Improving the New Mexico Indian Health Care System:

Pueblo Core Values and Federal Policy

by

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ABSTRACT

Due to the history of colonization, disruption of Indigenous life ways, and encroachment of external Western ideals and practices upon tribal peoples in New Mexico, the protection and preservation of tribal customs, values, traditions, and ways of thinking are critical to the continued existence of the tribes. It has taken many years for tribal communities, such as the 19 Pueblos of New Mexico, to get to where they find themselves today: In a paradoxical situation stemming from the fact that Pueblo people are told to pursue the iconic American Dream, which was not actually designed or intended for tribal peoples and that always seems to be just out of reach for many community members. Yet many of them do their best to emulate the capitalistic consumption and the Western way of life. What is troubling about this is that perhaps many of these people are starting to forget that it was the strength of their ancestors and their dreams that allowed Pueblo people to be here today. So, how do Pueblo people address this paradox? How do they begin to give newer generations, such as the youth, the tools to question and to assess future programs and the future of the tribal communities? Furthermore, what does such a process of preserving and reclaiming mean for future governance? Are these communities prepared to accept the outcomes?

This compilation seeks to address these issues by examining a) the creation and delivery of Western medicine for American Indians in New Mexico and b) a discussion of Pueblo culture and belief systems. The exploration will include not only discussing health and health care concerns, but it will also engage the future considerations that tribal governments in New Mexico, specifically Pueblo Indian communities, must reflect on to ensure the preservation of the culture and values of Pueblo people. Finally, specific

recommendations for action and discussion will be delivered in the form of a policy paper that is designed for tribal leadership and tribal administrative audiences and suggested for implementation.

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Introduction

The American Indian health care system in New Mexico is a mixture of Federal, State, Tribal and private entities. Within the government and private sectors is an overwhelming number of systems of services available to American Indians and Alaska Natives (AI/AN). Although there may appear to be adequate systems in place and despite federal support of AI/AN health programs and services, American Indians and Alaska Native populations in general lead the way in many health disparities. This chapter will seek to provide an overview of the health care systems available to AI/AN populations in New Mexico. This overview will first describe the legal framework and the federal, state and tribal policies that led to the creation of the system. It will then describe the types of care available to AI/AN populations in New Mexico. The overview will also include a review of the health disparities that exist in the AI/AN population in New Mexico. Finally, there will be a discussion of the mechanisms in place to improve the health care systems and health outcomes for AI/AN populations in New Mexico.

The Indian Health Service and Me: The Patient, Critic, Advocate and Policy Maker

I began working in Tribal government in the year 2000. I worked for Zia Pueblo for eight years. In those eight years I had an opportunity to work in Education, Economic Development, Law Enforcement, Housing, Child Care, Enrollment, Natural Resources,

Historical Preservation and Health care. The work was incredibly enriching and yet often frustrating. Misunderstanding and ignorance of Pueblo peoples' ways of thinking came from all directions, including myself. Although I am closely connected to the community through dances and other traditional activities, I was not educated about how tribal government worked. I was educated in financial institutions and had a certain opinion about how organizations should be run and carried my own measuring stick for success. I soon discovered that I had much to learn about how to conduct business with tribal people and how to represent the Pueblo. I was fortunate to have a great mentor at the office and I was quickly educated on dealing with the federal, state and local governments and with private industry from a tribal point of view. One thing that I learned very quickly was the pace of business. In my community, business is conducted in a steady and deliberate pace. Initially I mistook this slow pace for lack of interest or an unwillingness to act. I soon learned that it was a conscious act to proceed with caution and that if the project or opportunity was going to be successful that it did not need to be done in haste. The overall mindset is that we have been in this place and our community has existed for thousands of years, and one or two days was not going to make or break the community.

In the first half of my tenure with Zia Pueblo, I was blessed to undertake many opportunities to have a direct positive impact on my community. On day one of my employment, I was told that I would be the Project Manager for the construction of a brand new K-8th grade school. The responsibility was especially meaningful for me, due to the deep connection that the facility had to my family. My father, Gilbert Lucero, was Principal for the local elementary school for 21 years. One of the last projects that he

worked on before retirement was the application for the construction of a new school. For the next 15 years, the Pueblo made many trips to Washington D.C. to advocate for funding to build the facility. My Grandfather along with other elders from the community was asked to testify on behalf of the project. Finally in 1998, the Pueblo was informed that the school would be built. My father applied for the school, my grandfather testified to Congress for the school and I was able to oversee the construction of the school. In the design of the school, the Pueblo took great care to ensure that the facility was more than a mechanism for western education. The building exterior and a courtyard is full of designs meant to teach the students and staff about the culture and beliefs of Zia people.

Other projects included the revival of a dormant Housing program, construction of ceremonial homes and the introduction of broadband Internet through collaboration with the University of New Mexico and Navajo Technical College. During all of these projects I was also responsible for attending meetings of the Indian Health Service (IHS) service unit health board.

When I began work at Zia I had little interest in the area of health or heath care. I had always utilized the IHS facilities in Albuquerque and in Zia. However, I gave little thought to the system as a whole. I was fortunate to visit the clinics for nothing more than routine dental care and the occasional ankle sprain or sore throat. As I attended the board meeting it was disturbing to learn about the challenges patients faced with accessing the facilities for more serious issues and the lack of services that the IHS could actually offer to patients. It quickly became apparent to me that there was a need to assist tribal leaders and their communities to interpret and navigate the complex health care delivery system. The health board, which membership was meant for tribal leadership, was delegated to

clinic directors and community health advocates and tribal staff who had little authority to make decisions. Time and time again, important meetings to discuss the Indian Heath Service (IHS) budget and changes to policies at the federal and state levels were not attended by Tribal Leadership. When my father became Governor for Zia I asked him why he and other Governors did not attend the IHS meetings. He explained to me that the meetings intimidated him. He did not understand the jargon and the decisions he was being asked to make. He went on to explain to me that he was not afraid to make a decision, but he wanted to fully understand the decision he was being asked to make. From that point, I utilized my position on the health board to challenge the IHS and other health board members to discuss the issues in terms that were relevant to their tribal leaders. I engaged with the All Indian Pueblo Council, a consortium of 20 Pueblos in New Mexico and Texas, and requested that they create a committee specific to health issues. The Pueblo Health Committee (PHC) began to educate the Governors about important issues in health. As Chairman of the PHC, I led a powerful team of advocates and tribal leaders. Among our accomplishments were the establishment of Tribal Consultation Policies with the Health and Human Services departments of New Mexico, the creation of a National IHS committee for Direct Services Tribes, and the successful establishment of the Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC). I am particularly proud of the creation of the AASTEC as it is the only tribally run organization in New Mexico that combines the efforts of all Indian tribes in New Mexico and the states of Colorado and Texas. Dr. Don Clark of the Indian Health Service and I, spent many hours and logged hundreds of miles travelling to each community to gain Tribal Council approval.

After several years of activity with the PHC, I was approached with the opportunity to start up a health policy center that would expand on the work of the committee. The Indian Pueblo Culture Center had received a grant from the Marguerite Casey Foundation to engage communities in empowerment and equality issues. The policy center gave me the opportunity to engage in health policy full time and to expand the work of the PHC. In less than a year, the center became fully funded through the Robert Wood Johnson Foundation and became the RWJF Center for Native American Health Policy at University of New Mexico (UNM).

My affiliation with UNM allowed me to expand my health policy work and presented unique opportunities. This is exemplified in my work with graduate nursing students participating in the RWJF Nursing Fellowship. For two years, I had the opportunity to mentor Native American nursing students on health policy issues. I interviewed Fellows and assisted them is exploring policy issues that were of interest to them. We were fortunate to find issues related to their interests introduced into the New Mexico State Legislature. The students proceeded to follow the issues throughout the session and to develop a policy brief under my guidance. One student took her research one-step further and used her policy brief to work with her community and to engage in the legislative process.

I have been privileged to work with many tribal leaders and tribal communities in this manner. My methods for engaging with these communities have varied depending on the wishes of the communities and the purpose of the engagement. In a National Institutes of Health funded conference, Roadmap to Healthier Communities, I utilized health policy experts, tribal leaders and nationally know journalists to engage with Native

American communities from New Mexico, Colorado, Texas and Off-reservation areas. Content was delivered through breakout sessions and the conference culminated in tribal communities working together to develop their own health policies for implementation in their communities. However, the important community engagement was done during the application process for funding. I worked with the All Indian Pueblo Council, the Albuquerque Area Indian Health Board, and other local health boards to seek input on what information was important to them regarding health and health care. The communities' input drove the content and the application to the NIH. This resulted in a conference that was well attended and led to other projects with individual communities.

In another project, Tribal Input on Establishment of Health Insurance Exchanges in New Mexico (2011), the State of New Mexico sought information on the level of interest of AI/AN had in participation in a health insurance exchange. The state was interested in the level of understanding of the program and the challenges or barriers that the population would face in participation in the exchange. I utilized on-line surveys, community meetings and social events, to gage the knowledge and understanding of the recently passed Affordable Care Act. This required multiple visits to the communities to work with the Tribal Leadership, health care workers and community members. The resulting report led to the creation of a Native American specific workforce at the New Mexico Health and Humans Services department for the Health Insurance Exchange. Working with tribal communities always requires patience and respect. I understand that there is a need to develop a relationship with the communities and an even greater need to maintain that relationship well beyond a project. I have always believed that as a native person seeking to work with a tribal community, that I have greater obligation to secure

trust and fidelity in my work. The places and people I work with are relations and are in the places I will always live and be a part of. Most important to me has been the work that I have done within my community and the Pueblos in general through the Leadership Insititute (LI).

I was introduced to the LI through Michele Suina and Joyce Naseyowma-Chalan. Some of the earliest LI gatherings were with the Center for Native American Health and Joyce and Michele invited me to my first LI convening. The work and the message resonated with me immediately. The lead facilitator/speaker Regis Pecos did a masterful job of challenging the group to think more deeply about the way we operate our programs and the long term effects of not being conscious of how those programs impact Pueblo tradition and culture. I immediately could relate my conflicts with the federal and state agencies to the presentations being made. The programs did not align with our core values. The programs did not accommodate the desire of the community to make goals and objectives relevant to our people. The LI forever changed my approach to the planning, management and advocacy of programs for Pueblo People. When it was announced that the LI was in the process of planning a large convocation of Pueblo people and Nations, I was honored to be a part of the planning process.

The LI Convocation Health team consisted of Governor Gilbert Lucero (Zia), Carlton Albert (Zuni), Joyce Naseyowma-Chalan (Taos/Hopi/Cochiti), Michele Suina (Cochiti), Lia Abeita-Sanchez (Isleta). The health team met for over a year and worked on combining each of our expertise areas into one cohesive statement about the strengths and challenges of Pueblo health. Our presentation focused first and foremost on the strengths of the communities and the tools that we have at our disposal to address our

health issues. Gilbert Lucero was running a Teaching Garden at the Indian Pueblo Culture Center and discussed the garden as a good model for working with youth around healthy eating, exercise and learning tradition and core values. Carlton Albert, a former Zuni Councilman, was heavily involved with the Special Diabetes Program for Indians and contributed information about the challenges of addressing Diabetes in tribal communities. Joyce and Michele provided the heart of the presentation. Their years of work with tribal communities provided examples of what health meant to the tribal communities and presented solutions developed by communities to address their health disparities.

At the time of the Convening, I was heavily involved in boards and committees at the local, state and national levels. Much of my work was based on analysis and interpretation of the Affordable Care Act and the Indian Health Care Improvement Act. Lia Abeita-Sanchez and I involved ourselves with educating Tribal leadership about the history of the Indian Health Service and how the system that exists today was created. There is a lot of work that needs to be done to create a more viable and robust system of care for Indian people. It is important to understand how the system was created and to understand the challenges and opportunities that the system and tribal communities have before them.

Legal Framework

The American Indian health care system had its foundation established through various actions taken during the creation of the United States and through Supreme Court decisions and acts of Congress. The U.S. Constitution and the Supreme Court decisions

cited are important precursors to legislation enacted by Congress. They historically defined the relationship that the United States would have with American Indian Tribes, which has shaped the current status of American Indian Tribes today. This section describes the sections of the Constitution that mention American Indians and the three seminal Supreme Court decisions that further defined and solidified the relationship.

