklahoma Territory. It set up the Dawes Commission to register Indian families and parcel out individual plots of land. In 1889, the Oklahoma Territory was opened to White settlement. The ensuing land run overwhelmed the Choctaw Nation. The Choctaw suffered thefts, violent crimes, and murders at the hands of Whites and other tribal members.

### Self Determination

From the mid-1940s to the mid-1960s, the United States pursued a policy of Indian termination, whereby the rights of sovereign tribes were eliminated and Native Americans were assimilated into mainstream America. The Choctaw Nation of Oklahoma was scheduled for termination

when Congress repealed the law in 1970, citing the policy's documented failure in helping Native Americans.

The repeal galvanized a new generation of Choctaw. In 1971, the Tribe held its first popular election of a chief since Oklahoma achieved statehood in 1907. During the same decade, it established a tribal newspaper, enrolled more Choctaw, and launched a movement to preserve the Choctaw language. The 1970s also marked congressional passage of the Indian Self-Determination and Education Assistance Act, which gave the Choctaw power to negotiate and contract directly with the federal government for services that benefited its people most.

If the 1970s set the Choctaw in a new direction, the 1980s paved the Nation's future. During this decade, a new constitution was ratified by a vote of the people, providing for an executive, legislative, and judicial branch of the government. On the economic front, the Choctaw opened a Bingo hall in Durant that would eventually become a successful resort and lead to new casinos. The Tribe also launched new business enterprises, planned new schools, initiated educational programs and scholarships, and established new health centers.

Today, the Choctaw Nation of Oklahoma is nearly 200,000-strong and self-sufficient, dedicated to improving the lives of its people. As they continue their long journey through history, the Choctaw's future looks brighter than ever.

## Apache

*Apache* is the collective term for several culturally-related groups of Native Americans in the United States who are originally from the Southwest United States. These indigenous peoples of North America speak a Southern Athabaskan (Apachean) language, which is related linguistically to the languages of Athabaskan speakers of Alaska and Western Canada.

The modern term *Apache* excludes the Navajo people. Since the Navajo and the other Apache groups are clearly related through culture and language, they are all considered Apachean. Apachean peoples formerly ranged over Eastern Arizona, Northern Mexico, New Mexico, West and Southwest Texas, and Southern Colorado. The Apachería consisted of high mountains, sheltered and watered valleys, deep canyons, deserts, and the Southern Great Plains.

### History

The Apachean groups had little political unity; the major groups spoke seven different languages and developed distinct and competitive cultures. The current division of Apachean groups includes the Navajo, Western Apache, Chiricahua, Mescalero, Jicarilla, Lipan, and Plains Apache (formerly Kiowa-Apache). Apache groups live in Oklahoma and Texas, and on reservations in Arizona and New Mexico.

Some Apacheans moved to cities while others worked as migrant farm laborers, moving to the central agricultural regions of Southern California including the Coachella, Imperial, and Colorado River Valleys, where tens of thousands of Apacheans now live.

The Apachean tribes fought the Spanish and Mexican peoples for centuries. The first Apache raids on Sonora appear to have taken place during the late 17th century. During 19th-century confrontations, the U.S. Army found the Apache to be fierce warriors and skillful strategists.

### Current Apache Tribes

The following Apache tribes are federally recognized:

- Apache Tribe of Oklahoma
- Fort McDowell Yavapai Nation
- Fort Sill Apache Tribe of Oklahoma
- Jicarilla Apache Nation
- Mescalero Apache Tribe of Mescalero Reservation
- San Carlos Apache Tribe of the San Carlos Reservation
- Tonto Apache Tribe of Arizona
- White Mountain Apache Tribe of Fort Apache Reservation
- Yavapai-Apache Nation of the Camp Verde Indian Reservation

## Pueblo

The Pueblo people are Native American people in the Southwestern United States comprising several different language groups and two major cultural divisions, one organized by matrilineal kinship systems and the other by a patrilineal system. These determine the clan membership of children, and lines of inheritance and descent. Their traditional economy is based on agriculture and trade. At the time of the Spanish encounter in the 16th century, they were living in villages that the Spanish called *pueblos*, meaning towns.

### History

The Pueblos trace their history back to the 1100s when the original tribes moved down into New Mexico and spread out through the Sangre de Cristo Mountains to establish communities along the waterways. Each share a common building pattern using adobe blocks to create structures around a central plaza; the oldest dwellings are in these main village areas. Upkeep of these homes is as important as the community's social and religious activities. Most pueblos have spread outward from the central village to include new developments and all have contemporary water, sewage systems, and utilities.

The proud heritage of the Pueblos has been kept alive for almost 1,000 years. The Pueblo people continue to speak their tribal language and still retain their ancient, largely secret, ceremonial lives. Many of the ancient crafts have been revived and, today, Pueblo artisans and craftsmen are of the highest caliber, and are recognized nationally and internationally for their craftsmanship.

