



Supporting American Indian & Alaskan Native Communities Combating COVID-19



Understanding Data Gaps, Needs and
Strategies
2020

Introduction

Racial inequities and health and socioeconomic disparities between American Indian/Alaskan Native (AI/AN) people and the U.S. non-Hispanic white population have harmed tribal communities for many generations. The seriousness and depth of longstanding public health problems have been brought into sharp focus with the onset of the COVID-19 pandemic. Increases in funding and improvements in data collection, information sharing, infrastructure, and culturally responsive health-care services are urgently needed to eliminate these inequities across rural and urban tribal communities in the U.S.

In August 2020, eHealth Initiative Foundation (eHI) and Philips hosted a virtual Roundtable meeting, titled Supporting Native American Communities Combating the COVID-19 Pandemic.

The purpose of the meeting was to explore the impact of the novel coronavirus (COVID-19) on rural and urban American Indian and Alaskan Native (AI/AN) populations throughout the United States; enumerate the social determinants of health (SDOH) and other factors driving disparities in COVID-19 infection rates, treatment, prevention, testing, contact tracing and secondary behavioral health issues across the country's diverse tribal communities; and gather insights regarding the resources needed to enable AI/AN communities to more effectively reduce infection rates and gain access to services.

The meeting was organized to provide a starting point for the development of programs and materials – beginning with this issue brief – to raise awareness among healthcare professionals of the daunting challenges facing tribal populations related to COVID-19, and to help the healthcare sector work more closely with tribal leaders and citizens, advocacy groups, public health experts, and government agencies in responding to the needs of AI/AN communities.

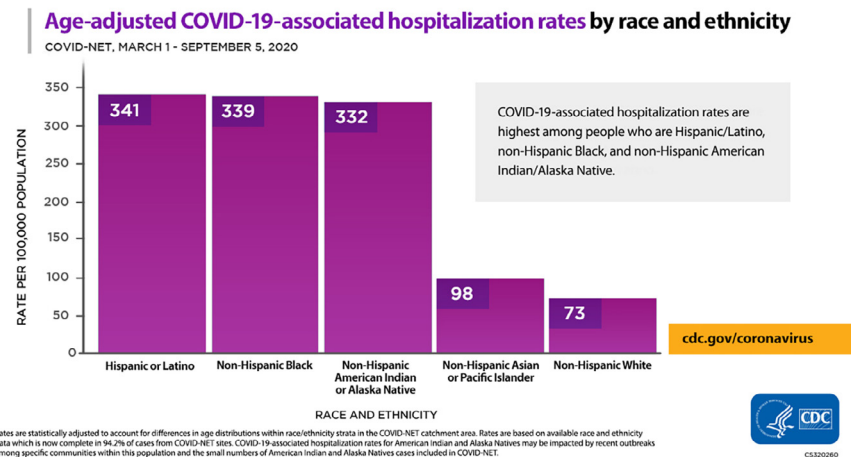
Roundtable participants included experts and leaders in AI/AN health, tribal culture and economics from the government, non-profit, and academic sectors (see Appendix for a full participant list). eHI plans to convene future Roundtables and to collaborate further with AI/AN organizations to develop additional resources to expand the learning and support initiated by this meeting; explore more fully some of the most pressing needs and issues identified; and generate a framework that can be used for COVID-19-related advocacy and information-sharing in support of AI/AN communities.



SDOH and Drivers of Disparities in AI/AN Communities

Perhaps more than any other event in modern U.S. history, the COVID-19 pandemic has exposed the striking economic and healthcare inequities that affect Blacks, Latinx, and AI/AN, as well as other vulnerable and underserved populations, including immigrants, individuals in correctional facilities, and homeless and disabled individuals.

These groups, AI/ANs included, have been disproportionately hurt by the pandemic. Data show that in 23 states with adequate race/ethnicity data, the cumulative incidence of laboratory-confirmed COVID-19 among AI/AN persons was 3.5 times that among non-Hispanic white persons.¹



A study published in the Journal of Public Health Management and Practice (July/August 2020), cited during the Roundtable, underscores the impact of social determinants on COVID-19 infection rates, indicating that the disease is more likely to occur in AI/AN communities lacking indoor plumbing and access to potable water, and where English is not the primary spoken language. The authors conclude that “funding investments in tribal public health and household infrastructure, as delineated in treaties and other agreements, are necessary to protect American Indian Communities.”²

As one Roundtable speaker succinctly described it, “for Native Americans, COVID-19 has added stress to an already stressed situation.” Long before the pandemic, that situation was characterized by higher rates of economic poverty; food insecurity; chronic disease and behavioral health issues; unemployment; reduced or no health insurance coverage; limited access to medical care and preventive services; geographic rurality and remoteness; lack of basic infrastructure, including running water, electricity and broadband connectivity; and social isolation.

