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For the Love of Native People
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Statement of Abigail Echo-Hawk, MA
Executive Vice President, Seattle Indian Health Board
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Hearing for Committee on Health, Education, Labor, and Pensions
Examining our COVID-19 Response: Improving Health Equity and Outcomes by Addressing Health Disparities
Thursday, March 25, 2021

Members of the Health, Education, Labor, and Pensions (HELP) Committee, my name is Abigail Echo-Hawk, and I am an enrolled citizen of the Pawnee Nation of Oklahoma, currently living in an urban Indian community in Seattle, Washington. I am the Executive Vice President of the Seattle Indian Health Board and Director (SIHB) of the Urban Indian Health Institute (UIHI), a tribal epidemiology center, where I oversee our policy, research, data, and evaluation initiatives.

I am an American Indian health researcher with more than 20 years of experience in both academic and non-profit settings, and am part of numerous local, state, and federal efforts to support and American Indian and Alaska Native communities in research, including serving on the Tribal Collaborations Workgroup for the National Institutes of Health All of Us precision medicine initiative. I am co-author to four groundbreaking research studies on sexual violence and Missing and Murdered Indigenous Women and Girls (MMIWG) where I have called national attention to the institutional barriers in data collection, reporting, and analysis of demographic data that perpetuate violence against American Indian and Alaska Native people. Most recently, I was a committee member for the National Academies of Sciences, Engineering, and Medicine: *Framework for Equitable Allocation of COVID-19 Vaccine*. As the only representative from the Native community, I worked to ensure the needs of our Indian Healthcare System and tribal and urban Indian communities were appropriately included in the framework that is informing states and policymakers nationwide.

For over five years, I have worked to address institutional barriers to public health surveillance data experienced by Tribal Epidemiology Centers. During the COVID-19 pandemic, this advocacy has been amplified through the collective power of the We Must Count Coalition - a group of health and racial equity and civil rights organizations. Together we are calling for the uniform collection and release of COVID-19 testing, cases, health outcomes, and mortality rates using data disaggregated by race, ethnicity, primary language, gender, disability status, and socioeconomic status. However, the crumbling public health data infrastructure nationwide is inhibiting our ability to reach these goals as evidenced by UIHI's recently released report, Data Genocide.

These experiences guide my statement today that is directed at the government's failure to appropriately address the COVID-19 health disparities raging within our communities – including

American Indian and Alaska Native, Black, Hawaiian and Pacific Islanders, Hispanic/Latinx, and Asian American communities.

Data, Evaluation, and Research by and for Indigenous Communities

UIHI is an Indian Health Service (IHS)- funded Tribal Epidemiology Center, providing services to more than 62 urban Indian organizations who provide culturally attuned health and social services in areas that represent approximately 1.5 million American Indian and Alaska Native living in urban settings nationwide. UIHI recognizes research, data, and evaluation as an integral part of informed decision making for not only our American Indian and Alaska Native community, but also our policy and funding partners. We assist our communities in making data-driven decisions, conducting research and evaluation, collecting and analyze data, and providing disease surveillance to improve the health and well-being of our entire American Indian and Alaska Native community. UIHI's mission is to advocate for, provide, and ensure culturally appropriate, high quality, and accessible data for American Indian and Alaska Native public health organizations that provide culturally attuned care to American Indian and Alaska Natives living off tribal lands in urban settings. Recognizing the migratory patterns of our population as they move between urban and rural locations, we also serve tribal nations and tribally based organizations.

Tribal Epidemiology Centers are IHS division-funded organizations who serve the Indian healthcare system compromised of IHS Direct, Tribal 638, and Urban Indian Health Programs by managing public health information systems, investigating diseases of concern, managing disease prevention and control programs, responding to public health emergencies, and coordinating these activities with other public health authorities. There are currently 12 Tribal Epidemiology Centers nationwide with the mission to improve the health status of American Indian and Alaska Natives through identification and understanding of health risks and inequities, strengthening public health capacity, and assisting in disease prevention and control. UIHI is unique in that it serves the urban American Indian and Alaska Native population nationally, while sister Tribal Epidemiology Centers service regional IHS areas including Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma, Phoenix, and Portland.