### Current Pueblo Tribes

The following Pueblos are federally recognized in New Mexico, Arizona, and Texas:

- Acoma Pueblo
- Cochiti Pueblo
- Isleta Pueblo
- Jemez Pueblo
- Kewa Pueblo
- Laguna Pueblo
- Nambe Pueblo
- Ohkay Owingeh Pueblo
- Picuris Pueblo
- Pojoaque Pueblo
- Sandia Pueblo
- San Felipe Pueblo
- San Ildefonso Pueblo
- Santa Ana Pueblo
- Santa Clara Pueblo
- Taos Pueblo
- Tesuque Pueblo
- Zia Pueblo
- Zuni Pueblo
- Hopi Tribe
- Ysleta del Sur Pueblo

## Iroquois

The Iroquois people have inhabited the areas of Ontario and Upstate New York for well over 4,000 years. Technically speaking, *Iroquois* refers to a language rather than a particular tribe. The Iroquois consisted of five tribes prior to European colonization. Those tribes include Mohawk, Seneca, Cayuga, Onondaga and Oneida. Their society serves as an outstanding example of a political and military organization, a complex lifestyle, and elevated roles of women.

### History

During the hundred years preceding the American Revolution, wars with French-allied Algonquin and British colonial settlements forced them back within their original boundaries. Their decision to side with the British during the Revolutionary War was a disaster for the Iroquois. The American invasion of their homeland in 1779 drove many of the Iroquois into southern Ontario where they have remained. With large Iroquois communities already located along the upper St. Lawrence in Quebec at the time, roughly half of the Iroquois population has since lived in Canada. This includes most of the Mohawk, along with representative groups from the other tribes. Although most Iroquois reserves are in Southern Ontario and Quebec, one small group (Michel's band) settled in Alberta during the 1800s as part of the fur trade.

In the United States, much of the Iroquois homeland was surrendered to New York land speculators in a series of treaties following the Revolutionary War. Despite this, most Seneca, Tuscarora, and Onondaga avoided removal during the 1830s and have remained in New York. There are also sizeable groups of Mohawk, Oneida, and Cayuga still in the State. Most of the Oneida, however, relocated in 1838, to a reservation near Green Bay, WI. The Cayuga sold their New York lands in 1807 and moved west to join the Mingo relatives (Seneca of Sandusky) in Ohio. In 1831, this combined group ceded their Ohio reserve to the United States and relocated to Indian Territory. A few New York Seneca moved to Kansas at this time but, after the Civil War, joined the others in Northeast Oklahoma to become the modern Seneca-Cayuga Tribe of Oklahoma.

The Iroquois are one of the most important Native groups in North American history. Culturally, however, there was little to distinguish them from their Iroquian-speaking neighbors. All had matrilineal social structures—the women owned all property and determined kinship. After marriage, a man moved into his wife's longhouse, and their children became members of her clan. Iroquois villages were generally fortified and large. The distinctive, communal longhouses of the different clans could be over 200 feet in length and were built about a framework covered with elm bark, the Iroquois' material of choice for all manner of things. Villages were permanent in the sense that they were moved only for defensive purposes or when the soil became exhausted (about every 20 years).

It was the Iroquois political system, however, that made them unique and, because of it, they dominated the first 200 years of colonial history in both Canada and the United States. Strangely enough, there were never that many of them; the enemies they defeated in war were often twice their size. Although much has been made of their Dutch firearms, the Iroquois prevailed because of their unity, sense of purpose, and superior political organization. Since the Iroquois League was formed prior to any contact, it owed nothing to European influence. Proper credit is seldom given, but rather than learning political sophistication from the Europeans, Europeans learned from the Iroquois, and the League, with its elaborate system of checks, balances, and supreme law, almost certainly influenced the American Articles of Confederation and Constitution.

## The Iroquois Confederacy Today

Altogether, there were over 50,000 Iroquois in the United States in 1990. Some 17,000 Mohawk and over 11,000 Oneida live in the United States, in addition to around 10,000 people of Seneca or mixed Seneca-Cayuga heritage. Close to 10,000 Mohawk live in Canada, many on the St. Regis and the Six Nations Reserves in Ontario and the Caughnawaga Reserve in Quebec. Many Cayuga, who were strong allies of the British, also live on the Six Nations Reserve, which is open to all members of the Confederacy. Most of the remaining Iroquois, except for the Oneida of Wisconsin and the Seneca-Cayuga of Oklahoma, are in New York; the Onondoga reservation is still the capital of the Iroquois Confederacy. Large numbers of Iroquois in the United States live in urban areas rather than on reservations. Many Mohawk and Oneida work as structural steelworkers, and the Oneida opened a large gambling casino near Syracuse, NY, in 1993. In recent years, the Iroquois nations have pursued land claims in New York in the federal courts with mixed results. Most Iroquois are either Christians or followers of Handsome Lake, a Seneca prophet of the 18th century who was influenced by the Quakers.

## Muscogee (Creek)

The Creek people are descendants of a culture that spanned the entire Southeastern United States before 1500 A.D. The Muscogee lived in autonomous villages in river valleys throughout present-day Tennessee, Georgia, and Alabama, speaking several related Muskogean languages. In 1832, the Tribe was forced to accept a removal treaty and, as a result, over 20,000 Muscogee (Creek) people were relocated to a new homeland" in what is today the State of Oklahoma. Today, the Muscogee Nation, the third-largest federally recognized tribe in the United States, is a non-reservation Tribe with a jurisdictional area extending across part, or all, of 11 counties in Eastern North-Central Oklahoma, including the city of Tulsa. There are about 88,000 Muscogee Nation members.

### History

Early ancestors of the Muscogee constructed magnificent earthen pyramids along the rivers of this region as part of their elaborate ceremonial complexes. The historic Muscogee later built expansive towns within these same broad river valleys in the present States of Alabama, Georgia, Florida, and South Carolina. The Muscogee were not one tribe, but a union of several. This union evolved into a confederacy that, in the Euro-American-described *historic period*, was the most sophisticated political organization north of Mexico. Member tribes were called *tribal towns*. Within this political structure, each tribal town maintained political autonomy and distinct land holdings.