United States Constitution- The Constitution contains two specific clauses that relate directly to AI/AN populations. The Commerce Clause (Article I, §(8, clause 3) authorizes Congress to regulate commerce "with foreign Nations, and among the several States, and with Indian Tribes." The Treaty Clause (Article II, §A2, clause 2) grants to the federal government the exclusive authority to make treaties on behalf of the United States. Through these authorities, the United States Government entered into hundreds of treaties with tribes in exchange for millions of acres of land. In many of these treaties, the US Government promised to provide land, housing, education, and health care to the tribes.

Supreme Court- In the early-1800s the US Supreme Court, under Justice John Marshall ruled on three cases, which ostensibly defined the United States and AI/AN relationship. These cases, commonly referred to as the Marshall Trilogy, set the stage for Congressional action and other federal government actions. The Marshall Trilogy Supreme Court cases consist of the cases:

1. (Johnson v. McIntosh, 1823): This case considered the question of who had the right to sell and acquire Indian lands. The Supreme Court in finding for the defendant McIntosh used the "Doctrine of Discovery". The doctrine gives legal title to the United States as "discoverers," of lands occupied by Indians. In his majority opinion, Justice Marshall stated regarding Indians, "…their power to

dispose of the soil, at their own will, to whomever they pleased, was denied by the original fundamental principle, that discovery gave exclusive title to those who made it" (21). This ultimately meant that Indian people could occupy lands, but they did not have the right to sell those lands to anyone but the federal government. This ruling established, "Indian Title."

2. (Cherokee Nation v. Georgia, 1831): This case considered the question of whether the state of Georgia could impose state laws on the Cherokee people. The court ruled that Georgia did not have the right to impose law over tribes. On one hand, this was a benefit to tribes across the country. On the other, the rule also stated Tribes were not foreign nations but were instead, "domestic dependent nations." The Tribes were also referred to as," wards" of the United States and in a "state of pupilage." This rule established the initial Federal-Tribal Trust relationship.

3. (Worcester v. Georgia, 1832): This case further considered statesf whether the state of Georgia could impose state laws on the Cherokee non-Indians living on Cherokee lands to purchase permits to live on Indian land. The court's ruling stated that Georgia did not have powers over the Cherokee; therefore it could not enforce the permit policy. The court went further in protecting tribes from infringement by the states. Justice Marshall stated, "They, Georgia, are in direct hostility with treaties, repeated in a succession of years, which mark out the boundary that separates the Cherokee country from Georgia…" Worchester V. Georgia further defined Tribes as separate nations with the authority to manage their own affairs. This should have led to legislation that allowed Tribes to have direct relations with the Federal government. However, much of the health care

legislation passed in the last 50 years require the Tribes to receive funding, services and administration under State government.

All three of these cases set the tone for much of the federal government interactions with the Tribes. These cases had implications in the area of land ownership, federal jurisdiction, and the overall trust relationship.

Furthermore, there are many laws enacted by Congress that have impact on the delivery of health care services for AI/AN. The following Acts had the largest impact on the creation of an AI/AN health care system.

1. Snyder Act (25 U.S.C. § 13) 1921: This was the first Act to specifically fund physicians and provide other services nationally to all Federally Recognized tribes. Even though Congress had allocated funding and had provided health services for specific tribes and situations in the past, The Act provided," explicit legislative authorization for federal health programs for Indians by mandating the expenditure of funds for "the relief of distress and conservation of health … [and] for the employment of … physicians … for Indian tribes." It is important to note that the services were authorized by Congress to be delivered by the Bureau of Indian Affairs under the direction of the Secretary of the Interior.
2. Indian Self Determination and Education Assistance Act (ISDEA) (Public Law 93-638, as amended) 1975: This Act was specifically directed at the Secretary of the Department of Interior and the Secretary of the Department of Health and Human Services. This Act contained many provisions directly related to Indian education however it also provided Tribes the option of assuming from the IHS the administration and operation of health services and programs in their

communities. The overall goal of the Act was to, "provide for the full participation of Indian tribes in programs and services conducted by the Federal Government for Indians…" The participation included the development of human resources, education programs and other activities that supported tribal control.

3. Indian Health Care Improvement Act (IHCIA) (Public Law 94-437, as amended) 1976: Although this Act did not create the IHS, it provided a comprehensive framework for operation of Indian health services and facilities programs. The Act was created, "To implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs, and for other purposes." These numerous authorities and amendments were created to enhance existing law, which then allowed the IHS and Tribes to create better systems of care. For example, the IHS was officially moved to the Department of Health and Human Services. And the IHCIA amended the Social Security Act to authorize the IHS and Tribes contracting under ISDEA eligible to collect Medicaid and Medicare reimbursements as well as providing 100% federal funding to states providing services to Indian Medicaid beneficiaries at IHS and tribal operated facilities.
4. Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) 2010: On March 23rd 2010, President Obama signed into law new health insurance reform legislation. According to the Indian Health Service, "This new law will impact how Native Americans access health care services and also creates new opportunities for advancements in the Indian health system." In addition to the

many new programs created and renewed existing program, the Affordable Care Act (ACA), contains additional provisions specific to AI/AN." The ACA also included a permanent reauthorization of the IHCIA. Section 10221of the ACA consists of 276 pages, 8 Titles and726 Sections of new authorities for the IHS, Tribes, Tribal Organizations and Urban Indian programs.

Overall, the ACA will provide much needed authorities and access to resources for the Indian Health Care System. However, many of the new authorities and accompanying funds are provided at the discretion of the States. The Health Insurance Marketplace and Medicaid are two programs important to the Indian Health Care system. The ACA allowed States to address the requirement of providing low or no cost health insurance to its citizens in three ways. The States could operate its own Exchange, a joint Exchange with the federal government or a completely federally operated Exchange. Be Well New Mexico is a state operated marketplace. It is primarily a web based marketplace, "where New Mexicans can come to shop. Compare and buy health insurance." The Exchange was created by state law in 2013 and is governed by a thirteen-member board. In addition to the web portal the ACA requires states to provide Navigators to assist in enrollment with the Marketplace. New Mexico law also required an entity, Native American Professional Parent Resources, to be contracted specifically for Native American outreach and enrollment.

Centennial Care is the name of the New Mexico Medicaid Program. It is administered by the New Mexico Human Services Department. An important provision of the ACA is Medicaid Expansion. The ACA expanded the income eligibility requirements for the program. However, the ACA did not require the states to adopt the

expanded eligibility requirements. Fortunately, New Mexico opted to adopt Medicaid expansion.

Centennial Care and Be Well New Mexico serve different populations according to income guidelines. However, the two programs work together to provide seamless coverage between the two programs. This allows virtually every New Mexican up to the 400% federal poverty level access to low or no cost health insurance. This includes AI/AN who utilize IHS or tribal facilities, state facilities, private facilities or a combination of the three. This is a positive step to accessing services available in New Mexico.

Health care delivery system(s) and services in New Mexico

AI/AN populations make up an estimated 9.4% of 2.01 million New Mexicans according to the 2010 US Census data. The AI/AN population in New Mexico is a blend of the 19 Pueblos, two Apache Tribes (Mescalero and Jicarilla) and the Navajo Nation who all have land in New Mexico. In addition there is a diverse mixture of AI/AN with tribal affiliations outside of New Mexico. In Bernalillo County, for example, there are more than 400 tribal affiliations (Blue Print for Health).

Figure 1. Tribal Communities in New Mexico
(Source: http://www.ihs.gov/albuquerque/newsunrise)

Snapshot of the Indian Health Services System in the U.S.

The IHS provides a comprehensive health service delivery system for approximately 2.2 million American Indians and Alaska Natives. The IHS clinical staff consists of approximately 2,480 nurses, 750 physicians, 670 engineers/sanitarians, 700 pharmacists, and 300 dentists. Facilities are a mixture of hospitals and clinics and are operated by both IHS and Tribes.

TABLE 1. IHS and Tribally Operated Facilities (IHS Fact Sheet)

	Hospitals	Health Centers	Alaska Village Clinics	Health Stations
His	28	62	N/A	25
TRIBAL	18	282	150	80

The Albuquerque Area Indian Health Service (AAIHS) provides oversight and delivery of a combination of direct health care services, tribal contracts and urban Indian

programs. The AAIHS provides direct health care services to members of 27 federally recognized tribes in New Mexico, Colorado, Texas & Utah.

TABLE 2. Albuquerque Area Indian Health Service Communities

PUEBLOS			
• Acoma • Cochiti • Isleta • Jemez • Laguna	• Nambe • Picuris • Pojoaque • Sandia • San Felipe	• San Ildefonso • San Juan • Santa Ana • Santa Clara • Santo Domingo	• Taos • Tesque • Ysleta Del Sur • Zia • Zuni
NATIONS			
• Alamo Navajo • To'Hajillee • Ramah Navajo			
TRIBES			
• Jicarilla Apache • Mescalero Apache	• Ute Tribe • Ute Mountain • Southern Ute		

Health care services are administered through a decentralized health care system of nine Service Units, 24 health care facilities & one Residential Treatment Center. The AAIHS also works with 48 Tribal contracts and four Tribal health care facilities with a total funding level of $40 million. The two Urban programs are located in Albuquerque, NM and Denver, CO and have a combined Title V funding level of $1.8million and Grant funding totals $675,000. What has been provided are some facts of the Indian Health Services system in the U.S., however, what is most critical to discuss is an analysis of the IHS system that is provided in the next section.

Indian Health Service Challenges and Opportunities

Ever since the Federal government began providing health services to AI/AN it has always been an uphill battle. As documented in the seminal work by Brett Lee Shelton, Legal and Historical Roots of Healthcare for American Indians and Alaska Natives in the United States, " the legal and historical background in which the Indian health care system exists is the result of an ever-changing political landscape." The U.S. Government has a trust responsibility based on treaty obligations and federal statues to provide care to members of federally recognized tribes. (Shelton, 2004) This is done primarily through Congressional appropriations. The IHS is not an entitlement program and can provide services only to the extent permitted by its annual appropriations from Congress. (Cunningham, 1993, 225).

Although funding for services is the primary challenge for the Indian Health Service, there are several cross cutting, funding related and non-funding related, issues for the Indian health care system. There is an immediate need for facilities repair and new facilities, health care professional shortage and cultural competency for existing staff.

Funding Issues

As described above the IHS operates 12 Area Offices that operate with a complex mixture of Indian Health Service Direct service facilities, Tribally operated centers and Urban clinics (I/T/Us). The IHS Headquarters are based in Rockville, MD that houses the Director and the Office of Direct Service and Contracting Tribes and the Office of Self Governance. Although the offices operate very differently they are all bound together by Congressional appropriations. The Indian Health Service budget process is a constant struggle for even the most astute and informed Tribes. Every year, Tribes across the country must juggle three years of budget information. Tribes must work with a current

year budget that has been appropriated, the next year's congressional budget bill and then a two-year advance budget that is developed by the IHS to be included in the Presidents budget. For example, in 2015, the tribes are operating on the FY 2015 appropriations for the period of October 1, 2014 through September 30, 2015. The IHS is responsible for submitting its budget justification as part of the 2016 Presidents budget by February 2015. And the tribes have been engaged with the IHS over the 2017 budget since October 2014 and culminated the process with a national meeting in Washington D.C. on February 10-11, 2015.

Most recently, in the Albuquerque Area the IHS met with tribes on October 20, 2014 to kick off the 2017 Budget Formulation process (Indian Health Service, 2014). The tribes then met within their service units to discuss their funding priorities and to complete a budget workbook. These workbooks were then submitted to the Area office and were combined into an area wide workbook. On December 15, 2014, the IHS met with the Area tribes to discuss the results of the process and to consult on the submission to the National Workgroup. The workbook includes several different components. They include:

- Budget worksheet-Identify and rank the Top 5 budget increases by line items using three levels of funding. 17% increase over current budget, 5% increase over current budget and 5% decrease under current budget.
- Budget Narrative/Justification-describing the budget priorities being recommended at each level.
- Discussion topics-Also referred to as hot topics for your area. E.g. Sequestration, Continuing Resolution, Shutdown, Rescission.