In response to the COVID-19 pandemic, UIHI has mobilized to create COVID-19 fact sheets, reports, and online resources for tribes, tribal organizations, and urban Indian organizations. This includes conducting original research to guide the creation of culturally attuned public health messaging. In late January of this year UIHI released the first, and to date, the only national survey on vaccine hesitancy in Native communities. Since August 2020, UIHI and other Tribal Epidemiology Centers co-authored two COVID-19 studies on American Indian and Alaska Native people in partnership with the Centers for Disease Control and Prevention (CDC). These Morbidity and Mortality Weekly Report (MMWR) revealed American Indian and Alaska Native communities experience disproportionate morbidity and mortality due to the COVID-19 pandemic, with the rate of new infections and death among American Indian and Alaska Native people are estimated to be 3.5 and 1.8 times that of non-Hispanic Whites,

respectively.[1] However, the MMWR report on COVID-19 infections notes the authors were only able to include 23 states in the analysis, as they were the only states that had collected at least 70% or more of race and ethnicity data,[2] highlighting the need for Tribal Epidemiology Centers to advise and improve data collection and reporting practices of American Indian and Alaska Native data by federal, state, and local agencies.

As healthcare and public health organization on the forefront of serving urban Indian communities, we are alarmed by the on-going data genocide that continues to perpetuate negative COVID-19 outcomes among American Indian and Alaska Native people by eliminating them in the data.

Disproportionate Impact to Indigenous People

As Director of a national Tribal Epidemiology Center, UIHI's service population represents approximately 71% of the 5.2 million American Indian and Alaska peoples (alone or in combination) in this country. In this work, I am often asked to speak on the pervasive health disparities experienced by American Indian and Alaska Native people. What I must continue to remind people, is that these disproportionate outcomes are a direct result of centuries of chronic underfunding of trust and treaty obligations, particularly chronic underfunding of our health care, public health systems, and infrastructure have long impacted access to medical care, education, housing, clean water, healthy foods, and traditional medicines among Indigenous communities.

It is clear that the disproportionate impact that COVID-19 is having on Native communities is not an accident. It is the product of systems of inequities that have created and perpetuated rampant health disparities for Native people.

Disparities Across Communities of Color

The *Color of Coronavirus* project by APM Research Labs provides weekly updates on COVID-19 mortality by race and ethnicity. According to the APM Research Lab, as of March 5, 2021, the past four weeks have yielded the highest number of new deaths since the start of the COVID-19 pandemic for all racial groups except Black and Pacific Islander Americans, for whom it is the second most deadly stretch.[3] As our nation continues to roll out vaccination programs, it is more important than ever to accurately collect, report, and analyze race and ethnicity data. These data are essential to understanding racial equity impacts and developing equitable strategies for vaccine distribution. The following statistics reveal the devasting impacts of COVID-19 among Black, Indigenous and people of color (BIPOC) communities. As of March 5, 2021:

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[1] Arrazola J, Masiello MM, Joshi S, et al. COVID-19 Mortality Among American Indian and Alaska Native Persons - 14 States, January-June 2020. *MMWR Morb Mortal Wkly Rep*. 2020;69(49):1853-1856. doi:10.15585/mmwr.mm6949a3.

[2] Hatcher SM, Agnew-Brune C, Anderson M, et al. COVID-19 Among American Indian and Alaska Native Persons - 23 States, January 31-July 3, 2020. *MMWR Morb Mortal Wkly Rep*. 2020;69(34):1166-1169. doi:10.15585/mmwr.mm6934e1

[3] APM Research Lab. The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S. February 4, 2021. Retrieved from: https://www.apmresearchlab.org/covid/deaths-by-race.

- **Indigenous Americans had the highest actual COVID-19 mortality rates nationwide.** While the CDC reports a mortality rate of American Indians and Alaska Natives 1.8 times higher than the non-Hispanic Whites, reports by the APM Research Lab suggest is it closer to 2.2 times higher than White Americans.[4] Data from APM also notes they were unable to gather data from all states due to the lack of data reported by them, and rates are not calculated for those identified as "Other" race. Indian Country has had at least 5,477 Indigenous Americans lose their lives to COVID-19,[4] but we know this number is a massive undercount due to the missing and inconsistent data collected by health care providers and governments nationwide; and
- **73,236 Black Americans have lost their lives to COVID-19** and Black Americans have the second-highest mortality rate of all groups, behind Indigenous people and are 2 times more likely to have died compared to Whites.;[4] and
- **Nationwide, Pacific Islanders are 2.6 times more likely to have died as Whites.**[4] Since March 5, 2021, the Pacific Islander community has had at least 830 community members lose their lives to COVID-19.[4] However, we know these are not exact numbers. Arizona, Connecticut, Delaware, Michigan, New Mexico, North Carolina, Virginia, and Wisconsin report deaths for Asians and Pacific Islanders jointly. Without disaggregated data, the true impacts to the Pacific Islander community continue to be undercounted; and
- **89,071 Latinos have lost their lives to COVID-19** and Latinos are 2.4 times more likely to have died as Whites from COVID-19;[4] and
- **Over 17,747 Asian Americans are known to have lost their lives to COVID-19.** Nationwide, Asian Americans have experienced 3.6% deaths by race, while they represent 5.6% of the population.[4]