The confederacy was dynamic in its capacity to expand. New tribal towns were born of *mother towns* as populations increased. The confederation was also expanded by the addition of tribes conquered by towns of the confederacy and, in time, by the incorporation of tribes and fragments of tribes devastated by the European imperial powers. Within this confederacy, the language and the culture of the founding tribal towns became dominant.

Throughout the period of contact with Europeans, most of the Muscogee population was concentrated into two geographical areas. The English called the Muscogee peoples occupying the towns on the Coosa and the Tallapoosa Rivers the Upper Creeks, and those to the Southeast, on the Chattahoochee and Flint Rivers, the Lower Creeks. The distinction was purely geographical. In part, due to their proximity to the English, the lower towns were substantially affected by intermarriage and its consequent impact on their political and social order. The upper towns remained less affected by European influences and continued to maintain distinctly traditional political and social institutions.

In the late 1800s, the Dawes Commission began negotiating with the Muscogee Nation for the allotment of the national domain. In 1898, the United States Congress passed the Curtis Act, which made the dismantling of the national governments of the Five Civilized Tribes, and the allotment of collectively-held tribal domains, inevitable. In 1890, noted statesman Chitto Harjo helped lead organized opposition to the dissolution of the Muscogee national government and

the allotment of collectively-held lands. In his efforts, he epitomized the view of all Muscogee people, that they possessed an inherent right to govern themselves. For individuals like Chitto Harjo, it was unimaginable that the Nation could be dissolved by the action of a foreign government. This perception proved to be correct.

The end of the Muscogee Nation, as envisioned by its architects within the United States Congress, did not occur. In the early 20th century, the process of allotment of the national domain to individual citizens was completed. However, the perceived dismantling of the Muscogee government was never fully executed. The nation maintained a principal chief throughout this stormy period.

In 1971, the Muscogee people, for the first time since the partial dismantling of their national government, freely elected a principal chief without presidential approval. In the 1970s, the leadership of the Muscogee Nation drafted and adopted a new constitution, revitalized the National Council, and began the challenging process of Supreme Court decisions that affirmed the nation's sovereign rights to maintain a national court system and levy taxes. The federal courts have also consistently re-affirmed the Muscogee Nation's freedom from state jurisdiction. Now, the Mound Building, located at the tribal headquarters, houses the National Council Offices and Judicial Offices. In the 1990s, almost 100 years after the dark days of the allotment era, the Muscogee people are actively engaged in the process of accepting and asserting the rights and responsibilities of a sovereign nation. As a culturally distinct people, the Muscogee are also aware of the necessity for knowing and understanding their extraordinary historical and cultural inheritance.

## Tribal Government

The Muscogee Nation 1974 Constitution continued the 1867 constitutional organization of the executive, legislative, and judicial branches of the government with distinct separations of power among the three. The Executive Branch includes the Office of the principal chief, second chief, tribal administrator, and chief of staff who oversee the daily operations of the Tribe. The Legislative Branch includes a 16-member national council which represents the eight districts located in the Tribe. The Judicial Branch is divided into two branches including the Muscogee Nation District Court and the Supreme Court. The Supreme Court is the nation’s highest court with original jurisdiction over challenges to the Constitution of the Muscogee Nation, and appellate jurisdiction over cases appealed from the District Court. The Supreme Court is the final authority on the Constitution and laws of the Muscogee Nation.

## Health Care Infrastructure

The Muscogee Nation Department of Health is one of the largest Tribal Health Systems in Oklahoma. The foundations of the current Muscogee Nation Health System can be traced to the Snyder Act of 1921 and the Indian Health Care Improvement Act of 1976, which provide specific legislative authority for Congress to appropriate funds for the health care of Indian

people. The basis for the development of the present system of health for the Muscogee Nation began in 1975, with the passage of the Indian Self-Determination and Education and Assistance Act. This legislation gave tribal governments the ability to contract and operate programs of the Bureau of Indian Affairs and the Indian Health Service (IHS).

On November 4, 1977, the Muscogee Nation signed a Sub-Lease agreement and an Operation and Maintenance agreement with the Trustees of the Okfuskee Memorial Hospital Authority and the Okfuskee County Commissioners to occupy and operate the former Okfuskee County Hospital in Okemah on a 30-year lease purchase. That facility is now the Creek Nation Community Hospital in Okemah, OK.

From 1976 through 1988, the health system was operated under the broad guidance of the Inter-Tribal Council of the Five Civilized Tribes, which included the Muscogee Nation. In 1988, the Muscogee Nation National Council approved the Hospital and Clinic Board Act of 1988, which established a board to provide for the functional management of the health system. In 1992, legislation was passed that created the Division of Health Administration, moving the functional management of the health system directly under the Executive Branch of the Nation. The division was managed by a director who was appointed by the principal chief with the consent of the National Council. This was changed with the passage of the Hospital and Clinics Act of 1994, which established the health system as an independent agency of the Muscogee Nation, separate from the Executive Branch, and under the direct oversight and management of a Health System Board. The division director was to be recommended by the board and approved by the National Council and principal chief.

Prior to 2002, the Muscogee Nation had contracted with IHS to provide health care services to its citizens. In 2002, the Muscogee Nation entered into an Indian Self-Determination compact with the IHS to provide for the health care needs of its people. This method of agreement allowed the Muscogee Nation much greater flexibility in the provision of services for the tribal population.