Many Tribes feel that the Budget Formulation Process is an exercise in futility and does not adequately portray the severe underfunding. Rather than give up on the process they continue to engage with the IHS and Congress to adequately gage the true need for tribes. This has led to the development of the Federal Disparities Index (FDI) Workgroup. The FDI measures the proportion of funding provided to the Indian health system, relative to its actual need, by comparing healthcare costs for IHS beneficiaries in relation to beneficiaries of the Federal Employee Health Benefits (FEHB) plan. According to the report, The FY 2016 Indian Health Services Budget by the Northwest Portland Area Indian Health Board, the application of the FDI results in an annual budgetary need of $9-10 billion (NPAIHB, 2015). Compared to the 2015 enacted budget of $4.7 billion this demonstrates that the IHS is funded at approximately 50% of the true level of need. This cost does not include the cost of providing additional facilities and staff if full funding for services were provided. The FDI workgroup indicates that an additional $9-10 billion would be necessary for facilities. This $19 to $20 billion is sometimes stated as the Tribal needs-based budget (NPAIHB, 2015).

Facilities

The Albuquerque Area has a number of facilities that are in need of replacement, expansion or repair. However, only the Alamo Navajo clinic and the Albuquerque Ambulatory care clinic are the only two facilities on the IHS Priority list. These facilities have been on the list since 2009. The challenge for facilities funding is not limited to new facilities. Although as indicated earlier, there is a need for an additional $9-10 billion for new facilities, there is a tremendous backlog of maintenance and repairs needed for existing facilities. According to the IHS, facilities have a total space of 1.6 million square

meters. Many of these facilities are located in remote and isolated areas. These spaces are crowded and the average age of the facilities are 35 years. The IHS Maintenance and Improvement budget has not received adequate increases to effectively maintain the physical condition of IHS and tribally owned facilities which has resulted in a backlog of $465 million in essential maintenance and repairs (NPAIHB, 2015).

In the most remote and isolated areas, the IHS is also responsible for providing staff living quarters. Unfortunately, these facilities are also subject to chronic underfunding and often do not meet the needs of essential personnel. This further exacerbates the problems with recruiting health care professionals to the IHS and tribal clinics.

Health Professionals shortage

The United States has always had a problem with providing enough health care professionals to serve the AI/AN population. In 1880, 77 physicians were serving the entire American Indian population in the United States and its territories. (Cohen 1982). A recurring theme with the challenges for the IHS is the lack of funding. This is coupled with the rural and isolated locations, which make housing and spousal job opportunities difficult to find. In 2011, the IHS sought the assistance of an outside consulting firm to assess the health professional shortage and to assist with improving recruitment and retention. There were many key findings and they were consistent with the issues that patients and Tribal Leaders have been expressing over the years. There are not enough professionals, physicians, nurse practitioners, physician assistants, dentists, nurses and pharmacists to cover the needs of the facilities. The professionals that are recruited do not stay for an extended period of time. And for the few that have stayed with the IHS, they

are getting closer and closer to retirement. Here is a brief list of the key findings (Merritt Hawkins, 2011):

- 45% of Indian health program administrators indicated their facilities have an urgent need for primary care doctors
- The average vacancy rate for physicians reported by Indian health program administrators was 22%, considerably higher than the vacancy rates experienced by facilities in the private sector.
- Indian health program facility administrators indicated that 25% of physicians on their staffs are 61 years old or older
- Indian health service administrators report losing more clinicians in the last year than they were able to replace.

The last bullet point is an issue that is discussed often by tribal leadership and by community members in the clinic. Many are concerned that they never know who their physician is. And every time they come to the clinic there is someone new. The concern is more than just having a provider who knows you; it is also about having a provider who understands your community, culture and beliefs.

American Indian/ Alaska Native Professionals

In the best case, AI/AN health care professionals would be the best solution for these concerns. Even if a professional is not from the specific tribe they were serving the fact that they have the same racial and ethnic background would increase the trust and respect for that professional. Unfortunately, there are very few AI/AN entering the health care professional field. In 2004, there were 2,457 AI/AN physicians, which was .3% of the

total number of physicians in the US. In a recent report for Indian Country Today, it was reported that in 2011, only 157 AI/AN enrolled as first year medical students. In the same report, Dr. Donna Galbreath, offers that not many AI/AN think about getting into medicine because there are not enough role models. The Dr. also offers that it is not an easy road. The practices are hard and are sometimes contradictory to the students' beliefs.

In my experience, the University of New Mexico and the Indian Health Service have a number of programs geared towards recruiting AI/AN students. They offer internships as well as summer programs to high school students ranging from sophomores to seniors. There is a concerted effort to have the students focus on the science and the chemistry courses in their high schools. In addition, high schools have been asked to focus their curriculum on science, technology, engineering and math. The intention is that the students will be better prepared to enter these fields when they get to college. It may be several years to see if the increased outreach and attention to these fields will lead to more health care professionals. In the meanwhile, there is still a need to ensure that the existing pool of providers are trained and are knowledgeable in cultural and ethnic diversity.

Cultural issues

The challenge of finding a health care professional that is committed to stay long term is almost an impossible challenge for the Indian Health Service and Tribes. In the best-case scenario, the Tribes would have their own people working as physicians, nurses and dentists. There are many efforts underway to meet this goal, however, most physicians in the IHS are non-Indian. This is of great concern for AI/AN patients all across the IHS system. In general, " many AI/AN believe that their health care providers need to know

about the history and culture of their tribe before they can accept them and respect them as individuals." (Dixon and Iron, 2006). Today, many of the IHS and Tribal clinics do provide a certain amount of cultural competency training for their particular facility. However, as mentioned earlier, many of the professionals do not stay with the community and the clinics constantly have to retrain a new employee.

We cannot control budget issues for services, facilities and professional salaries, however we can work with the staff and providers we do have in our communities and continue to partner with them to provide the best care for our community.

Interventions Albuquerque Area Indian Health Board (AAIHB)

At the same time as there are many and troubling challenges to the Indian Health Services system, there are also some interesting programs that have emerged that have the capacity to address some of the gaps created by the IHS and can therefore serve perhaps as interventions. The Albuquerque Area Indian Health Board (AAIHB) is one such critical program located in the state of New Mexico.

The AAIHB is a consortium of six tribes within the IHS Albuquerque Area. To'Hajiilee Band of Navajos; Jicarilla Apache Nation; Mescalero Apache Tribe; Ramah Band of Navajos; Southern Ute Indian Tribe; Ute Mountain Ute Tribe in New Mexico and southern Colorado. The AAIHB runs two specialty programs and also manages two programs under their non-profit, tribal organization umbrella.

The AAIHB provides an Audiology Program that promotes the hearing health of American Indians through early identification of hearing loss and appropriate intervention. Its HIV/AIDS Prevention Program provides prevention education and advocacy outreach to tribal communities in New Mexico and southern Colorado.

The AAIHB also manages a Native American Research Center for Health grant and houses the Southwest Tribal Epidemiology Center. These two research centers are unique to the AAIHB as they are managed and advised by their own specific advisory boards. The boards and the participating Tribes expand beyond the six members of the AAIHB. The AAIHB is one of a network of area health boards who provide services and also provide a mechanism for tribes to discuss health policy.The AAIHB works with its member tribes to keep them informed about the latest issues in Indian health care and to promote input in to the issues. AAIHB works in collaboration with the Pueblos and the AAIHS to provide input on issues like the IHS budget, Special Diabetes Program for Indians, Health and Human Services budget. Their members also participate on regional and national boards on behalf of the Albuquerque area.

Albuquerque Area Southwest Tribal Epidemiology Center

AASTEC is one of 12 Tribal Epidemiology Centers serving American Indians and Alaska Natives throughout the country. The AASTEC is the only tribally run health organization in the IHS Albuquerque Area that is advised by all 27 tribal communities. Its services and activities range from conducting Tribal Community Health Assessments, Database Development, Program Evaluation, Tribal Colorectal Health Program and Student Development. The AASTEC is also part of a national network of IHS area Epi centers. Together these centers are playing an important role in collecting and storing health data for AI/AN. As the tribes and tribal organizations become more involved with the delivery of their own health care services, they have realized the importance of data and data collection. Tribes are discovering that good data about their populations is not readily available and want to begin to collect better data. The Epi centers provide an

extremely important function in the data collection process. The Epi centers work with the tribes to ensure that the research and collection process in done in a culturally appropriate and beneficial manner. It is fortunate that the AAIHB houses the AASTEC and also is a partner in the Southwest Tribal Native American Research Center.

Southwest Tribal Native American Research Center (NARCH)

The NARCH program partners with the University of New Mexico Health Science Center to increase the participation of AI/AN and Tribes in health research. According to its website, the Southwest Tribal NARCH has these specific objectives: 1) to develop a cadre of American Indian/Alaska Native scientists and health professionals engaged in biomedical, clinical behavioral and health services research who will be competitive in securing NIH funding; 2) to increase the capacity of both research-intensive institutions and AI/AN organizations to work in partnership to reduce distrust by AI/AN communities and people toward research; and 3) to encourage competitive research linked to the health priorities of the AAIHB communities and to reducing health disparities. The NARCH programs offers a great opportunity for tribal communities to begin the process of collecting and analyzing their own data. By recruiting tribes, students and community members the NARCH partners with the local university to develop the tools necessary to conduct good community research. The NARCH and AASTEC have a combined mission to assist tribal communities to understand their health issues and to work towards solutions to address these issues. This can come on the form of grant applications or the development of new programs driven by the community.

New Mexico Department of Health

NMDOH is the lead entity in New Mexico providing core public health functions and essential services. The NMDOH main campus is located in Santa Fe and the agency employs approximately 3,250 people in more than 60 locations around the state and administers an annual budget in excess of $540 million. The NMDOH is divided into 7 divisions Public Health, Epidemiology and Response, Scientific Laboratory, Developmental Disabilities Support, Health Improvement, Facilities Management and Administrative Services. The NM DOH is the lead for all state health services. However, it works closely with the Department of Health and Human Services, Aging and Long Term Care Services and Children, Youth and Families Department.

University of New Mexico Hospital

The hospital operates New Mexico's only Level I Trauma Center, treating nearly 90,000 emergency patients and more than 450,000 outpatients annually. The Barbara & Bill Richardson Pavilion, which opened in the spring of 2007, added nearly 500,000 square feet of emergency and clinical space uniquely configured for medical efficiency and patient safety, and fitted with cutting-edge imaging, laboratory and surgical technology. The UNM Hospital system includes Carrie Tingley Hospital, UNM Children's Psychiatric Center and UNM Psychiatric Center. In addition to the main hospital, the UNM system operates 43 off-site clinics throughout the state, including the UNM Cancer Center South in Las Cruces, NM. The hospital further expands into New Mexico's rural communities through a nationally recognized Telemedicine/Telehealth network, linking patients and physicians throughout the state to the most up-to-date research and medical information available. The UNM Hospital system serves all New Mexicans' needs for routine medical procedures, chronic disease management and catastrophic health events. From central

New Mexico to the four corners of the state, UNM Hospitals and all of its clinical components strive to identify and solve the most important questions of human health in our communities through education, scholarship and service. The University Hospital also maintains a lease agreement with the Pueblo Indians in New Mexico. The Agreement provides access to 100 "virtual" beds to Indians in New Mexico. The access is provided through the department of Native American Health Services. Patients can access their services and coordinate care with IHS and tribal facilities through this office.

Private Health Care Systems

Private hospitals are important to the AI/AN healthcare system, due to the lack of specialty care that the IHS can provide. A significant portion of the IHS budget goes toward the purchase of services outside of the system. Purchased and Referred Care Program, formerly known as Contract Health Services, provides hospital and outpatient care, as well as physician, laboratory, dental, radiology, pharmacy, and transportation services.

In the Albuquerque Area, the Santa Fe Service Unit is the only hospital facility. All other IHS and Tribally operated facilities are ambulatory care centers. This places a tremendous burden on the limited financial resources available. This has created an overly complicated and restrictive system that is equivalent to rationed care. The limited resources has caused the IHS to create a priority care system. Towards the end of a budget period, typically after June, only the most severe medical cases are approved for referral to private providers. Priority one is the equivalent to the immediate loss of life or limb. For many areas, the IHS can only pay for Priority one cases. This means that any

preventive care or less urgent medical issues go untreated. In many cases, the medical issue eventually does turn into a medical issue that meets the need of Priority one. Since the ACA has passed, and expanded Medicaid program and the Health Insurance Exchange plans have helped to ease the burden on the Purchased and Referred Care Program.

Although there appears to be an increase in the access to health care services, AI/AN continue to lead the general population in health disparities. The next section will provide an overview of those disparities.