As devasting as these data are, we know they are an undercount of the true impact COVID-19 is having in our communities of color. The gaps in this mortality data are a stark reminder that our nation's inability to accurately collect, report, and analyze race and ethnicity data that directly contributes to health inequity and erasure. Today, Native people – and communities of color – are fighting to address the COVID-19 pandemic and are demanding equitable solutions and equitable distribution of the vaccine to communities most impacted.

A National Data Failure

On February 15, UIHI released a national report card, titled *Data Genocide,* analyzing the current status of collecting and reporting state COVID-19 surveillance data on American Indians and Alaska Natives. This analysis reviews state and national data reported on American Indian and Alaska Native people including percent of confirmed cases with complete race and ethnicity information.

The report revealed more than half the states in the nation received a C grade or below with a total of thirteen states receiving a F. The five states in the nation that ranked the worst in collecting and reporting racial demographic data are Texas (50th), New York (49th), Maryland

(48th), West Virginia (47th), and Delaware (45th). The national average was a grade of D+. Overall, states are doing a poor job of tracking and reporting racial demographic COVID-19 data for American Indians and Alaska Natives and other people of color. A recent study by the CDC,[4] found that current data on vaccinations is missing 48% of race/ethnicity data.

It is not possible for policy makers to make data-driven decisions on COVID-19 with incomplete data. States must be held accountable to improving their data practices if we are to ever achieve data-driven decision making for allocation of resources to end this pandemic.

Gaps in the Indian Healthcare System

Due to chronic underfunding of trust and treaty obligations, the Indian healthcare system is only resourced to serve a fraction of American Indian and Alaska Native people. Across the nation, Indian Health Care Providers are seeing an influx of IHS beneficiaries visiting tribal and urban Indian clinics seeking the COVID-19 vaccine and other healthcare services. We welcome our relatives into culturally attuned care – many for the first time. Yet, our Indian healthcare system is in need of additional resources and support to appropriately serve our community.

The California based Indian Health Center of Santa Clara Valley, along with Urban Indian Health Programs nationwide, report rising cost including increased personnel and sanitation costs of serving the growing number of relatives seeking care. Many programs are holding vaccination clinics along with mass vaccination sites. A mass vaccination site requires 25-30 people to be effective, which requires diverting staff from their normal duties and hiring temporary staff which can be cost prohibitive. Urban Indian Health Programs that do not provide direct clinical care, such as Lifelines of Boston and Baltimore, have found themselves struggling to find partners to host vaccination clinics for their American Indian and Alaska Native clients. The urban Indian provider in Great Falls, Montana has seen an influx of patients who tried to access the vaccine elsewhere and despite being eligible under the state distribution guidelines were told “go to the Indian clinic.” Indian Health Care Providers are making decisions every day on what services to prioritize recognizing that with the scarce funding and resources, they will not be able to provide all the services our community needs.

This is not a new issue for the Indian healthcare system. In a 2009 report to Congress, IHS identified 17 urban areas that would benefit from and Urban Indian Health Program.[5] In 2017, UIHI expanded their service population to reach 62 urban Indian organizations nationwide. Among the 17 IHS-identified cities with high American Indian and Alaska Native populations, many have strong local support and active efforts to develop health care programs for urban Natives. The report also recommended increasing funding to grantees for satellite expansion sites, new partnerships with community health centers, and identifying local providers to serve

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[4] Painter EM, Ussery, EN, Patal A, et al. Demographic Characteristics of Persons Vaccinated During the First Month of the COVID-19 Vaccination Program –United States, December 14, 2020-January 14, 2021. MMWR Morb Mortal Wkly Rep 2021; 70;174-177. DOI: http://dx.doi.org/10.15585/mmwr.mm7005e1

[5] U.S Department of Health and Human Services Indian Health Service. New Needs Assessment of the Urban Indian Health Program and the Communities it Serves. Accessed March 2021. Retrieved from: https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/ReportToCongressUrbanNeedsAssessment.pdf.

the needs of urban Native people. We know that the current health needs of urban Natives are not being met, despite the mounting evidence that increased Urban Indian Health Program facilities would benefit the health status of American Indian and Alaska Native nationwide.