The health system remained under the control of the Health System Board until February 2009. At that time, the National Council passed legislation thereby eliminating the Health Board, returning the status of the health system from an independent agency to the direct supervision of the Executive Branch, with the secretary of health appointed by the principal chief and confirmed by the National Council.

## Blackfeet

The Blackfeet Nation consists of Pikuni/Peigan, North Peigan Pikuni, Blood/Kanini, and Blackfoot/Siksika people. The groups are all members of the greater Algonquian linguistic family and they share common cultural and religious beliefs. The Blackfeet of Montana are the only Pains group to have a reservation in the United States. The other groups occupy reserves in Southern Alberta, Canada.

The Indian Reorganization Act of 1934 stemmed the tide of Blackfeet land losses by placing most Indian lands into trust status. In the years since the Indian Reorganization Act, the Tribe has steadily progressed in terms of economic, health, education, and housing standards. Currently, there are modest developments of coal, oil, and natural gas reserves on the reservation.

People of the Blackfeet Nation continue to practice traditional cultural and religious ceremonies like the Sun Dance and sweat lodges. Members continue to speak the indigenous languages and trial scholars encourage language revitalization programs.

The Province of Alberta, Canada, on the north, and Glacier National Park and Lewis and Clark National Forest on the west, border the Blackfeet Reservation. It is also bordered by Birch Creek on the south and Cut Bank Creek on the east. The general topography consists of rolling plains rising westward to the forests of the Continental Divide.

There are 16,000 enrolled members, making it the largest Indian tribe in Montana, and one of the largest tribes in the United States. In the 2010 Census, 23,583 people identified themselves as Blackfeet. The 1.5 million-acre (3,000 square miles) reservation in Montana has a population of about 10,000, including 8,500 enrolled Blackfeet.

### Tribal Government Structure

Under the Indian Reorganization Act of 1934, the Tribe adopted a new tribal council and bylaws. It is recognized as a domestic sovereign nation by the federal government. The reservation is governed by a popular election tribal business council, which consists of nine members elected to 4-year, staggered terms. The business council nominates executive officers (a chairman, vice-chairman, and secretary). The reservation is divided into four districts, each represented by two council members, except for the Browning District, which has three representatives.

# Appendix J: State Specific List of Federally Recognized Tribes and Alaska Native Villages

## Alaska Area

### Alaska Native Villages

- Native Village of Afognak
- Agdaagux Tribe of King Cove
- Native Village of Akhiok
- Akiachak Native Community
- Akiak Native Community
- Native Village of Akutan
- Village of Alakanuk
- Alatna Village
- Native Village of Aleknagik
- Algaaciq Native Village (St. Mary's)
- Allakaket Village
- Native Village of Ambler
- Village of Anaktuvuk Pass
- Yupiit of Andreafski
- Angoon Community Association
- Village of Aniak
- Anvik Village
- Asa'carsarmiut Tribe
- Native Village of Atka
- Village of Atmautluak
- Atqasuk Village (Atkasook)
- Native Village of Barrow Inupiat Traditional Government
- Beaver Village
- Native Village of Belkofski
- Village of Bill Moore's Slough
- Birch Creek Tribe
- Native Village of Brevig Mission
- Native Village of Buckland
- Native Village of Cantwell
- Native Village of Chenega (aka Chanega)
- Chalkyitsik Village
- Cheesh-Na Tribe
- Village of Chefornak
- Chevak Native Village
- Chickaloon Native Village
- Chignik Bay Tribal Council
- Native Village of Chignik Lagoon
- Chignik Lake Village
- Chilkat Indian Village (Klukwan)
- Chilkoot Indian Association (Haines)
- Chinik Eskimo Community (Golovin)
- Native Village of Chitina
- Native Village of Chuathbaluk (Russian Mission, Kuskokwim)
- Chuloonawick Native Village
- Circle Native Community
- Village of Clarks Point
- Native Village of Council
- Craig Tribal Association
- Village of Crooked Creek
- Curyung Tribal Council
- Native Village of Deering
- Native Village of Diomede (aka Inalik)
- Village of Dot Lake
- Douglas Indian Association
- Native Village of Eagle
- Native Village of Eek
- Egegik Village

- Eklutna Native Village
- Native Village of Ekuk
- Ekwok Village
- Native Village of Elim
- Emmonak Village
- Evansville Village (aka Bettles Field)
- Native Village of Eyak (Cordova)
- Native Village of False Pass
- Native Village of Fort Yukon
- Native Village of Gakona
- Galena Village (aka Louden Village)
- Native Village of Gambell
- Native Village of Georgetown
- Native Village of Goodnews Bay
- Organized Village of Grayling (aka Holikachuk)
- Gulkana Village
- Native Village of Hamilton
- Healy Lake Village
- Holy Cross Village
- Hoonah Indian Association
- Native Village of Hooper Bay
- Hughes Village
- Huslia Village
- Hydaburg Cooperative Association
- Igiugig Village
- Village of Iliamna
- Inupiat Community of the Arctic Slope
- Iqurmuit Traditional Council
- Ivanof Bay Village
- Kaguyak Village
- Organized Village of Kake
- Kaktovik Village (aka Barter Island)
- Village of Kalskag
- Village of Kaltag
- Native Village of Kanatak
- Native Village of Karluk
- Organized Village of Kasaan
- Kasigluk Traditional Elders Council
- Kenaitze Indian Tribe
- Ketchikan Indian Corporation
- Native Village of Kiana
- King Island Native Community
- King Salmon Tribe
- Native Village of Kipnuk
- Native Village of Kivalina
- Klawock Cooperative Association
- Native Village of Kluti Kaah (aka Copper Center)
- Knik Tribe
- Native Village of Kobuk
- Kokhanok Village
- Native Village of Kongiganak
- Village of Kotlik
- Native Village of Kotzebue
- Native Village of Koyuk
- Koyukuk Native Village
- Organized Village of Kwethluk
- Native Village of Kwigillingok
- Native Village of Kwinhagak (aka Quinhagak)
- Native Village of Larsen Bay
- Levelock Village
- Lime Village
- Village of Lower Kalskag
- Manley Hot Springs Village
- Manokotak Village
- Native Village of Marshall (aka Fortuna Ledge)
- Native Village of Mary's Igloo
- McGrath Native Village
- Native Village of Mekoryuk