Health Disparities

The Indian health care delivery system in New Mexico is complicated. There are multiple entities and systems through which American Indians access their care. American Indians in New Mexico have access to care provided by the Indian Health Service, Tribally run facilities, private hospitals and clinics and public facilities managed by the State. Certain individuals also are able to access the Veteran Administration (VA) facilities for their care. This makes the collection and reporting of health data for American Indians extremely challenging and frustrating. Individuals, organizations and tribes seeking to understand the health disparities of American Indians in New Mexico often have to seek multiple sources of data to get a complete picture of a specific tribe.

In 2003, the U.S. Commission on Civil Rights issued "A Quiet Crises: Federal Funding and Unmet Needs in Indian Country." Among the Commission report's findings, Native Americans are more than four times more likely to die from diabetes and more

than seven times more likely to die from alcoholism or tuberculosis in comparison to the rest of the United States, including white and minority populations.

Additional research shows that the health of New Mexico's AIs is relatively poor when compared to non-Hispanic Whites (NHWs) in the states. Diabetes is the fourth leading cause of death for New Mexico AIs, and AI infant mortality rates are 20% higher than all races in the US. AIs with cancer are diagnosed at later stages, and cause-specific survival for all cancers is poorer than in their NHW counterparts. AIs are 1.5 times more likely to die from drug related deaths, and seven times more likely to die from alcohol-related causes than the general U.S. population. Most tragically, AI suicide rates are 1.7 times higher than in the general population, with the bulk of those suicides occurring in young adults.. More recently the NMDOH has begun to issue an annual report tracking the health disparities of AI/AN.

The Department of Health uses the New Mexico Indicator-Based Information System (NM-IBIS) to produce certain reports at a state level. One report, "American Indian Health Equity: A report on Health Disparities in New Mexico ", was released in October 2013. This section will discuss the information contained in the report and it will provide some insight on its advantages and limitations.

The New Mexico Department of Health (NMDOH) began to report ethnic and racial disparities in 2006. NMDOH then began issuing a "Report Card" specifically on American Indian health disparities. According to the Forward of the report, the purpose of the report is to, "identify important racial and ethnic health disparities in New Mexico so that diverse organizations and agencies, including the Department of Health, can design and implement evidence-based interventions to improve health equity." The

report card provides information in five major categories: 1) Mother and Child Health 2) Chronic Disease 3) Infectious Disease 4) Injury and Violence 5) Risk Behaviors. Within each category, the following Race/Ethnic group: American Indian, Hispanic, White, Black /African American, and Asian /Pacific Islander, are compared for specific disparities. The data is collected from various sources. The NMDOH Office of Policy and Accountability and the New Mexico Office of Health Equity compiled the data for the report.

As indicated earlier the indicators are expressed as disparities between various race/ethnic groups. The report card expresses these levels in various ways. Disparity Level, Rates, and Disparity Ratio. The Disparity Level is considered the measure of how well society is doing in address the particular nee of the specific group. It indicates how much higher a group's rate is from the reference group or group with the lowest rate as well as how critical an intervention is needed to eliminate the disparity. The Rates are used to allow direct comparisons between populations of differing sizes. Rates are derived by taking the number of events occurring during a given time period and dividing by the population at risk and multiplying by a constant, so that the rate is expressed as a whole number. The Disparity Ratio is calculated by dividing the rate for each population by the reference group population rate. This is a way to compare the racial/ethnic groups to one another to look at the severity of health problems. The report card provides some useful although bleak information regarding American Indian Health Disparities. Although some of the outcomes are concerning and do not all together make sense. The following is a classic example that has occurred over several years of the study.

A critical consideration: Adults with Diabetes Not Receiving All Recommended Diabetes Prevention Services and Diabetes Deaths

The American Indian Health Equity Report Card from 2013, a report on Health Disparities in New Mexico, indicates that American Indians have the best rates of all racial groups for receiving all recommended Diabetes prevention services. For this particular disparity American Indians are the Reference Group. At the same time, American Indians have the highest disparity in deaths due to Diabetes. The Rate of deaths was 72.1 compared to 17.9 for Whites (reference group). The Disparity Ratio was 4 to 1 compared to Whites. The Level of disparity is Major. However, the report does not provide any interpretation of the conflicting data. The questions that may need to be posed are: 1) What is not happening between receiving services and the point of death? 2) What is meant by "all recommended Diabetes prevention services"? Overall, the report card is a good snapshot of the data that the NMDOH has access to. It is not clear if information collected by the Indian Health Service and Tribally operated facilities are included in the report. The report does not provide any mention of those facility types. Additional research and review of the NM-IBIS datasets are necessary. It is also important for the Tribes in New Mexico to begin to question the data that is being reported and to ensure that conflicting issues like the one identified are explained and researched more thoroughly.

It is clear with these findings that more needs to be done to address the alarming health disparities. Many tribal leaders feel that they need more control and input into the systems that provide health services to their people. There are several mechanisms that seek to address this issue.

American Indian and Tribal Health Policy

We find that it is often a challenge for leadership and the tribal communities to understand the health care system. A large part of this issue is the overly complex system in which AI/AN populations are required to navigate for their health care. At the same time, tribal governments and tribal organizations seeking to provide services to their communities are faced with federal and state laws and regulations that conflict with the systems they wish to implement. As a result, many laws and regulations that are implemented today have additional requirements to consult with Tribal Governments. At the highest levels of the federal government, there have been several Executive Orders issued. Executive Order 13084 of May 14, 1998, issued by President Bill Clinton required that the federal agencies enter into "Consultation and Coordination with Indian Tribal Governments". Executive Order 13175 of November 6, 2000, also issued by Clinton restated the requirement for the cabinet level agencies to consult and coordinate with Indian Tribal Governments. These two Executive Orders were followed up my President Obama with a "Memorandum for the Heads of Executive Departments and Agencies". The memorandum required that all Executive Departments and Agencies that work with Tribal Governments are required to develop formal Tribal Consultation Policies.

The Department of Health and Human Services has adhered to the Presidential Memorandum and has taken the requirement one step further. In 2010, Secretary Kathleen Sibelius created the first ever-cabinet level tribal advisory committee. The Secretary's Tribal Advisory Committee (STAC) signals a new level of attention to Government-to-Government relationship between HHS and Indian Tribal Governments.

According to the committee Charter, "In 2010, the HHS proposed a set of initial activities to step up the Department's efforts to improve services, outreach, and consultation efforts. The STAC is one key piece of this plan and will bring the work of HHS's reform and improvement efforts to a new level."

The STAC's primary purpose is to seek consensus, exchange views, share information, provide advice and/or recommendations; or facilitate any other interaction related to intergovernmental responsibilities or administration of HHS programs, including those that arise explicitly or implicitly under statute, regulation or Executive Order. This purpose will be accomplished through forums, meetings and conversations between Federal officials and elected Tribal leaders in their official capacity (or their designated employees or national associations with authority to act on their behalf).

New Mexico Department of Health (NMDOH)

The NMDOH has a long history of working and collaborating with American Indian nations, pueblos, tribes in New Mexico, as well as Off-Reservation Groups. This work is carried out through the Office of the Tribal Liaison. The mission statement of the Office of the Tribal Liaison is to support better health and wellness outcomes among sovereign nations in New Mexico. According to the NMDOH website the objective of the Office of the Tribal Liaison is to," strengthen tribal health and public health systems through on-going collaboration with American Indian tribes, pueblos, and nations that is rooted in tribal leadership guidance in creation, cultivation, and expansion of services and resources which respect the tenets of sovereignty and self-determination held by indigenous nations in the state."

This effort is guided by the language provided in the Senate Bill 196 (State Tribal

Collaboration Act). In 2009, a new commitment was established that required the State to work with the American Indian tribes, pueblos, and nations of New Mexico on a government-to-government basis. An Interagency Group comprised of representatives from NMDOH; Aging and Long Term Services Department; Children, Youth, and Families Department; Department of Veterans' Services; Human Services Department; Indian Affairs Department; Office of African American Affairs, and several tribes met to develop an overarching policy that:

- Promotes effective collaboration and communication between the agency and Tribes
- Promotes positive government-to-government relations between the State and Tribes.
- Promotes cultural competence in providing effective services to American Indians/Alaska Natives.
- Establishes a method for notifying agency employees of the provisions of the STCA and the policy that the agency adopts.
- Use of the processes and protocol is an established policy at NMDOH.

Conclusion

The AI/AN health care system has a long and storied past. Even though the Supreme Court cases under Chief Justice John Marshall were decided over 200 years ago, they have left a permanent mark on the interaction between Tribes and the U.S. Government. The courts decision to treat Tribes as, "wards of the federal government" will forever bind the tribal governments to a subservient role. As tribes have become more self sufficient and autonomous, this restriction has become more problematic.

Tribes who manage their own health care systems and for all purposes operate without the assistance of the federal government are still required to seek approval for activities that any other "sovereign" nation would not be required to do. And the establishment of Indian land title and land held in trust further inhibits a tribe's ability to conduct business like any other business entity.

Tribal communities have a strong desire to have health care facilities that not only meet their needs for Western medicine but also the incorporation of their tradition and culture for their patients. The management and operation of these facilities is one avenue that tribes have undertaken. While other tribes have decided to utilize the Indian Health Service to provide those services. In either system, there is a tension between Western medicine and a Pueblo way of doing things. There is always a need for health care providers to be more sensitive and familiar with the community in which they work. The challenge in many of these communities is finding a health care provider who is already familiar with the community. The best case would be for the provider to be from the community or at least to be AI/AN. In the absence of a AI/AN provider, tribes must develop strategies to increase cultural competence. There are a number of ways in which the provider could become familiar with the community.

Medical schools can add additional course work that includes education about history and culture of American Indians on a regional basis. Communities can also make it their policy to embrace new providers and teach them about their culture once they are in the community. These examples may be able to be effective in the short term but there also has to be something more. Strategies and models need to be developed that go beyond cultural competency and sensitivity.

Tribes must be able to begin to reframe how medicine is delivered in our clinics and how we think about the clinics themselves. Too often we think of the clinic in only the Western model of medicine. We do not stop to consider how it would look and feel if we run our clinic to be more Pueblo-centric. How do we incorporate more discussions about our religion and our ways of healing into a clinic setting? And how do we recognize the strengths we have as Pueblo people; hunting, planting, singing and dancing and prayer as models for healthy living. The ultimate goal is to achieve a blend of traditional ways of living and the science of modern medicine.

One idea is to look for models of health care delivery that are similar to the ways we think as Pueblo people. Many times we describe ourselves as being more a part of a community than as an individual. As individuals our family and our community surround us. In addition to that our tribal leadership is responsible for looking after the community as his children. The leadership is intimately involved with the families and individuals in the community through the tribes programs and services, school systems, courts and law enforcement. This holistic view of the community and the families and individuals gives a unique perspective to the leader. In my experience I feel it is synonymous to looking at issues through the lens of social determinates of health. This model looks at an individual's health by considering all the social factor s that surround him. The individual's employment, education, marital status, housing, alcohol/ drug use and other social factors are all considered to have an effect on her health. The Indian Health Service has begun to utilize a health care delivery model that is similar in its positioning of the individual. The patient medical home model designates a clinic as a patient's medical home. In this home, the patient has a team of providers who provide her with

comprehensive services. This is similar to how a family or tribal community puts its sick or ailing members at the center and provides care to the individual. It is not clear to me if the IHS model is deliberate in its selection and use of this particular model. Meaning, did the IHS choose this model because it is similar to the way tribal communities treat their members? IF it is, the community should also contribute its knowledge and its strengths to this system of care.

There are many ways in which tribal communities can begin to take ownership over the way health services are delivered in its community. This can be accomplished regardless if the Pueblo runs its own facility or if the IHS manages on behalf of a community. This can also be accomplished outside the clinical setting.

An example of this effort is the *Indian Pueblo Cultural Center Teaching Garden.*

Mr. Gilbert Lucero from Zia Pueblo runs the *community garden* at the Indian Pueblo Cultural Center. Mr. Lucero wanted to do something positive to give back and to get back to Pueblo core values to take action in determining our own health and future as Pueblo people. The community garden is not just about planting, but it is also about bringing back old implements like the planting stick and old ways such as not using fertilizer. In order to make sure this was truly a project that was going to be based in our core values Mr. Lucero used some of his own corn seeds that were provided to him during a traditional dance in the Pueblo. Many children have gone through the Indian Pueblo Cultural Center community garden to learn about the Pueblo lifestyle, what was planted in the past, and how we do our irrigation systems today. Students from the University of New Mexico also have helped.