Tribal partners are also calling out the concern for our urban dwelling relatives who do not have access to the Indian healthcare system. In February 2021, the National Indian Health Board passed Resolution 21-01[6] requesting the Department of Health of Human Services and IHS to implement COVID-19 vaccination clinics in the Washington, D.C. Metropolitan Area and prioritize American Indian and Alaska Native people in the 17 cities identified in the 2009 IHS report. This call for an equitable distribution model that prioritizes high-risk communities should be reproduced throughout local health jurisdictions to support Indigenous, Black, and communities of color who disproportionately experience negative impacts of COVID-19.

In addition to addressing gaps in provider access, Indian Health Care Providers are in need of additional vaccine access. As the Biden Administration has implemented its initiative to distribute the vaccine directly through Community Health Centers, we have seen only a fraction of Indian Health Care Providers represented. Of the 250 Community Health Centers invited thus far, ten were Urban Indian Health Programs and sixteen were Tribal health programs. It is urgent to supply more Indian Health Care Providers and Community Health Centers with additional access to the vaccine. As seen in Alaska, who represents eleven of the sixteen tribal facilities receiving vaccines through this initiative, additional access to the vaccine has amplified the success of Alaska Native health providers to reach their priority groups. Currently, 28% of Alaskan residents have received a first dose of the vaccine—higher than the national average. Alaska is now encouraging other states to do the same: invest in protecting our most impacted communities, enlist entrusted members of the communities to educate, and adapt to the health care needs of local residents.

Impacts to Maternal and Child Health

As our nation moves towards addressing COVID-19, we must simultaneously work toward improving healthcare systems impacted by COVID-19. COVID-19 has also disrupted routine care in the healthcare system for child immunizations.[7] In Washington State, the Department of Health (DOH) reported a drop in immunization rates among children during the COVID-19 pandemic, as well as a drop in vaccines ordered by providers. During the pandemic, DOH reported that thus far, 30% fewer vaccines were given in 2020, compared to the year before.[8]

At SIHB, we have seen a 13% drop in our relatives seeking prenatal care and a 38% decrease in relatives seeking pediatric immunizations. We are hearing similar stories across the nation as

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[6] National Indian Health Board Resolution 21-01: Promoting and Prioritizing AI/Ans in the DC Metropolitan Area for the COVID-19 Vaccine. February 2021. National Indian Health Board. Retrieved from: https://www.nihb.org/docs/03012021/21-01_NIHB%20Resolution%20Prioritizing%20Vaccines%20for%20AIANs%20in%20DC.pdf.

[7] Sanoli JM, Lindley MC, DeSilva MC, et al. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration – United States, 2020. MMWR Morb Mortality Wkly Rep 2020; 69:591-593. DOI: http://dx.doi.org/10.15585/mmwr.mm6919e2.

[8] Washington State Department of Health. May 2020. Drop in vaccination leaves children vulnerable to other diseases. Accessed March 2021. Retrieved from: https://www.doh.wa.gov/Newsroom/Articles/ID/1161/Drop-in-vaccination-leaves-children-vulnerable-to-other-diseases.

birthing people express fears related to exposing themselves and their child to COVID-19. Responding to this crisis requires safe environments to be created such as dedicated pediatric clinics that are family-friendly and COVID-19 safe. However, with already over-stressed systems, many clinics do not have the resources needed to rapidly adapt and respond without impacting other essential programs. There needs to be additional support efforts to stabilize prenatal and child immunization healthcare systems among Native communities who most impacted by maternal and infant health disparities.