- Metlakatla Indian Community, Annette Island Reserve
- Native Village of Minto
- Naknek Native Village
- Native Village of Nanwalek (aka English Bay)
- Native Village of Napaimute
- Native Village of Napakiak
- Native Village of Napaskiak
- Native Village of Nelson Lagoon
- Nenana Native Association
- New Koliganek Village Council
- New Stuyahok Village
- Newhalen Village
- Newtok Village
- Native Village of Nightmute
- Nikolai Village
- Native Village of Nikolski
- Ninilchik Village
- Native Village of Noatak
- Nome Eskimo Community
- Nondalton Village
- Noorvik Native Community
- Northway Village
- Native Village of Nuiqsut (aka Nooiksut)
- Nulato Village
- Nunakauyarmiut Tribe
- Native Village of Nunam Iqua
- Native Village of Nunapitchuk
- Village of Ohogamiut
- Village of Old Harbor
- Orutsararmiut Native Village (aka Bethel)
- Oscarville Traditional Village
- Native Village of Ouzinkie
- Native Village of Paimiut
- Pauloff Harbor Village
- Pedro Bay Village
- Native Village of Perryville
- Petersburg Indian Association
- Native Village of Pilot Point
- Pilot Station Traditional Village
- Native Village of Pitka's Point
- Platinum Traditional Village
- Native Village of Point Hope
- Native Village of Point Lay
- Native Village of Port Graham
- Native Village of Port Heiden
- Native Village of Port Lions
- Portage Creek Village (aka Ohgsenakale)
- Pribilof Islands Aleut Communities of St. Paul & St. George Islands
- Qagan Tayagungin Tribe of Sand Point Village
- Qawalangin Tribe of Unalaska
- Rampart Village
- Village of Red Devil
- Native Village of Ruby
- Native Village of Saint Michael
- Village of Salamatoff
- Native Village of Savoonga
- Organized Village of Saxman
- Native Village of Scammon Bay
- Native Village of Selawik
- Seldovia Village Tribe
- Shageluk Native Village
- Native Village of Shaktoolik
- Native Village of Shishmaref
- Native Village of Shungnak
- Sitka Tribe of Alaska
- Skagway Village
- Village of Sleetmute

- Village of Solomon
- South Naknek Village
- Stebbins Community Association
- Native Village of Stevens
- Village of Stony River
- Sun'aq Tribe of Kodiak
- Takotna Village
- Native Village of Tanacross
- Native Village of Tanana
- Tangirnaq Native Village
- Native Village of Tatitlek
- Native Village of Tazlina
- Telida Village
- Native Village of Teller
- Native Village of Tetlin
- Central Council of the Tlingit & Haida Indian Tribes
- Traditional Village of Togiak
- Tuluksak Native Community
- Native Village of Tuntutuliak
- Native Village of Tununak
- Twin Hills Village
- Native Village of Tyonek
- Ugashik Village
- Umkumiut Native Village
- Native Village of Unalakleet
- Native Village of Unga
- Native Village of Venetie Tribal Government (Arctic Village and Village of Venetie)
- Village of Wainwright
- Native Village of Wales
- Native Village of White Mountain
- Wrangell Cooperative Association
- Yakutat Tlingit Tribe

## Albuquerque Area (New Mexico, Southern Colorado, Texas)

### New Mexico

- Pueblo of Acoma
- Pueblo de Cochiti
- Pueblo of Jemez
- Pueblo of Isleta
- Pueblo of Laguna
- Pueblo of Nambe
- Pueblo of Ohkay Owingeh
- Pueblo of Picuris
- Pueblo of Pojoaque
- Pueblo of Sandia
- Pueblo of San Felipe
- Pueblo of San Ildefonso
- Pueblo of Santa Ana
- Pueblo of Santa Clara
- Pueblo of Santo Domingo
- Taos Pueblo
- Pueblo of Tesuque
- Pueblo of Zia
- Pueblo of Zuni
- Jicarilla Apache Nation
- Mescalero Apache Tribe
- Alamo Chapter of the Navajo Nation
- Tohajiilee (formerly Canoncito) Chapter of the Navajo Nation
- Ramah Chapter of the Navajo Nation