“We know that diabetes, respiratory infections and coronary heart disease are large risk factors for coronavirus, and we have high rates of those. That is a huge concern. And that is one of the reasons we know that there is going to be more vulnerability [among AI/ANs].”

Francys Crevier, National Council on Urban Indian Health

The pandemic has only intensified many of the economic, social, and public health problems that have long plagued tribal lands and urban and suburban AI/AN people. Among the key data points shared during the Roundtable, were the following:

- AI/AN people are three times as likely as non-Hispanic whites to have diabetes,⁵ more than 1.5 times as likely to have been hospitalized for respiratory infections in the past,⁶ and more than 1.5 times as likely to have coronary heart disease.⁷ The Centers for Disease Control and Prevention (CDC) has identified these conditions as specific risk factors for more serious illness due to COVID-19.³

- In May 2020, the COVID-19 infection rate in the Navajo Nation surpassed that of New York City.⁴

- According to state rate data compiled by the Johns Hopkins Center for American Indian Health for June 2020, five tribal nations (the White Mountain Apache, Pueblo of Zia, Pueblo of San Felipe, Navajo Nation and Kewa Pueblo) had higher rates of COVID-19 cases per 100,000 people than New York State, which had the highest number of cases in the U.S.⁵

- Though Native Americans make up only 10% of the total population of New Mexico, they represent 55% of the state's COVID-19 cases. In Wyoming, tribal people represent 34% of COVID-19 cases but only 2.9% of the population. Similar disparities are shown in Montana, where tribal people represent 12% of COVID-19 cases but only 6% of the population.⁶

- The pandemic has had a tremendously negative impact on tribal economies. Unlike states and local governments, tribes lack traditional tax bases and depend entirely on business enterprises and government revenues. The abrupt shutdown of 245 tribal casinos necessitated by the pandemic produced an immediate shock to the economy that has devastated tribal governments. In 2019, tribal gaming enterprises alone contributed \$17.7B in taxes to federal, state, and local governments. These businesses contributed 1.1 million jobs to the economy, of which 915,000 were held by non-Indians.⁷ As a result, the impact on tribal economies due to casino shutdowns has had a cascading impact on non-tribal citizens as well.



Government Support During the Pandemic: The Work of the Indian Health Service (IHS)

IHS Emergency Response

As the federal agency responsible for providing health services to AI/ANs, the Indian Health Service (IHS) responded to these challenges with focused resources and expertise. For example, a newly established critical response team of expert physicians, nurses, and respiratory therapists has been providing urgent, life-saving medical care to patients admitted to IHS or tribal hospitals on an as-needed basis. The team, which can be mobilized on 24 to 48 hours' notice, also provides hands-on clinical education to healthcare professionals while treating patients.

In addition, as of August 2020, IHS had distributed 470 rapid-ID COVID-19 test analyzers and 400,000 test kits to 342 tribal and urban service locations and performed 615,960 COVID-19 tests, which equates to 37 percent of the IHS user population. It is also in the process of distributing 20,000 vials of

the therapeutic drug remdesivir to 44 tribal and IHS facilities across the U.S. and an additional 6,400 vials from the Veterans Administration (VA) for treatment of AI/AN veterans.⁸

Whenever deploying resources or engaging with tribes, IHS has a general policy to always defer to tribal leadership. During the pandemic, IHS has continued to follow its established policy of consulting with tribes. (According to the policy, “consultation occurs when there is a critical event that may impact tribes, new or revised policies or programs are proposed, or the IHS budget request and annual performance plan are being developed.”) IHS has implemented a process of rapid consultations with tribes during COVID-19 to expedite the delivery of federal funds to the front lines.



“We were able to respond quite well because we could shift resources in ways that other institutions probably couldn’t. I could take my clinical staff who were no longer seeing patients in the height of the outbreak and shift them to field work because there were no patients coming to clinics or we were doing mostly telehealth. That was phenomenal flexibility, and it worked well for us.”

James B. McAuley, White River Indian Hospital

In making decisions, IHS relies on clinical data revealing the most heavily impacted areas, including the Pacific Northwest and the Southwest (Navajo and White River tribes). Input from tribal leaders has informed IHS decisions regarding allocation of funds appropriated through the Coronavirus Aid, Relief, and Economic Security (CARES) Act for discrete areas, such as telehealth and safe water sanitation projects, to ensure that funds are channeled to the areas of greatest need.