Increase in Domestic Violence, Gender Based Violence and Missing and Murdered Indigenous Women and Girls

Studies have shown one in three Native women will experience violence in their lifetime, a much higher rate as compared to the general population. In a soon to be released survey, UIHI assessed the impact of COVID-19 on Native female identifying sexual assault survivors. We found that 20% of the respondents were experiencing an increased lack of physical safety due primarily to domestic violence. Another national study found, 40% of rape crisis centers have seen an increase in demand for services since COVID-19, with over 534 of these organizations requesting $100 million in emergency stimulus funding to provide support and emergency assistance to survivors.[9] These finding echo what many advocates have been sharing, that there is a national increase in violence as COVID-19 continues to increase stress on every American. For those unable to leave, they are now quarantine with their abusers increasing the likelihood of more violence. This violence impacts the entire family and children who are not yet in school, are now experiencing violence they would normally escape while attending in person schooling.

In UIHI's groundbreaking report on Missing and Murdered Indigenous Women and Girls, we found that there is an ongoing crisis. And now we are seeing the crisis increase as rates of violence go up nationwide. Over the course of the pandemic there have been horrific murders and numerous Indigenous women and girls who have gone missing. One leading organization reports they have seen a spike in requests for assistance to find missing people and increased need for support services to families of murder victims. Many of these essential support services are provided by county, tribal, and non-profit organizations with support from Violence Against Women Act (VAWA) funds. These funds have allowed these providers to continue and expand essential services to victims of violence while allowing for culturally specific services for tribes and Native organizations. In UIHI's recent survey of sexual assault survivors, 90% asked for culturally specific services citing their struggles with non-Indigenous methodologies for healing highlighting the need for continuing to allocate funds for culturally attuned programs and services.

[9] National Alliance to End Sexual Violence. April 6, 2020. Responding to COVID-19: Rape Crisis Center & Survivor Needs. Retrieved from: https://documentcloud.adobe.com/link/track?uri=urn:aaid:scds:US:1d3534ee-960e-4f94-96dd-8196d2017c90#pageNum=1.

National Institutes of Health Research

The National Institutes of Health (NIH) has been working to quickly roll out research initiatives to address and understand the disproportionate impacts of COVID-19. However, we continue to see under enrollment of Native people in clinical trials for COVID-19 vaccines and treatments nationwide. This lack of diversity in the clinical trials continues to increase hesitancy and has been used by anti-vaccination advocates to push misinformation into Native communities. Recently UIHI responded swiftly to misinformation targeting Native people nationwide that was misinterpreting clinical trial data that was resulting in increased vaccine hesitancy. The impact of lack of Native people in the clinical trials is having, and will continue to have, tangible impacts.

Current NIH initiatives also are often not inclusive of urban Indian populations, despite 71% of all Native people living in urban settings. We do not advocate for taking away funding for tribally based research, instead we urge the NIH to increase funding overall with dedicated funds for research on health disparities for urban Indian populations.

The Expense of Not Leading with Equity

In July, the average cost for COVID-19 inpatient care ranged $51,000-$78,000 depending on age, with younger people paying the most.[10] In 2020, it is expected that COVID-19 related hospitalizations cost will range from $9.6 billion to $16.9 billion with Medicare expected to pay $3.5 billion to $6.2 billion.[11] As the mounting costs of preventing, preparing, and responding to COVID-19 totals, we must look to equity as the fastest solution to ending this pandemic.

With over a year of devasting economic impacts to individuals, industries, and governments, the vaccine has been a sign of hope for many. Yet, inequity in vaccine distribution threatens to increase costs and slow our national recovery. While many policy makers are committed to mass vaccination in short time periods, it is becoming increasingly clear that our most resourced community members are among the first to access the vaccine.

According to the CDC,[5] in December 2020, the Moderna and Pfizer vaccines were distributed to health care personnel and long-term facility residents. However, available demographic data shows of people vaccinated, 63% were women, 55% were 50 and older, and 60% were non-Hispanic White while 39% of those vaccinated were represented racial and ethnic minorities.[4] Of the racial and ethnic minorities vaccinated, 11% were Hispanic/Latino, 5% were Black, .3% were Pacific Islander, and 2% were American Indian and Alaska Native. However, of the data collected on individuals vaccinated, race/ethnicity was unknown or not reported for 48% or people. This first report of vaccine distribution reveals vaccine distribution is inequitable and not

[10] Mallory Hackett. November 5, 2020. Average cost of hospital care for COVID-19 ranges from $51,000 to $78,000 based on age. Healthcare Finance. Accessed 2021. Retrieved from: https://www.healthcarefinancenews.com/news/average-cost-hospital-care-covid-19-ranges-51000-78000-based-age#:~:text=In%20July%2C%20the%20report%20showed,23%20to%2030%20age%20bracket.