### Colorado

- Southern Ute Reservation
- Ute Mountain Ute Reservation

### Texas

- Ysleta Del Sur Pueblo

## Bemidji Area (Michigan, Minnesota, Wisconsin)

### Michigan Tribes

- Bay Mills Indian Community
- Grand Traverse Band of Ottawa & Chippewa Indians
- Hannahville Indian Community
- Keweenaw Bay Indian Community
- Lac Vieux Desert Band of Lake Superior Chippewa Indians
- Little River Band of Ottawa Indians
- Little Traverse Bay Band of Odawa Indians
- Match-E-Be-Nash-She-Wish Band of Pottawatomi Indians
- Nottawaseppi Huron Band of Potawatomi
- Pokagon Band of Potawatomi Indians
- Saginaw Chippewa Indian Tribe
- Sault Ste. Marie Tribe of Chippewa Indians

### Minnesota Tribes

- Bois Forte Band of Chippewa
- Fond du Lac Band of Lake Superior Chippewa
- Grand Portage Band of Lake Superior Chippewa
- Leech Lake Band of Ojibwe
- Lower Sioux Indian Community
- Mille Lacs Band of Ojibwe
- Prairie Island Indian Community
- Red Lake Band of Chippewa Indians
- Shakopee Mdewakanton Sioux Community
- Upper Sioux Community
- White Earth Nation

### Wisconsin Tribes

- Bad River Band of Lake Superior Chippewa Tribe
- Forest County Potawatomi
- Ho-Chunk Nation
- Lac Courte Oreilles Band of Chippewa Indians
- Lac du Flambeau Band of Lake Superior Chippewa Indians
- Menominee Indian Tribe of Wisconsin
- Oneida Tribe of Indians of Wisconsin
- Red Cliff Band of Lake Superior Chippewa Indians
- Sokaogon Chippewa Community
- St. Croix Chippewa Indians of Wisconsin
- Stockbridge-Munsee Community Band of Mohican Indians

## Billings Area (Montana and Wyoming)

### Montana Tribes and Nations

- Blackfeet Nation
- Chippewa Cree Tribe of Rocky Boy Montana
- Confederated Salish & Kootenai Tribes
- Crow Nation
- Fort Belknap Indian Community
- Fort Peck Indian Community
- Northern Cheyenne Tribe

## California Area

- Agua Caliente Band of Cahuilla Indians
- Alturas Indian Rancheria
- Augustine Band of Cahuilla Indians (formerly the Augustine Band of Cahuilla Mission Indians of the Augustine Reservation)
- Bear River Band of the Rohnerville Rancheria
- Berry Creek Rancheria of Maidu Indians of California
- Big Lagoon Rancheria
- Big Pine Paiute Tribe of Owens Valley
- Big Sandy Rancheria Band of Western Mono Indians
- Big Valley Band of Pomo Indians of the Big Valley Rancheria
- Blue Lake Rancheria
- Bridgeport Indian Colony
- Buena Vista Rancheria of Me-Wuk Indians of California
- Cabazon Band of Mission Indians
- Cachil DeHe Band of Wintun Indians of the Colusa Indian Community of the Colusa Rancheria
- Cahuilla Band of Indians
- Cahto Indian Tribe of the Laytonville Rancheria
- California Valley Miwok Tribe (formerly the Sheep Ranch Rancheria of Me-Wuk Indians of California)
- Campo Kumeyaay Nation
- Capitan Grande Band of Diegueño Mission Indians of California:
- Barona Band of Mission Indians
- Viejas Band of Kumeyaay Indians
- Chemehuevi Indian Tribe
- Cher-Ae Heights Indian Community of the Trinidad Rancheria
- Chicken Ranch Rancheria of Me-Wuk Indians of California
- Cloverdale Rancheria of Pomo Indians of California
- Cold Springs Tribe
- Colorado River Indian Tribes of the Colorado River Indian Reservation (Arizona and California)
- Cortina Indian Rancheria of Wintun Indians of California
- Coyote Valley Band of Pomo Indians of California
- Timbisha Shoshone Tribe
- Dry Creek Rancheria Band of Pomo Indians
- Elem Indian Colony of Pomo Indians of the Sulphur Bank Rancheria
- Elk Valley Rancheria
- Enterprise Rancheria of Maidu Indians of California
- Ewiiaapaayp Band of Kumeyaay Indians
- Federated Indians of Graton Rancheria
- Fort Bidwell Indian Community of the Fort Bidwell Reservation of California
- Fort Independence Indian Community of Paiute Indians of the Fort Independence Reservation
- Fort Mojave Indian Tribe (Arizona, California and Nevada)
- Greenville Rancheria of Maidu Indians of California
- Grindstone Indian Rancheria of Wintun-Wailaki Indians of California
- Guidiville Rancheria of California