Throughout the pandemic, the IHS has focused on maximizing its capacity to treat patients with the most severe cases of COVID-19 while minimizing the risk of exposure among citizens and conserving supplies. To that end, the agency has encouraged the use of healthcare visits by phone and other forms of telehealth. As a result of the federal expansion of allowable telehealth services during the pandemic, IHS has seen a 10-fold increase in telehealth service use by tribal communities, including tele-mental health visits, as well as the increased use of telehealth specialty consultations for critical care.⁹

With these combined efforts, overall positivity in the AI/AN population has fallen to 3.9 percent, which is less than the rate for the U.S. (all races). However, this rate combines the COVID-19 rates of areas in which positivity has been as low as 0.9 percent (areas of Alaska), and others in which positivity has been as high as 16 percent (Navajo Nation and Phoenix).¹⁰

IHS has been working closely with the CDC, which is leading contact tracing education and providing specific technical assistance to tribes on data collection and public health outreach.

Vaccine Trials in AI/AN Populations

Members of the AI/AN community are participating in two trials of COVID-19 therapeutics, and academic medical centers are actively reaching out to tribal populations to solicit their participation in additional trials. However, increasing minority representation in COVID-19 vaccine trials is a significant concern within the Department of Health and Human Services (HHS).

IHS has advised HHS to collaborate with such organizations as the National Indian Health Board, the National Congress of American Indians, and the National Council of Urban Indian Health on strategy once a vaccine is approved, including messaging and distribution planning. The Office of the Assistant Secretary for Public Affairs (ASPA) will lead the organization of focus groups in Indian Country and the development of a communication plan to address concerns about the vaccine among native citizens. IHS recommends that it, rather than the states, manage distribution of a vaccine directly to tribes because of the wide variability in relationships between tribes and their states across Indian Country.

Gaps and Needs in Pandemic-Related Services

Roundtable participants spoke about the gaps, challenges, and unique needs of the AI/AN population for services and resources related to COVID-19. Following is a distillation of some of the key issues raised.



1 Infrastructure to Support Virtual Care

Lack of infrastructure, underfunding, and the remoteness of many AI/AN communities make the delivery of healthcare in tribal lands particularly challenging. Those challenges grew with the rapid response required by the pandemic.

Although telehealth shows promise for the more efficient and effective delivery of healthcare services across tribal lands, the lack of broadband connectivity in many communities hinders widespread implementation of these services. HHS and other federal agencies are collaborating to implement a strategy to improve infrastructure and expand access to telehealth in AI/AN communities. These expansions will build on the telehealth work begun by the Centers for Medicare and Medicaid Services (CMS) during the pandemic to more than double telehealth services across tribal communities.

2 Pandemic Revealed Historical Underfunding of AI/AN Healthcare

AI/AN people have historically been plagued by insufficient resources for the provision of healthcare services. Pre-pandemic data on annual expenditures for healthcare goods and services, public health activities, government administration, the net cost of health insurance and investment related to healthcare reveal deep disparities in healthcare expenditures between the general U.S. population and AI/ANs that have fueled a continuing public health crisis within tribal communities. The national average per-person healthcare expenditure for the U.S. population as a whole is

\$11,172 per person,¹¹ which stands in stark contrast to the \$4,087 per person spent for AI/ANs through IHS programs (almost two-thirds less)¹² and an estimated \$600 per person through Urban Indian Organizations (UIOs), as discussed in greater detail below.¹³

These challenges only grew with the onset of the pandemic. As with the rest of the U.S., the necessity for social distancing and isolation during the pandemic drastically reduced the number of non-essential patient visits at IHS facilities. Although adherence to these safety practices has helped flatten the infection rate curve, it has also had the unintended consequence of significantly decreasing third-party collections for Medicare, Medicaid, and private insurance, sharply reducing the IHS's already stretched revenue stream.

The CARES Act allocated \$8 billion in financial assistance to tribal governments for COVID-19 relief.¹⁴ However, delivery of the funds was delayed for months due to a lawsuit over whether Alaska Native Corporations (ANCs) were eligible to share in the relief aid. ANCs are for-profit corporations organized under state law and owned by shareholders, including non-Indians. In late June, a U.S. District Court judge in Washington, D.C. ruled that the ANCs were tribes, and, as such, were eligible to receive part of the \$8 billion in relief funds.¹⁵ But the prolonged delays in delivery of the funds have taken a toll on tribal communities as the coronavirus has spread.

3 Underfunding of Urban Areas

One of the biggest deficits affecting the AI/AN population, which has become even more pronounced during the pandemic, is the marked gap in federal funding and services for AI/AN people in urban areas as compared with rural areas.

Though AI/AN people are often perceived as living primarily in remote rural areas, this is not the case. More than 70% of the 5.2 million AI/ANs live in urban and suburban communities. Health and social services are provided to these citizens through a structure of 41 UIOs in 22 states via 74 health facilities that have current contracts with the IHS through the Title V Indian Health Care Improvement Act.¹⁶ UIOs are non-profit corporate bodies governed by an urban AI/AN-controlled board of directors, which provides for the maximum participation of all interested AI/AN groups and individuals.