The program has also been adapted by using mobile planting units with children that live in Albuquerque who don't have access to reservation lands or a place to plant. There was a need to find a way to move the plants for children that live in apartment complexes. The mobile planting station can be moved inside at night so the plants won't be disturbed and moved back outside during the day to get sunlight. Even though it was an adaptation it still provided an opportunity for Mr. Lucero to share what is important to Pueblo people in terms of planting, nurturing, and taking care of each other. Community members have also been asked to share stories about planting with those that visit the community garden.

Gilbert Lucero, Indian Pueblo Cultural Center Teaching Garden (2011)

Although the Indian Health Service and the Indian health delivery system have enormous challenges in addressing the significant health disparities of AI/AN, there are some positive steps forward. The recent passage of the Affordable Care Act, which includes the permanent reauthorization of the Indian Health Care Act, promises to enable the IHS and Tribes to create a health care system that meets the needs of the 21st century. It also provides much needed alternative resources to health care for individual American Indians and Alaska Natives. As asserted by the IHS Director Dr. Yvette

Roubideaux,"The goal of the health insurance reform legislation, PPACA, is to expand health care coverage to 32 million more Americans." The Act includes expansions to Medicaid and creates a whole new opportunity to access mainstream insurance through the insurance marketplace.

The hope is that this will bring in much needed resources to the existing Indian health care system in New Mexico. However, it will be up to the Federal and State governments, Indian Health Service, Tribal health centers and private providers to ensure that an adequate system is in place to recruit and enroll eligible American Indian patients. Each stakeholder must also be willing to work together to reinvest the resources into creating a seamless system of care that addresses the most pressing health disparities faced by Indian people in New Mexico.

The Medicaid expansion and insurance exchange are a significant yet small part of the overall Affordable Care Act. The Indian Health Care Improvement Act is almost 800 pages of new authorities and programs. Unfortunately, many of these programs are unfunded. There are also many provisions that are being implemented and need "fixes" to the law. Tribes across the country are continually working to address the needs of health care delivery for American Indians and Alaska Natives. Many Tribes are working with national organizations such as the National Indian Health Board and the National Congress of American Indians as well as state and national lawmakers.

As the New Mexico health care system for American Indians evolves and matures, it will be critical for tribes in New Mexico to continue to maintain a strong relationship with the state health and human services departments. Many programs and authorizations from the Affordable Care Act have yet to be implemented will require

close collaboration between these departments and Tribes. It is imperative that all providers and patients work together to create a better system of care for its American Indian population.

SECTION 2: Journal Article
Incorporating Pueblo Core Values into Tribal Government-Operated Programs: The Process of Filtering Federal and State Government Programs to Align with Pueblo Community Governance

Introduction: Foreign impositions and the persistence of Pueblo governance in Pueblo Country

Since the Spanish Conquistadores first came to Pueblo Country in what is now the U.S. state of New Mexico, foreign governments have imposed their systems of rule on Pueblo People. Today there are 19 Pueblo, which occupy mostly the Northern to Middle Rio Grande area of New Mexico. These Pueblos belong to three distinct language groups that are further differentiated to five separate languages and many discrete dialects. The New Mexico Pueblo language groups are: Keres, Tanoan and Zuni which encompass the Keresan, Tewa, Tiwa, Towa and Zuni Languages. The Pueblos share many common traditions and religious customs, yet they also are very different and unique people. Despite both early colonial and contemporary impositions, the Pueblos have maintained a system of government and way of life that blends long-established governance systems, Spanish government, Mexican government and U.S. government practices.

In many ways, Pueblo systems of government are consistently evolving to accommodate new laws and evolving ways of thinking, and our adaptability has allowed us to maintain functional communities and to thrive. However, in a little over 400 years, Pueblo people must still contend with a number of health, social and economic issues. Juxtaposed with external efforts to control and even "civilize" the Native people of New Mexico is the memory rooted in practices that pre-date outside influences that Pueblo

people still exercise today, Pueblo people have lived under their own system of governance that has allowed them to survive for thousands of years. If Pueblo communities are to survive, we must rely on the strengths of our traditions, values and principles in this paper, I will delineate those areas based on my observations of the current system of government of a Southern Pueblo. I will also discuss issues and challenges that tribal government face today. Additionally, the works of several indigenous scholars and institutions are used here in order to argue how the use of indigenous and, more specifically, Pueblo cultural values are valid in modern society. These values are critical and will be exercised in this paper through a series of probing questions that have the potential to contribute to Pueblo tribal government conceptualization and adoption of services and economic development.

My Positionality: My family, my work and my community

I am an enrolled member of the Pueblo of Zia and my mother is from Cochiti Pueblo. My parents were both Bureau of Indian Affairs (BIA) employees and for a brief time participated in the BIA Relocation Program. After a year in California, we came back to New Mexico. The isolation and being away from home was too much for my mother to take. Although they were also both a part of the boarding school experience and were used to being away from home, it was just too far and too difficult to be that far away. We spent several years living in Albuquerque until my dad was called on by Zia Pueblo to serve as Governor. We eventually moved to Zia and we maintained a home there ever since. My years spent in Zia were an interesting mix of BIA politics and deep cultural learning. Dinnertime conversations were filled with the news and politics of the

BIA Southern Pueblos Agency and the BIA school system. On the weekends and occasionally during the week my grandparents visited. Their conversations were significantly different from the dinner conversations. My grandfather was an accomplished storyteller and he moved deftly between traditional stories, his own experiences and things he just made up. His favorite line at the end of his stories was, " Now I have just told you a lie!" My father and I still puzzle over what he meant and why he said that. My grandfather was heavily involved in the activities of the traditional religious societies. So his stories often talked about the reasons why certain activities took place. He never shared the details of the processes, because that is knowledge only for the religious members, but the meaning and significance of those actions. His overarching message to us was that everything was done for the people. The prayers, the hunting, the planting of crops and the dances were to keep Zia people and all the people of the world well. He was the single biggest influence on my decision to be minimally Catholic and to follow the traditional beliefs of our community.

Working for your Tribe.

A year after my grandfather's death I was pulled into service for the Pueblo. On December 29 1999, I entered the chambers of our religious leaders in the same way that my father and grand father had done since they turned 18 years of age. I was provided with a cane and a badge and was appointed as a Governor's Assistant. My primary responsibility was to deliver the Governor's messages to each household as necessary and to function as the police force for the community. During that time, I saw the best and the worst of our community. I participated in the birth of a child at 4 a.m. and I broke up too

many domestic disputes and confiscated way too much alcohol. My outlook on my community was forever changed. I felt the need to help and the need to be involved with the community. The following year I applied for and was selected to be the Assistant Tribal Administrator for the Pueblo.

The Assistant Tribal Administrator (ATA) position was responsible for oversight of all the federal and state grants and contracts that were operated by the Pueblo. This oversight included attending meetings with federal and state officials and seeking additional funding and programs from them. Although the relationships with the federal and state officials were amicable, we often disagreed on how a particular program's goals and objectives should be met. The Pueblo often felt that we knew what was best for our community and that often conflicted with federal or state rules and regulations. A perfect example of this was the design and construction of the Tsiya Day School.

I had the privilege of managing the design and construction of a K-8th grade school when I first came on board with the tribal office. It was the culmination of a life long dream for my father and many iterations of the Zia School Board. A couple years prior to my arrival, the initial design phase of the project had started. The process that was required by the Bureau of Indian Education (BIE) frustrated the Pueblo. The lack of involvement the Pueblo had in the design of the school was the main point of contention. The last school built in the Pueblo was 1924 and the tribal members wanted to ensure that this school was going to reflect the culture and spirit of the community. It soon became evident that the only option was for the tribe to take over the process through an Indian Self Determination contract. Once the process was completed the Pueblo was in a position to incorporate many teaching mechanisms in to the facility. We incorporated the

Zia Pueblo pottery layout into the exterior walls, we used a courtyard/plaza area to teach the directions and colors associated with the directions and two towers that function as a sun dial and signify the mothers of the community. Throughout the process I continued to learn more about the federal government and their dealings with the tribes. Not only did the Pueblo continue to have its challenges with the BIE, the tribe seemed to encounter issues with the IHS, New Mexico Department of Health and other branches of the BIA.

As my network of Tribal leaders and their staff grew we began to be more coordinated in our efforts. A committee for health grew out of the All Indian Pueblo Council. As Chairman of the Pueblo Health Committee, I worked with many other health advocates to assist the Pueblo leadership to stay on top of health issues at the federal and the state levels. In 2005, New Mexico Governor Bill Richardson issued Executive Order 2005-005 which required the States departments to develop tribal consultation policies with the tribes. The PHC, seized the opportunity and by 2007 developed the first Tribal Consultation Policies with the Department of Health, Human Services, Long term Care and Aging and the Children, Youth and Family. The PHC and other tribal entities used these efforts to work productively with the State departments and to begin to create policy and law that were favorable to the Pueblos' way of doing things. At about the same time that I began my career with the Pueblo of Zia, the Leadership Institute was starting the process of deliberately questioning the challenges I was facing as a Pueblo administrator and was hard at work putting the values and the culture of the Pueblos at the center of discussions.

The Leadership Institute, under the direction of Carnell Chosa and Regis Pecos have put together a thought provoking process that challenges participants to think abut their work, their government and their communities though a Core Values Paradigm. The work and the message resonated with me immediately. Regis Pecos challenged participants in his presentation, "100 Years of Federal and State Policy", to consider if the programs and policies that we implement in our communities are contributing to the preservation of our culture or are we taking away from it. And were these programs really helping our tribal way of life or were they carrying out past federal policies of Assimilation or Termination. The LI forever changed my approach to the planning, management and advocacy of programs for Pueblo People. After attending several LI sessions through the invitation of Michele Suina and Joyce Naseyowma-Chalan, I was invited to become a faculty member of the Leadership Institute. Over the years, we developed a presentation on health that combined the strength of Pueblo spirituality, community solutions for addressing disparities and an analysis of the Indian Health care system. It was through this work with my friends and allies at the LI that my voice for the creation of better health care solutions and delivery was strengthened.

Reflecting back on the eight years at Zia and the four years in health policy, I think the most prominent opportunity is the education of our community member of the history of the relationship between Tribes and other governments and to be reminded of the strengths of our own ways of doing things. In my experience, tribal people have begin to put forth an effective means for educating the federal government, state government, private industry and its own people on how to create programs, business, and tribal governance policy that reflect the strengths of the culture and tradition of the community.

A clash of worldviews: Pueblo vs. Western Values and Priorities

The difference in worldview can explain many of the significant conflicts and barriers between Native Americans and Western civilizations. V.F Cordova (2007), the Taos author/philosopher/poet does a remarkable job in fleshing out the differences between Western philosophy and general Native American worldviews, including analysis of a recurring and most important topic— religion. Cordova clearly articulates the differences between worldviews that make humans *a part* of this world and the worldview that humans are *above* this world. Pueblo people feel that they are *equal to* the water, air, animals and plants. Each one has a place and function and one is not more important than the other. Western philosophy places humans at the top of they world. Humans are the rulers of the Earth and have the right to change it as they please.

Dr. Joseph Suina, Cochiti Pueblo, captures the conflicts he faced when first attending school in his article, " And Then I Went to School". Dr. Suina explains, "The new set of values caused me much anxiety and embarrassment." (95) As a Pueblo person the new ways of thinking and changes in concepts caused conflict internally and caused him to question his communities way of doing things. In addressing Giftedness in Pueblo Indian students, Dr. Mary Romero implicates the differences in "fundamental values, cognitive and social development experiences and other aspects of the Keresan Pueblo culture," (Romero, 1994, pp. 36) and priorities derived from the experiences of "white class middle America" (pp. 36) as a determinant for underrepresentation of New Mexico's American Indian learners. These contradictory experiences support the idea that Pueblo values and priorities do not align very well.

These internal conflicts and imposition of Western ideals may help to explain why health care for Native Americans as provided by the United States Government is not effective. Pueblo people and Native Americans in general may have a different notion of health that stands in contrast to a Western approach and conceptualization, which has been superimposed on populations regardless of cultural differences. The Westernized concept of health and its formal delivery, specifically via a healthcare system, is actually a limited concept. As Wallerstein and colleagues (2003, p. 1517) describe in their study of health outcomes in Jemez Pueblo, Although the built environment was not the research focus, we found that issues of housing, land use, and cultural practice were interconnected with community health." Pueblo people feel health is not just about the physical body as perpetuated in Western medicine and the policies of the federal government. It is a more holistic and encapsulates the entire environment around an individual. There are several reasons for this misalignment, many of which may stem from how Native Americans view the world and positionality.