[11] Sloan, Chirs., Markware, Nathan., Young, Joanna., Frieder, Miryam., Grady, Lance., Rosacker, Neil., Vidulich.. June 19, 2020. COVID-19 Hospitalizations Projected to Cost up to $17 B in US in 2020. Avalere. Accessed 2021. Retrieved from: https://avalere.com/insights/covid-19-hospitalizations-projected-to-cost-up-to-17b-in-us-in-2020

going to our most marginalized communities most impacted by COVID-19. Vaccination programs must plan for distribution to priority groups at highest risk for infection, hospitalization, and mortality.

We will not end this pandemic by vaccinating the privileged masses that can afford to shelter in place. The Seattle Indian Health Board recently had an incidence, where well-resourced people showed up at our clinic because they had the privilege of language access, technology access, and transportation access. They were capable of social distancing, capable of accessing healthcare systems, and could wait to access the vaccine through their primary care provider, but they didn't. They swarmed our urban Indian clinic and demanded access to the vaccine. However, we did not comply with their demands. Instead we continue to prioritize those most at risk for morbidity and mortality as we apply an equitable approach to vaccine access.

We must be prioritizing people more likely to work in high risk settings, living in congregate and multi-generational settings, experiencing high rates of co-morbidities that increase COVID-19 risk and associated healthcare costs, and at risk for mortality. Leading with equity in our national vaccine distribution strategy is essential to reducing the number of hospitalizations, inpatient length of stay in hospitals, and associated costs to the healthcare system. Vaccine distribution can't just be about how many arms we inject, it has to be an equity-based decision that acknowledges it's about whose arm receives the injection.

Centering Communities Most Impacted Drives Equitable Success
Despite our nation's on-going challenges with data, tribal and urban Indian communities continue to demonstrate that culturally attuned and community-driven approaches are essential to reaching our most impacted communities. As our nation moves towards addressing data challenges, we must simultaneously resource and amplify the work of our trusted messengers and community organizations. To take a lesson from Indigenous communities, we must ensure trusted messengers are included in the creation and distribution of COVID-19 vaccine programs and outreach.

Throughout the pandemic, UIHI has disseminated culturally attuned through fact sheets, reports, and a COVID-19 Vaccine Poster series to address vaccine hesitancy in the Native community. A recent study from the UIHI, and to date the only national study conducted, reinforced what we already knew. Seventy-four percent of American Indian and Alaska Native people surveyed were willing to get vaccinated because of their cultural responsibility to protect Elders and next generation. These are the teachings the Elders instilled in us — our responsibility is to our community. This Indigenous knowledge is also a public health understanding that can increase adherence to COVID-19 safety measures, including masking, social distancing and vaccinations.

In December 2020, SIHB was the first organization in Washington to receive a shipment of the

Moderna vaccine[12] and since has vaccinated over 3,900 people in our community. In phase one, we vaccinated our health care providers and partners organizations that serve the local urban Native community. We are now in Phase 2, where we vaccinate American Indian and Alaska Native Elders and all people age 50 and older. Our vaccination plan is a model for a community-centered approach where we value those who are on the frontlines of addressing the pandemic, protecting our culture keepers, and ensure our intergenerational households are safe.

As an Indian Health Care Provider, we have been able to exercise sovereignty alongside our tribal partners in the Indian Healthcare System to respond to the needs of our community. While other vaccine distributors were forced to adhere to strict guidance from state and local governments, we have demonstrated that culturally attuned and community-driven approaches have meaningful impact. However, this provision of care has come with significant costs that are not covered by the federal reimbursement for the vaccine. Urban Indian and tribal programs providing vaccines have experienced an influx of American Indian and Alaska Native people nationwide who are not normally patients of record at our facilities. While we welcome all our relatives, including IHS beneficiaries, the chronic underfunding of our Indian healthcare system is again becoming evident. To adequately reach the American Indian and Alaska Native population in our current system, our state and local health jurisdictions must prioritize American Indian and Alaska Native people who experience higher rates of co-morbidities that worsen the impacts of COVID-19.