- Habematolel Pomo of Upper Lake (formerly the Upper Lake Band of Pomo Indians of Upper Lake Rancheria of California)
- Hoopa Valley Tribe
- Hopland Band of Pomo Indians of the Hopland Rancheria
- Inaja Band of Diegueño Mission Indians of the Inaja and Cosmit Reservation
- Ione Band of Miwok Indians of California
- Jackson Rancheria of Me-Wuk Indians of California
- Jamul Indian Village of California
- Karuk Tribe of California
- Kashia Band of Pomo Indians of the Stewart's Point Rancheria
- La Jolla Band of Luiseño Indians of the La Jolla Reservation
- La Posta Band of Mission Indians
- Los Coyotes Band of Cahuilla & Cupeno Indians of the Los Coyotes Reservation
- Koi Nation
- Lytton Rancheria of California
- Manchester Band of Pomo Indians of the Manchester-Point Arena Rancheria
- Manzanita Band of Diegueño Mission Indians of the Manzanita Reservation
- Mechoopda Maidu Indians
- Mesa Grande Band of Mission Indians
- Middletown Rancheria of Pomo Indians of California
- Mooretown Rancheria of Maidu Indians of California
- Morongo Band of Mission Indians
- North Fork Rancheria of Mono Indians
- Bishop Paiute Tribe
- Paiute-Shoshone Indians of the Lone Pine Community of the Lone Pine Reservation
- Pala Band of Luiseño Mission Indians of the Pala Reservation
- Paskenta Band of Nomlaki Indians
- Pauma Band of Luiseño Mission Indians of the Pauma & Yuima Reservation
- Pechanga Band of Luiseño Mission Indians of the Pechanga Reservation
- Picayune Rancheria of Chukchansi Indians of California
- Pinoleville Pomo Nation (formerly the Pinoleville Rancheria of Pomo Indians of California)
- Pit River Tribe (includes XL Ranch, Big Bend, Likely, Lookout, Montgomery Creek and Roaring Creek Rancherias)
- Potter Valley Tribe (formerly the Potter Valley Rancheria of Pomo Indians of California)
- Quartz Valley Indian Community of the Quartz Valley Reservation of California
- Quechan Indian Tribe of the Fort Yuma Indian Reservation (Arizona and California)
- Ramona Band or Village of Cahuilla Mission Indians of California
- Redding Rancheria
- Redwood Valley Rancheria of Pomo Indians of California
- Resighini Rancheria
- Rincon Band of Luiseño Mission Indians of the Rincon Reservation
- Robinson Rancheria of Pomo Indians of California

- Round Valley Indian Tribes of the Round Valley Reservation
- San Manual Band of Serrano Mission Indians of the San Maual Reservation
- San Pasqual Band of Mission Indians
- Tachi-Yokut Tribe
- Santa Rosa Band of Cahuilla Indians (formerly the Santa Rosa Band of Cahuilla Mission Indians of the Santa Rosa Reservation)
- Santa Ynez Band of Chumash Mission Indians of the Santa Ynez Reservation
- Iipay Nation of Santa Ysabel
- Scotts Valley Band of Pomo Indians of California
- Sheep Ranch Rancheria of Me-Wuk Indians
- Sherwood Valley Rancheria of Pomo Indians of California
- Shingle Springs Band of Miwok Indians
- Smith River Rancheria
- Soboba Band of Luiseño Indians
- Susanville Indian Rancheria
- Sycuan Band of the Kumeyaay Nation (formerly the Sycuan Band of Diegueno Mission Indians of California)
- Table Mountain Rancheria of California
- Torres-Martinez Desert Cahuilla Indians (formerly the Torres-Martinez Band of Cahuilla Mission Indians of California)
- Tule River Indian Tribe of the Tule River Reservation
- Tuolumne Band of Me-Wuk Indians of the Tuolumne Rancheria of California
- Twenty-Nine Palms Band of Mission Indians of California
- United Auburn Indian Community of the Auburn Rancheria of California
- Upper Lake Band of Pomo Indians
- Utu Utu Gwaitu Paiute Tribe of the Benton Paiute Reservation
- Washoe Tribe (Carson Colony, Dresslerville Colony, Woodfords Community, Stewart Community and Washoe Ranches) (California and Nevada)
- Wiyot Tribe (formerly the Table Bluff Reservation-Wiyot Tribe)
- Yocha Dehe Wintun Nation (formerly Rumsey Indian Rancheria of Wintun Indians of California)
- Yurok Tribe of the Yurok Reservation

## Great Plains Area (North Dakota, South Dakota, Nebraska and Iowa)

- Cheyenne River Sioux Tribe
- Crow Creek Sioux Tribe
- Flandreau Santee Sioux Tribe
- Lower Brule Sioux Tribe
- Oglala Sioux Tribe
  - Omaha Tribe of Nebraska
  - Ponca Tribe of Nebraska
  - Rosebud Sioux Tribe
  - Sac and Fox Tribe of the Mississippi
  - Santee Sioux Tribe of Nebraska
- Sisseton-Wahpeton Sioux Tribe
- Spirit Lake Dakota Nation
- Standing Rock Sioux Tribe
- Mandan, Hidatsa, and Arikara Nation
  - Turtle Mountain Band of Chippewa
  - Winnebago Tribe of Nebraska
  - Yankton Sioux Tribe

## Nashville Area (Alabama, Arkansas, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Tennessee, Vermont, Virginia, and West Virginia)

- Alabama-Coushatta Tribe of Texas
- Aroostook Band of Micmac Indians
- Catawba Indian Nation of South Carolina
- Cayuga Nation of Indians
- Chitimacha Tribe of Louisiana
- Coushatta Tribe of Louisiana
- Eastern Band of Cherokee Indians
- Houlton Band of Maliseet Indians
- Jena Band of Choctaw Indians
- Mashantucket (Western) Pequot Tribal Nation
- Mashpee Wampanoag Tribe
- Miccosukee Tribe of Indians of Florida
- Mississippi Band of Choctaw Indians
- Mohegan Tribe of Connecticut
- Narragansett Indian Tribe
- Oneida Indian Nation of New York
- Onondaga Nation of New York
- Passamaquoddy Tribe Indian Township