Pueblo value systems and researcher perspectives: Stories, Traditions, Song and Dance

This discussion must begin with a critical researcher reflection of how Pueblo people learn about how they belong in this world and from where these beliefs are derived. Very early on in life, Pueblo children are told stories about who they are through oral tradition, such as storytelling and participation in cultural activities, which convey a s sense of belonging to family, community, and place (Romero, 1994; Suina and Smolkin 1995). In my own experience I was fortunate to have a grandfather who was very active in the traditional roles and activities of the community. Almost every weekend, my

grandparents visited our home and talked about activities that had passed and the ones coming up next. It always seemed like my grandfather was involved with something every weekend. He often told stories to my dad and they did not always make sense to me. But as I got older, many of the things he said began to make sense. Today, I find myself having the very same relationship with my father and mother. Although we do not visit in person as often as my grandparents did, we seem to talk on the phone a lot. As I think back to the times of sitting on the floor listening to my grandfather telling my dad a story, I understand that these are the same stories that my father talks to me about. We discuss why certain activities are done the way they are. We also discuss who has the responsibilities to do the ceremonials during that time of the year. And very often we discuss people. Not just who they are as an individual but also who their parents, grandparents, cousins, aunts, uncles are.

Children are also taught how they are related to others in the community. The relations are not necessarily blood connected, but they are identifiers in the community that creates relations and groups. These relations and groups are useful for traditional activities. Two examples are Clans and Kivas. A clan is an identifier that is passed down through your mother. For example, my mother belongs to the Coyote clan and so I take on her clan. There are a wide variety of clans and they vary from Pueblo to Pueblo. The clans are used to assign certain roles within a community. The Kiva groups are consistent from Pueblo to Pueblo. The Pueblos have either a Turquois Kiva or a Squash/Pumpkin Kiva. This designation is passed down through the male of the family. Children are told about community, meaning how place is structured—the governance system, the traditional societies, and perhaps most importantly how this particular community fits

into the larger world. This information is relayed in many different ways, including through ceremonial practices and storytelling within the local environment. Children are told stories of Creation and Emergence, about the roles of the animals, the plants, and the role of the Earth, Moon and Sun. Many of these stories also make fun of humans, often portraying animals as the ones possessing greater knowledge.

In particular, Emergence[2] stories are important foundations for Pueblo people. In my own experience as a Zia Pueblo community member, I can recall being taught that we, as a people, are blessed to still be in the place that our Emergence stories tell us we are supposed to be. The central theme in these types of stories is that it is important that all community members have cultural knowledge of how our people came to live in this world. For many Pueblos, this shared knowledge provides individuals with a sense of belonging. It provides the reasons for why they do the things that they do and why it must always be done this way. Stated a different way, this is a way of thinking that binds people together and gives them a sense of Identity and belonging. The stories also provide the instructions for how to live in this world; they tell us who we are and who we are born for and how we belong in the place we are. These stories play an important role in teaching community norms and values. In many ways this is the basis of our belief system.

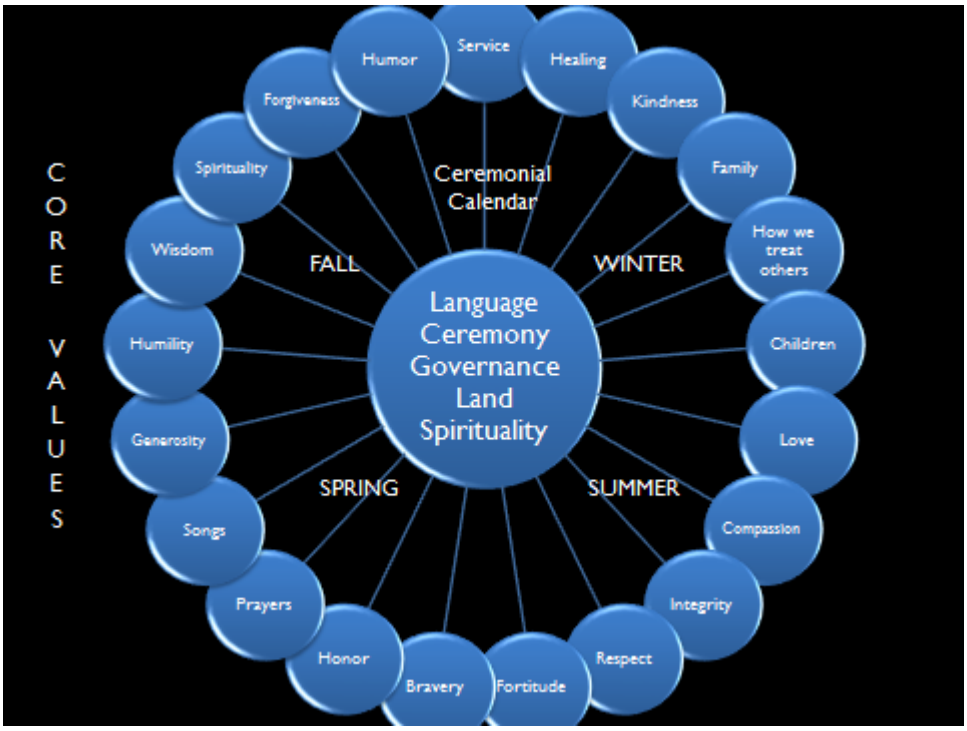
Song and dance in the Pueblo communities together constitutes another form of storytelling. Songs, sung in our Pueblo languages, tell stories about the spirits, the wind the rain and the clouds and are an important part of a Pueblo child's socialization process (Suina 2001). In Zia, for example, our songs are sung in the Keres language, and these

[2] Emergence is capitalized here because it is a formal story that is told on a particular day in Pueblo communities, and is not viewed as an anecdotal story, but rather a central story that conveys who we are as a people and our origins.

dances honor the Earth, the plants, and the animals that are important to the Pueblo way of life. The Harvest or Corn Dance songs are often simple stories that describe the planting season. How it is important that the clouds and the rain come to help the plants to grow. Furthermore, during many of the most sacred of the Pueblo dances, there is also an opportunity provided to the religious and traditional leaders to express to the community the expectations of the male and of the female. At these times of community gathering, there is also opportunity to reward good behavior and to make fun of bad behavior, which contributes to notions of community cohesion. While these important components of Pueblo belief systems are beyond the focus of the current study, the song and dance rituals highlight how traditional practices contribute to a sense of community. In the Pueblos, these songs and dances, as well as the stories told, all work together to ultimately create opportunities for belonging. These approaches all work together to speak to a sense of place and acceptance for all ages and all people and elements. Most importantly, a strong sense of identity is created for the people in the Pueblo, which is a critical component in how Pueblo peoples understand what is the healthy mind and spirit. The work of the Leadership Institute at the Santa Fe Indian School has been instrumental in developing Pueblo culturally-based notions of community development, to which Pueblo core values and concepts of identity are central (see the Leadership Institute website for more information: www.lisfis.org).

The Core Values diagram, describes values and concepts that are important in Pueblo communities. They are a part of the Ceremonial Calendar and they are tied directly to the essential elements contained in the middle.

Figure 2: Pueblo identity and belonging—A sample[3]



In addition to notions of belonging and identity, the idea of core values has entered the conversation over the past decade in Pueblo Country in New Mexico, particularly via the work of The Leadership Institute at the Santa Fe Indian School and Pueblo communities themselves that are adopting the language of a "return to" those elements that define Pueblo life ways. This call for a return has become an important tool to buffer the impact of Western philosophies superimposed upon Pueblo peoples. Such

[3] This model was developed as part of a team effort for the Pueblo Convocation held in New Mexico in 2011. Team members included: Kenneth Lucero, Michele Suina, Joyce N. Chalan, Lia Abeita-Sanchez.

work brings to the forefront Pueblo-derived concepts that are critical to the maintenance of a Pueblo individual, including healthy mind, body, spirit and heart. At the center of our worldview lies Pueblo languages, ceremonies, governance, lands, and spirituality (The Leadership Institute at the Santa Fe Indian School, various think tank sessions, 2009, 2010, 2012)—often demonstrated through clearly observable qualities such as love, humor, respect, honor, compassion, and humility.

Pueblo values and historical policy clashes: View from a southern Pueblo

Today, the worldview beliefs of Pueblo communities may vary in vibrancy due to the resiliency of each community, which is a post-colonial reality. Clashes with historical policy are also a reality that has created new conditions under which Pueblo people must negotiate. In this section, I offer one example of a historical policy clash and its implications for health. If Pueblo identity notions and ideas of belonging define the total mind-body-heart-spirit dynamic as a whole, the impact of federal policy impacting this concept is nothing short of troubling. My own home community of Zia Pueblo, for example, is considered one of the more "traditional" – in other words, more restrictive, conservative or strict in the adherence to cultural practices -- of the Pueblos. ". For example, the women are expected to look/dress a certain way for the Corn Dance. In many Pueblos the women are allowed some creative freedom with belt color, moccasins and hairstyle. In Zia, any deviation from the dress code of a red belt, no moccasins, and straight hair with bangs -- is brought to the person's attention and they are expected to correct their attire.

The Zia Pueblo Tribal Government operates under what the Federal Government deems as a Traditional government. This designation indicates that the Tribe is not

organized under a Constitution as described in the Indian Reorganization Act of 1934. The Governor, who is the designated tribal official to interact with outside entities, is appointed to his position on an annual basis. Every year on December 29th, all males' ages 18 and older are required to attend a meeting with the religious society leaders. It is these religious leaders who appoint 20 individuals to various positions of service. In order of authority the positions are: War Captain, Assistant War Captain, Governor, Lieutenant Governor, Water/Ditch Boss, Assistant Water/Ditch Boss, Church Boss, Assistant Church Boss, 8 Assistants to the War Captain, and 4 Assistants to the Governor. Although the Governor is not the highest-ranking official in the community, he is given the responsibility to represent the tribe to outside entities. These outside entities include the U.S. Government, State Government, and private businesses. It is also the Governor's responsibility to carry out the wishes of the Tribal Council. The role of the Governor is primarily to act as the liaison and intermediary between the Tribal Council and the outside entities that the Pueblo conducts business with. This role is supported by the numerous staff in the Tribal office. All of the staff employed at the office are permanent staff and are not brought in with new administrations. Although the Zia Pueblo has been a recognized tribal government since first contact with Spain in the 1600s, the tribal government office was not opened until around 1969. Prior to the office being opened, the Governor's office consisted of a briefcase that was handed off from one Governor to another.

In 1972, the Bureau of Indian Affairs and the Indian Health Service approached the Pueblo with two grants. One grant was to develop a constitution and the second was to adopt a membership ordinance. The grants were offered due to the Pueblos desire to

begin to actively participate in certain federal government programs. In 1973, two committees were formed: a Constitutional Committee and a Membership Ordinance Committee. The committees met for over six months and considered both initiatives. The Constitutional Committee met only a few times over the six months. It was decided pretty quickly that the Pueblo would retain its traditional form of government. There was little interest in the creation of a Constitution. The committee did create an organizational chart that reflected the authority structure of the traditional government and some initial policies and procedures to satisfy federal government officials. However, much of the processes and authorities of the traditional government and the role of the governor outside of the tribal office but within the community remained unwritten. Although some of the roles of the Tribal Council were also defined in the policies and procedures, many of the divisions of power remain unwritten. In 1978, a more formal set of policies and procedures were put in place for the purposes of contracting certain BIA programs under Public Law 93-638, Indian Self Determination and Educational Assistance Act. These policies primarily addressed procurement, personnel and accounting procedures.

Then, in 1986, the Tribal Council went through a month-long strategic planning process. The process resulted in a 10-year plan for economic development, tribal programs and the community in general. This process also led to some revised policies and procedures for the Tribal office. A part of the revised policies included job descriptions for some of the appointed officials and the addition of some tribal office management positions. Although the plan and resulting policies were formally adopted by the Tribal Council, many of the initiatives and plans were not implemented. One result

is that the roles and responsibilities of the traditional leaders, appointed officials, tribal council, and tribal office management are now being debated.