Tribal and urban Indian communities continue to demonstrate a culturally attuned and community-driven vaccine distribution model is essential to reaching our most impacted communities. In Washington State, Muckleshoot Indian Tribe, Lummi Nation, Suquamish Tribe, and Seattle Indian Health Board have demonstrated our commitment to ensuring Native elders and healthcare providers are fully vaccinated and are now moving toward vaccinating teachers to support the re-opening of schools.[13] Nationally, the Blackfeet Nation has vaccinated 95% of eligible residents.[14] Navajo Nation, who was impacted heavily by COVID-19 is now reporting 70% of its citizens are vaccinated administering over 120,000 doses to its community members.[15,16] Cherokee Nation has recently opened its COVID-19 vaccine distribution to its 14-county area for both Native and non-Native residents.[17] The Bay Mills Indian Community in Michigan has vaccinated over 1,300 adult tribal members who live in their service region,[18] and

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[12] Sandi Doughton. December 21, 2020. Moderna Vaccine Arrives in Seattle, with more coming later this week. The Seattle Times. Accessed 2021. Retrieved from: https://www.seattletimes.com/subscribe/signup-offers/?pw=redirect&subsource=paywall&return=https://www.seattletimes.com/seattle-news/health/moderna-vaccine-arrives-in-seattle-with-more-coming-later-this-week/.

[13] Hellmann, Melissa. February 2021. How a Native American COVID-19 vaccine rollout is a model for community-centered approaches. Seattle Times. Retrieved from: https://www.seattletimes.com/seattle-news/health/we-take-it-for-our-community-how-a-native-american-survey-and-vaccine-rollout-models-a-community-centered-approach/.

[14] Franz, Justin. March 2021. Blackfeet Tribe reopens border with Glacier. Montana Free Press. Retrieved from: https://montanafreepress.org/2021/03/17/blackfeet-tribe-reopens-border-with-glacier/.

[15] Healy, Jack. March 2021. Plenty of Vaccines, but Not Enough Arms: A Warning Sign in Cherokee Nation. New York Times. Retrieved from: https://www.nytimes.com/2021/03/16/us/vaccines-covid-cherokee-native-americans.html.

[16] Newton, Creede. February 2021. Navajo Nation forecasts 'community immunity': 120,000 jabs given. Aljazeera. Retrieved from: https://www.aljazeera.com/news/2021/2/26/navajo-nation-sees-community-immunitycoming-120k-jabs-given.

[17] Tulsa World. March 2021. Cherokee Nation opens vaccine to public living in 14-county area. Retrieved from https://tulsaworld.com/news/local/cherokee-nation-opens-vaccine-to-public-living-in-14-county-area/article_63891098-8124-11eb-a6bd-c3f6eeb8bd94.html.

[18] Steeno, Paul. February 2021. Bay Mills: Nearly 700 community members have received one dose of COVID vaccine. Up North Live ABC. Retrieved from: https://upnorthlive.com/news/local/bay-mills-nearly-700-community-members-have-received-one-dose-of-covid-vaccine.

remote villages in Alaska are reporting vaccination rates of 50-60% of adult village occupants.[19] Indian Country is proving the exercise of our sovereignty rights create equitable vaccine distribution that is attainable and successful for the benefit of our service population and surrounding communities.

We are encouraged by the allocation of $6.1 billion in COVID-19 resources authorized under the American Rescue Plan Act of 2021 to IHS. It will be necessary for IHS to make short- and long-term plans for these dollars, however this cannot be seen as a one-time investment. Since its inception, the IHS has suffered from chronic underfunding and systematic issues that have resulted in poor health outcomes for Native people. It will take continued financial support and systematic change across the federal agencies if we are ever to see the health care system required under the federal governments treaty and trust responsibility.

Nationwide, we must demand more accurate racial and ethnic demographic data collection, reporting, and analysis. We must identify gaps in service delivery and ensure the health disparities experienced by our Indigenous communities do not worsen as our healthcare systems adapt and respond to COVID-19. We must resource and amplify the work of our most impacted communities and trusted messengers. We must lead with racial equity to reach low-income, communities of color, and those most impacted by the virus. We cannot end the pandemic or re-stabilize our healthcare systems impacted by COVID-19 without equitable distribution of resources that advance health equity.

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[19] Andrew, Scott. March 2021. Rural Alaska is getting COVID-19 vaccinations right. Here's what the rest of the US can learn. CNN. Retrieved from: https://www.cnn.com/2021/03/09/us/alaska-covid-19-vaccine-success-trnd/index.html.