## Oklahoma Area (Oklahoma, Kansas, and Texas)

- Absentee Shawnee Tribe
- Caddo Nation
- Cherokee Nation
- Cheyenne & Arapaho
- Chickasaw Nation
- Choctaw Nation
- Citizen Potawatomi Nation
- Delaware Nation
- Delaware Tribe of Indians
- Eastern Shawnee Tribe
- Fort Sill Apache Tribe
- Iowa Tribe
- Kaw Nation
- Kickapoo Tribe
- Kiowa Tribe
- Miami Tribe of Oklahoma
  - Modoc Tribe
  - Muscogee (Creek) Nation
  - Osage Nation
  - Otoe-Missouria Tribe
  - Ottawa Tribe
  - Pawnee Nation
  - Peoria Tribe of Indians
  - Ponca Tribe of Oklahoma
  - Quapaw Tribe
  - Sac and Fox Nation of Oklahoma
  - Seminole Nation
  - Seneca-Cayuga Tribe
  - Shawnee Tribe
  - Tonkawa Tribe
  - United Keetoowah Band of Cherokee Indians
- Wichita & Affiliated Tribes
- Wyandotte Nation
- Iowa Tribe of Kansas and Nebraska
- Kickapoo Tribe of Indians in Kansas
- Prairie Band of Potawatomi Nation
- Sac and Fox Nation of Missouri
- Passamaquoddy Tribe of Pleasant Point
- Penobscot Indian Nation
- Poarch Band of Creek Indians
- Seminole Tribe of Florida
  - Seneca Nation of Indians
  - Shinnecock Indian Nation
  - Saint Regis Mohawk Tribe
  - Tonawanda Seneca Nation
  - Tunica-Biloxi of Louisiana
  - Tuscarora Nation
  - United South & Eastern Tribes
  - Wampanoag Tribe of Gay Head Aquinnah

## Phoenix Area (Arizona, Nevada, and Utah)

### Arizona Tribes

- Ak-Chin Indian Community
- Chemehuevi Tribe
- Cocopah Indian Tribe
- Colorado River Indian Tribes
- Fort McDowell Yavapai Nation
- Fort Mojave Tribe
- Gila River Indian Community
- Havasupai Tribe
- Hopi Tribe
- Hualapai Tribe
- Kaibab Band of Paiute Indians
- Quechan Tribe of Arizona
- Salt River Pima-Maricopa Indian Community
- San Carlos Apache Tribe
- San Lucy Village
- Tonto Apache Tribe of Arizona
- White Mountain Apache Tribe
- Yavapai-Apache Indian Community
- Yavapai-Prescott Indian Tribe

### Nevada and Utah Tribes

- Battle Mountain Band Council
- Duckwater Shoshone Tribe
- Elko Band Council
- Ely Shoshone Tribe
- Confederated Tribes of the Goshute Reservation
- Fort McDermitt Paiute-Shoshone Tribe
- Las Vegas Tribe of Paiute Indians
- Lovelock Paiute Tribe
- Moapa Band of Paiute Indians
- Paiute Indian Tribe of Utah
- Fallon Paiute-Shoshone Tribe
- Pyramid Lake Paiute Tribe
- Reno-Sparks Indian Colony
- Shoshone-Paiute Tribes of the Duck Valley Reservation
- South Fork Reservation Council
- Skull Valley Band of Goshute Indians
- Summit Lake Paiute Tribe
- Te-Moak Tribe of Western Shoshone Indians of Nevada
- Ute (Northern) Indian Tribe of the Uintah and Ouray Reservation
- Walker River Paiute Tribe
- Washoe Tribe of Nevada and California (Carson Colony, Dresslerville, Washoe Ranches, and Woodsford)
- Wells Band Council
- Winnemucca Indian Colony (Shoshone-Paiute)
- Yerington Paiute Tribe (Campbell Ranch)
- Yomba Shoshone Tribe of the Yomba Reservation
- Northwestern Band of Shoshone Indians of Utah (Washakie)

## Tucson Area

- Tohono O'odham (formerly Papago)
- Pascua Yaqui Tribe

## Portland Area

- Burns Paiute Tribe
- Coeur D'Alene Tribe of Indians
- The Chehalis Tribe
- Confederated Tribes of the Colville Reservation
- Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians of Oregon
- Confederated Tribes of Grande Ronde
- Confederated Tribes of Siletz Indians
- Confederated Tribes of Umatilla Indian Reservation
- Confederated Tribes of Warm Springs
- Coquille Indian Tribe
- Cow Creek Band of Umpqua Tribe of Indians
- Cowlitz Indian Tribe
- Hoh Indian Tribe
- Jamestown S'Klallam Tribe
- Kalispel Tribe of Indians
- Klamath Tribes
- Kootenai Tribe of Idaho
- Lower Elwha Klallam Tribe
- Lummi Nation
- The Makah Tribe
- Muckleshoot Indian Tribe
- Nez Perce Tribe
- Nisqually Indian Tribe
- Nooksack Indian Tribe
- Northwest Band of Shoshone Nation
- Port Gamble S'Klallam Tribe
- Puyallup Tribe of Indians
- Quileute Tribe
- Quinault Indian Nation
- Samish Indian Nation
- Sauk Suiattle Indian Tribe
- Shoalwater Bay Tribe
- Shoshone-Bannock Tribes
- Skokomish Indian Tribe
- Snoqualmie Indian Tribe
- Spokane Tribe of Indians
- Squaxin Island Tribe
- Stillaguamish Tribe of Indians
- Suquamish Tribe
- Swinomish Indian Tribal Community
- Tulalip Tribes
- Upper Skagit Indian Tribe
- Confederated Tribes and Bands of the Yakama Nation

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