The Membership Ordinance Committee was very different from the Constitutional Committee. The committee met often and for most of the year. This committee was very interested in establishing the parameters of membership. For the most part the policies of the committee were formulated from a template provided by the Bureau of Indian Affairs. In general, the policies require ½ degree of Zia blood in order to be an enrolled tribal member. There are many other factors that complicate the ordinance which add in marital status, overall degree of Indian blood and standing in the community. The ordinance also contains a process for adoption into the Pueblo. Adoption of spouses and children who are Indian but do not have Zia blood in them. Compared with other Pueblo ordinances, Zia requirements are stricter that most. They have not been revised since their initial adoption, however many of the past committee members have expressed regrets and a need for changes to the policy. This is primarily caused by the fact that their own grandchildren and other family members are not eligible to be tribal members.

Colonialism and Westernization

Russell (2005) has written several articles about colonialism and settler colonialism imposed upon the Indigenous populations in North America. His work provides a summation of the treatment of the Indigenous populations by Great Britain. He provides prospective on different methods utilized to reach the same goal—the goal of the acquisition of lands from native populations for the purpose of ownership and settlement—and the three dominant phases through which laws concerning indigenous

people evolved (Russell, 32): The first dominant phase was fundamentally Christian and papal. The second was the emergence of a secular international law-a Law of Nations-developed by the colonizing European imperial states, and the third has been the domestic laws-constitutions, agreements, and treaties, statutes and judicial decisions-of the nation-states, the successor states of the colonizing empires. A fourth phase coincides with the work of the United Nations to establish "worldwide standards on the rights of Aboriginal peoples which are acceptable to those peoples" (Russell, 33).

This comparative work can provide Pueblos with a deeper appreciation for the encounters experienced in the Southwestern region of the U.S., although with some important caveats. For example, Pueblo populations were able to negotiate somewhat lasting outcomes that other tribes in North America and around the world could not access, for example the recognition of the Pueblos' sovereign authority by the Spanish, Mexican and American governments. In 1620, the King of Spain issued a Royal Decree creating the civic office of Governor and other positions. According to David Lavash "the King of Spain required each Pueblo, at the close of the calendar year, to choose by popular vote a governor, lieutenant governor, and other officials as needed to carry on the affairs of the Pueblo." (Lavash, 2006, pp. 93). It was at this time that the Pueblos were also presented with a cane from the King symbolizing their authority.

From 1620 until the 1930's the Pueblos saw significant changes in the governance and control of the lands all around them. The Spanish government was eventually driven out by Mexican Independence in 1821. The Mexican government however only lasted in the area now known as New Mexico for 27 years. In 1848, the Mexican Government signed over much of Pueblo Country over to the United States in the Treaty de

Guadalupe Hidalgo. Although these were historical changes that impacted the lives of Pueblo people in deep and meaningful ways, the governance structure of the Pueblos did not change. The Mexican Government supported the Pueblo Governments and provided the Pueblo Governors with silver tipped canes in the same way that Spain had. And as the two previous Governments had, the United Sates, through President Lincoln presented the Pueblo Governors with a third cane in 1864. The Pueblo Governments were acknowledged and remained intact until US law began to change the relationship with all Indian Nations.

Within the Pueblos, however, the layers and experiences of Spanish settler colonialism need to be explored more deeply by Pueblo and other Indigenous researchers, potentially adding to the discussion of the experiences of colonialism and resistance on a global scale. As we move towards a global prospective and the assertion of Russell's fourth phase, a comprehensive education of settler colonialism from a comparative perspective can only enrich Pueblo discussions. Until Pueblos access understanding of such dynamics and how the current federal systems were intended to destroy our way of life, we may continue to struggle with an appropriate starting point to address the general idea of change that leaders and community members alike wish to see. These are significant struggles between modern day expectations and the "traditions" of the Pueblos.

Colonialism and Capitalism

In the case of American Indians, tribal communities today are very near to being as integrated and assimilated as the country's founding fathers could have hoped. We find ourselves dealing with a strong and lasting colonial legacy. According to Yellow Bird,

"Colonization refers to both the formal and informal methods (behaviors, ideologies, institutions, policies, and economies) that maintain the subjugation or exploitation of Indigenous Peoples, lands, and resources" (2005). As a result of a complex tribal-federal government relationship, on the ground impacts are evident, though not often explored explicitly in Pueblos. For example, our tribal communities have embraced many of our federal government-introduced programs such as housing, childcare programs, education programs, and tribal membership even though they often marginalize, exclude and violate our own people. And many other programs are not aligned with the core values and traditions of the community. This is certainly the case for some economic development.

All Western government models assume that there is a capitalistic engine-something is produced. And it is the government's role to decide what to do with what is produced. It must be horded, processed and sold for gain. Tribes did not traditionally produce items to gain but it was primarily for trade. Today, tribes participate in some of the most exploitive and extractive economic development enterprises such as gaming, commercial tobacco and mining. Ultimately, what this refers to is that economic development means many different things to different people. On U.S. reservations, like those of the Pueblos, many people believe the end goal is based on the following ideals—for example, how much more can a village look and feel like a town with stores, shops and restaurants? However these ideals ask us to consider—Do we stop to analyze and predict what that really means? Can it be argued that by not developing a community that the community is being protected from outside influences? Isn't it just as difficult to resist economic development within our communities, as it is to bring it into the community? By resisting development is that a positive step to preserving and protecting

the customs and traditions of the community? And by doing this, isn't it developing the customs and traditions of the tribe?

This work is ultimately concerned with the following types of questions related to values, decision-making, and what we might view as desired development in our communities:

1. *What would happen if tribes put culture, health, and other core values first and eliminated capitalism and monetary gain as a primary driver?*
2. *What was the primary driver prior to contact? Survival? It has to be more than just survival. If survival was the only priority, why or how was song, dance, societies, and other activities not directly related to survival were developed.*
3. *How do we begin the discussions of the underlying conspiracy?*
4. *How might we explain to our tribal leaders and community members that what we are doing may contribute to the degradation of the tribes own stated values? It is often difficult to explain to the people who hold the privilege or have bought into the system.*

The modern-traditional debate has been made more complex by globalization, and in particular, conflicting ideas of technology. A lack of research in this area is glaring, but is increasingly documented in other studies of indigenous populations worldwide. What has been the impact of globalization on the worlds Indigenous populations? Jerry Mander and Victoria Tauli-Corpuz (2006) describe the numerous ways that capitalistic ways of thinking are not sustainable and are in direct conflict with many Indigenous cultures and environments. In this discussion, technology emerges as a critical theme. Mohawk addresses this topic: "…indigenous peoples shouldn't be allowed to maintain themselves

and their cultures as they exist now; to do so denies them the access to such wonderful Western inventions as television and video games and those technological things that our kids must really want too" (27). This statement is made in the context of giving all people access to what Western society has to offer. However, technology has also brought a lot of undesirable information to the reservation: Through the increasing access to the internet, community members have unfiltered access to the best and worst of what is available and with little training regarding how to filter and why this is critical.

Decolonization and Critical Thinking

In order to move away from the subjugation and exploitation we must decolonize. What is Decolonization? It is the intelligent, calculated, and active resistance to the forces of colonialism that perpetuate the subjugation and/or exploitation of our minds, bodies, and lands, and it is engaged for the ultimate purpose of overturning the colonial structure and realizing Indigenous liberation. So, what must tribes do to begin to understand what is truly tradition and what has been provided to us by others? Michael Yellow Bird (2005) advocates for the need for critical thinking in the native communities. Critical thinking requires us to be open to carefully considering and analyzing all possibilities that may be presented, ignored, trivialized, or censored in any argument, opinion, or what are considered "the facts." Critical Thinking requires a mindful, dedicated, and honest process of inquiry that often requires us to question or reformulate our thinking and beliefs, to sometimes agree with those we do not like, and to admit to our limited viewpoint. It must be used to move away from colonialism. However, it is not the only source of thinking. Good thinking must also be proactive, creative, constructive, and

generative. Good thinking must also include the strengths of our own values and traditional expertise:

> Because the minute we found a way to gather and talk, we through away the outside agendas and began making theory out of the stuff in our pockets, out of the stories, incidents, dreams, frustrations, that were never acceptable anywhere else. (Morales, 2001)

Related to this discussion is a word on research and Indigenous communities. For example, the seminal work of Linda Smith argues: "Indigenous research approaches problematize the insider model in different ways because there are multiple ways of being either an insider or an outsider in indigenous contexts." (1999, 138) Reading about the entire issue of insider/outsider research is important to consider in historically research-exploited Pueblo communities. The statement above made me think about the perceptions and notions that we carry about being an "Insider." Are all of the common perceptions about being an insider true? Are the advantages we perceive real and are there disadvantages that we do not consider?

As an important reflection, part of my researcher voice also emerges from experience serving on Tribal Council in my community. I have been on my Tribal Council since 1999 and worked as an administrator for my tribe for eight years. And I have been working as a program director for a health policy center at UNM for about six years. During that time I have seen a number of dynamics play out with "Insiders". Probably the most common dynamic is what is often referred to as "Crabs in the Bucket". This is a situation where Indian people do not seem to give the same credibility or respect to their own people as they do to non-Indian people. I have seen my own council treat non-Indians as the "expert" and rely on information provided by that individual. This is

often the same information that had been presented by our tribal member. This dynamic goes against a commonly held perception that having an Indian or tribal member go with you to the Council meeting that you will somehow have an advantage. The perceived power or access that an outside researcher may think an insider would have may not always be true.

I have also seen though my own experience, that this same Tribal Council will not share certain information while a non-Indian is in the room. And the Council will gladly share this information with the Indian person in the room. That certainly is an advantage of being an insider. But what is an ethical insider researcher supposed to do with that information? Is there an ethical dilemma with the person using that information as part of their research? There is a real difference in access and "power" that the insider has access to. So what does this mean for the insider? Does that give them an advantage over outside researchers? And if it is ethical to use that power, in what ways is it useful. For the researcher and for the community that is being researched, is it worthwhile to research that dynamic?

If it is acceptable to begin to discuss these power dynamics, how is it done? Should more Indigenous researchers write about this? And at what point are we compromising our power by sharing this information? And are we violating some trust with our communities by revealing this information. Perhaps it would be useful information for other Indigenous researchers to understand these power dynamics. It may allow the researcher and the community to negotiate for better and or more appropriate terms and conditions of research in the tribal community. Perhaps too, community could look to its own tribal members to accomplish this type of research. It is one of the many

ways that it can grow its own capacities and to truly incorporate into the community. Perhaps one strategy to begin to increase the capacity of the tribal membership is to educate younger tribal members about the history and concepts like colonialism, and there are some attempts to do this already, such as the work of the Leadership Institute at the Santa Fe Indian School and their Summer Policy Academy.

Critical and Driving Questions

These critical questions can be applicable to almost any situation where tribes are considering new programs, new policy or new business relationships. Some are quite practical and are typical of what would be considered typical business questions. However, some require a community to reflect back to one's own tribal values and customary practices. The list is not exhaustive and not meant to lead to definitive answers. And not all questions will apply to every situation. They are meant to interrogate the priorities of the community and to remind the communities of the strengths that allowed them to continue to exist:

1) *How does this program affect the tribe's sovereignty?*
2) *What will be required of the tribe-financially, reporting, and legally.*
3) *What is the flexibility to the tribe about how the operation/ program/ grant will be run?*
4) *Do we have the ability to change the programs to better suit our needs?*
5) *What are the benefits to the other entity?*
6) *Who will own any data or information that is collected during the course of a program or grant? What are the conditions of sharing the information with others?*

7) *How many community members will it employ*

8) *How will leave for cultural activities be dealt with?*

9) *How will the activities proposed by the entities contribute to the core values of the community?*

10) *Do the activities propose a change in lifestyle or behavior that is different from the culture of the community?*

11) *How does the program affect women, children, elderly or other tribes*

12) *What affect will this program have on my community 100 years from now?*

The following is a Case Study of a situation that has happened is some of our Pueblo communities already and will possibly play out in other Pueblo communities in the very near future. This sample Case Study offers insight into how these questions and challenges might be confronted by communities that are being reflective of the processes they are engaged with that will have strong outcomes for Pueblo communities.

Case Study: Pueblo Women and Politics

For the Zia Pueblo, I believe we must begin to pay more attention to the women's role in tribal governance. Although the Federal Government considers our governance and court systems, "Traditional", we must recognize that there is a tradition that is different and predates the current form of government. It is in this tradition, which we still preach today, that women are honored and mothers are the leaders of our people. In many Pueblo communities, women are now participants in the governmental decision making process. Some are on Tribal Council and at least two Pueblos have elected women as their Governor in the past. The Pueblos that do have women as part of their Council are all Constitutional governments.

Pueblo Women in Tribal Government: Sample Case Utilizing Critical Questions

Context: In the ASU Pueblo[4] which is located in Quay county[5] in central New Mexico, the Tribal Council recently decided to not pursue a program that would provide support services to women experiencing domestic violence. The Tribal government is organized under a particular *traditional government model*, which means that in this case for this community, the government is a non-Constitutional government, headed by a secular Governor and Lieutenant Governor. The Tribal Council consists of 20 past Governors who are all male. This particular government leadership (Governor and Lt. Governor) are appointed by traditional, non-secular leaders in the community.

A new challenge: This government system does not have women tribal members who serve on the Council because since Spanish colonization, any pre-existing traditional (pre-contact) system whereby women possibly participated and led has been suppressed. So at this time, this government system observes a division whereby women do not participate in tribal government. Regarding the issue at hand, one of the primary reasons the Council did not approve the program is they did not feel they had enough knowledge about the issues and whether this was a good program for their community. One of the senior Councilmen raised the concern about the women and their issues were not being adequately addressed. The Councilman asserted that the Council needed to consider the inclusion of women on the Council.

[4] Fictional "Pueblo" name. This case is not based on any one particular New Mexico Pueblo, and in order to not compromise the confidentiality, work, and contemporary issues of any specific Pueblo, this case is constructed using a number of fictional elements that are, however, coupled with real-life questions and challenges that Pueblos are currently facing through conversation and debate today in Pueblo-wide forums, for example.

[5] Fictional county name

The debate: The Council discussed this issue at great length and decided that it needed more consideration and thought. The Council agreed to use a series of critical questions to consider for discussion at the next meeting. The Councilman's responses to the questions are as follows:

Critical Question 1: How does this change affect the tribe's sovereignty? The decision to include women in the Council will enhance our sovereignty. It is our decision alone as a Pueblo. Since we are a "traditional' government, this is a relatively easy process. We can formalize the change in anyway we see fit. There is no constitution to amend or policy to change. We can create the new "tradition" of women in council by simply doing it.

Critical Question 2: What are the benefits to the women? The benefits are potentially great, not only for women, but for all community members. There will now be a voice for women and their issues in the Council. The Council will no longer have the luxury of not dealing with women's issues because they will be at the table with us.

Critical Question 3: How will the inclusion of women in the Council contribute to the core values of the community? The inclusion of women may bring us closer to our true beliefs and practices as Pueblo people. We all know that our highest leaders in our community and our Societies are referred to as our mothers. I believe that females have always played an important role in our community, but the influence and effects of colonization have moved us away from our true governance system.

Critical Question 4: Does the inclusion of women on the Council propose a change in lifestyle or behavior that is different from the culture of the community? Pueblo

people are traditionally a matriarchal society. It is a change in our existing lifestyle and behavior. It is a change back to the way of life and culture that we once knew.

Critical Question 5: How does the inclusion of women on the Council affect women, children, and elderly? This will be a great benefit to the women, children and elderly of our Pueblo. The more voices, opinions and experience we have in the Council will only help our community. It may complicate issues and I do not think it will always be easy. It will help us to make better decisions for the Pueblo.

Critical Question 6: What affect will this program have on the community 100 years from now*?* If we want to preserve our traditions and culture for the next 100 years, we need to be inclusive of all our tribal members. Our women need to participate in the governance of our community. Together, we all have collective and shared knowledge of our ways of life. This will help our decision-making and ensure that our way of life will continue. Traditions are not static. And Pueblo people are not static. We have existed in this area for hundreds of years. We have survived many changes in our climate, our enemies and our way of life. We have continually adapted to ensure that we survive as a people. The inclusion of women in the Tribal Council will profoundly enhance our community 100 years from now.

Discussion

Once we are in the proper frame of mind and using the prior dialogue to center our conversation, we can begin a discussion on women's issues. We often try to separate what we do in the Council from what we do in the Kiva, this where I believe that critical analysis must take place. All too often, women's issues are treated as if we are discussing

people from a different community, not the women who are our mothers, daughters, sisters, and partners who participated in the ceremonies the weekend before. By framing our conversations and our though processes to reflect our actions in the Kiva and not Western society, I believe that we will begin to properly address the issues in the community. Our core values bring to the discussion all of the concepts that are critical to the maintenance of a healthy mind, body, heart and spirit. The core values of language, ceremony, governance, land and spirituality are at the center of everything that is important in the Pueblo way of life and are demonstrated through qualities such as love, humor, respect, honor, compassion, and humility. It is through the practice of these core values in our life that a community can be well.

Conclusion

The protection and preservation of tribal customs, values, traditions and ways of thinking are critical to the existence of our tribes. It has taken many years for our communities to get to the places we are now. Our situation is ironic in the fact that we are forever told to pursue the American Dream and yet the American Dream was not meant for us and always seem to be just out of reach for many of our community members. And yet we do our best to emulate the capitalistic greed and the Western way of life. Our people are starting to forget that it was the strength of our ancestors and their dreams that allow us to be here today. How do we address this? How do we begin to give the youth the tools to question and to critically assess future programs and the future of the tribal communities? What does it mean for future governance? Furthermore, are we prepared to accept the results?

Though there is an active push to revive many of the policies and procedures of the tribal office, there are many ideas and competing priorities. During discussions with the Tribal Council for example, a starting point is difficult to determine. Further, there are competing interests and a wide array of backgrounds and knowledge bases. As a result, there have been no decisions made about how the process will begin or even a proposal on the table, no matter the urgency of the issues. Perhaps a suggestion is that tribes could start at the beginning. That is, the Tribal Council could launch a collective and community-based process that examines our Creation story and explicitly draws out many of those lessons in order to directly apply them to the modern day needs and desires of the community. This would not be an easy or quick process and is one that would require full comprehension of the history and impact of Western civilization individual Pueblos and Pueblo people as a whole.

SECTION 3: Policy Brief
Federal Policy Recommendations to Improve Health Care Delivery in New Mexico

BACKGROUND OF THE ISSUE

The recent passage of the Affordable Care Act, which includes the permanent reauthorization of the Indian Health Improvement Care Act, promises to enable the Indian Health Services and Tribes to create a health care system that meets the needs of the 21st century. The opportunities to increase the access to care for American Indians and Alaska Natives (AN/AI) is tremendous. Unfortunately many provisions will not take effect immediately and are subject to the Congressional appropriations process. And still others are dependent on State governments to choose to participate in the program. As the provisions of the ACA are implemented there are legislative fixes that will be necessary in order for all AI/AN to benefit.

Affordable Care Act

The ACA is most noted for the potential to increase access to affordable health care for all Americans. The primary drivers of the increased access are Medicaid Expansion and the availability of affordable heath insurance plans through the Health Insurance Marketplace or Exchanges. In addition the ACA, provides reimbursements to health care providers, enhances patient protections, boosts recruitment and retention of providers (especially primary care), and provides grants for numerous health care programs such as services for prevention, health disparities, improved access. The Indian Health Service, Tribal providers and Urban clinics are eligible to benefit from these enhanced programs.

Individual American Indians are also afforded provisions specific to them. These exemptions include and are not limited to:

- Exemption from the shared responsibility mandate- The ACA requires all Americans to purchase and carry health insurance. AI/AN are exempt from a non-compliance penalty associated with the individual requirement to purchase health insurance.
- Exemption from most cost sharing in Exchange Plans- The ACA allows exemption from cost-sharing in Exchange plans for Indians below 300% of the federal poverty level.
- Eligible for monthly enrollment in the Exchange Plans-AI/AN are eligible for special monthly enrollment period in the State based Exchanges

Indian Health Care Improvement Act

The IHCIA is Section 10221 of the ACA and is 276 pages with eight Titles and 726 Sections. Sections 101 to 103; permanently reauthorizes the IHCIA and describes the goal of the United States to "enable Indian Tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States"

The IHCIA also contains what it calls The National Declaration of Indian Health Policy. The Declaration is deliberate in its proclamation that Congress will fulfill its trust responsibilities and legal obligations to Indians, with seven specific items that address

health status, tribal participation, health professions, consultation, government-to-government relations and funding for programs and facilities.

Key provisions that seek to address the chronic underfunding of the IHS, Facility issues and health care provider shortages include:

Section 112. Health Professional Chronic Shortage Demonstration Program. This section emphasizes the need for more health care professionals in the Indian health system, by allowing Indian health programs to offer practical experience to medical students.

Section 121. Indian Health Care Improvement Fund: This section authorizes funds to be used for the elimination of the deficiencies in the health status and resources for tribes, backlogs in health care services, and inequities in funding for direct care and Contract Health Services (CHS) programs, and also to supplement the ability of the IHS to meet its responsibilities. A report to Congress on the current health status and resource deficiency for each IHS Service unit is required within three years.

Section 141. Health Care Facility Priority System: This section authorizes the creation of s a Health Care Facility Priority System to be developed in consultation with Indian tribes and tribal organizations for the planning, design, construction, renovation and expansion needs of the Indian Health Service (IHS) and non-IHS facilities. The section also directs the Director of IHS to nominate new projects for planning, design and construction of health facilities at least once every 3 years as well as protects the priority of certain existing construction projects that were identified in past fiscal years. Lastly,

the Director of IHS is required to provide Congress with comprehensive reports on all health care facility needs in Indian Country.

CURRENT STATUS OF THE ACA FOR AI/AN IN NEW MEXICO

The state of New Mexico decided to participate in Medicaid expansion (Centennial Care) and opted to run its own health insurance exchange (Be Well New Mexico). Both programs are increasing access to health services and are creating jobs for New Mexicans. These two programs are bringing additional resources to individual Indians, IHS and Tribally operated hospitals and clinics and private healthcare facilities.

- Currently, over 91,000 American Indians in New Mexico are enrolled in Medicaid - about 43% of all Native Americans in the state.
- As of January 16, 43,054 people in New Mexico had completed their 2015 private plan enrollments through the exchange, including auto-renewals of 2014 plans.

Despite significant increases to access to health care, many AI/ANs and their tribes are experiencing issues with participation. The issues are discussed below along with recommendations made by the National Indian Health Board, National Congress of American Indians, regional health board and individual Tribes.

ISSUES AND RECOMMENDATIONS

1. Definition of "Indian" fix:

In the ACA, the Indian specific provisions do not uniformly reference the same statutory definition of "Indian." If a uniform definition is not implemented, it is likely that the protections and benefits under the ACA will be made available to Indians inconsistently. The term is used in several critical areas of the ACA. In some instances the term "Indian" is defined as a member of a Federally Recognized Tribe. In other instances it refers to a definition used by the Centers for Medicare and Medicaid Services, which is a broader definition than the initial definition. The clarification of the definition is critical as it affects: exemption from cost-sharing in Exchange plans for Indians below 300% of the federal poverty level; special monthly enrollment period in the State based Exchange; and exemption from non-compliance penalty associated with the individual requirement to purchase health insurance.

Recommended action:

The ACA's goal of a simple, integrated form for Medicaid and Exchange plan eligibility is best served by adopting the definition of "Indian" used by the Centers for Medicare and Medicaid Services (CMS) in its implementation of Medicaid cost sharing protections enacted in the American Recovery and Reinvestment Act. See, 42 C.F.R. 447.50.

2. Patient Navigator Grants for American Indians:

The ACA provides funding for the education and enrollment of Americans in the Health Insurance Marketplace. These funds are allocated based on weather a State operates a State run Exchange or a Federally Facilitated Exchange. State run Exchanges, like New Mexico, make the decisions about how funds are allocated for education and enrollment. Federally run exchanges allow Tribes and Tribal Organizations to apply directly for these

funds. Many Tribes feel that not enough resources are being directed to outreach and enrollment to American Indians by the State run Exchanges.

Recommended Action

The Patient Navigator Grants for American Indians needs to be amended to allow Tribes and Tribal Organizations in any state to apply for direct funding. Education and outreach conducted by the Tribes and Tribal Organizations would allow for better coordination and culturally appropriate outreach to occur in tribal communities.

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