Despite the relatively large size of the urban AI/AN population, UIOs represent only 1% of the IHS budget. As a result, UIOs do not have access to many of the critical programs available to other tribal communities and organizations. For example, UIOs will not be the recipients of future federally funded infrastructure improvements in tribal lands.

4 Data Quality and Access to Tribal-Level Information

Problems with data collection and data quality often lead to negative consequences for AI/AN populations, including underfunding of health and social services, and these problems have only been exacerbated by the pandemic.

In addition, the fact that federal data cannot be disaggregated at the tribal level makes it difficult for diverse tribal communities to make informed decisions that accurately reflect

the unique needs of their members due to the pandemic in terms of infection rates, age of the population, types and quantities of resources needed and other factors. Lack of access to reliable and comprehensive data limits the ability to make policy decisions and allocate funding for much-needed resources. These data issues open tribes, once again, to underfunding during and after the pandemic—underfunding that can hinder health, social and economic recovery.

Many data-related issues revolve around the challenges of simply being counted as Native Americans. For example:

- Roundtable participants reported that AI/AN patients often have difficulty being counted accurately as a Native American by healthcare providers, who, left to their own devices, will often indicate an AI/AN patient's race as "White" rather than Native American. This skews demographic data and results in undercounting of AI/ANs.
- The CDC and other agencies often count AI/ANs as "other" rather than as "Native American" because of the relatively small population size. This makes it difficult if not impossible for tribes to obtain accurate information on the impact of COVID-19 on their populations. In addition, people who are both AI/AN and Hispanic are often counted as Hispanic.

As a result, AI/ANs are often completely "invisible" to local governments and, therefore, receive no government-funded resources or assistance. AI/ANs are undercounted approximately 5% more than any other group in U.S. Census data.¹⁷



"American Indians and Alaskan Natives are often misidentified or under counted in various vital statistical records. It's critical that we sort that puzzle out to be able to get good information to help tribal leaders make informed decisions. It's also critical to have [COVID-19] information and messaging in linguistically and culturally relevant ways so that people receive the message on the ground."

Megan Minoka Hill, Harvard Project on American Indian Economic Development

Understaffing

One Roundtable participant spoke of the problem of understaffing in the healthcare system in Navajo Nation, a territory occupying portions of Utah, Arizona, and New Mexico and one of the tribal areas most deeply affected by COVID-19. The pandemic has only heightened the struggles of caring for people in an environment of extreme rurality and long distances between IHS facilities and homes.

Among the regional IHS's biggest gaps is the current understaffing of its community public health workforce. Although Doctors Without Borders, the Johns Hopkins Center for American Indian Health, and a cadre of 500 volunteers have provided temporary support with community outreach, a lean but formidable public health team shoulders the bulk of the responsibility.

Despite its small size, the team monitors gating criteria (data-driven criteria that individual states—in this case, reservations—should meet before proceeding to a phased opening) and other indicators weekly to advise the Navajo Nation President on the tightening or loosening of community restrictions and has established a system with strict triggers for an aggressive response in the event of any COVID-19-rate rebounds or outbreaks.

IHS built a team of 300 contact tracers at the height of the pandemic that reached all 12,000 cases in the Navajo Nation. The current team continues to closely monitor contact tracing turnaround times and other measures of contact tracing effectiveness as key indicators.



6 Cultural Literacy and Elders

Tribal communities in rural areas face the logistical challenge of delivering meals and services to their vulnerable elders and finding ways to help these citizens combat loneliness and social isolation during the pandemic.

Roundtable participants also pointed to a need for cultural literacy training for healthcare professionals and caregivers in caring for AI/ANs with COVID-19. Challenges arise when more severely ill tribe members must be transferred to tertiary care and other facilities off the reservation for inpatient care, far from their communities and loved ones. Often, healthcare professionals and caregivers at these facilities do not have the cultural literacy and cultural competence to provide culturally congruent care, leaving tribal members, often elders, without the comfort and support of their own community and traditions during a frightening and difficult time. Some of these cultural issues may also involve elements of historical trauma (see below).



7 Behavioral Health Needs and Historical Trauma

Behavioral health issues, most notably substance abuse and suicide, which are already more prevalent among AI/ANs than the U.S. population overall, have risen during the pandemic.

In Navajo Nation, the public health team has offered a series of eight virtual training sessions to train staff and citizens throughout the reservation in recognizing signs and symptoms of suicidal ideation and major depression and then implementing appropriate intervention strategies. These trainings arose from significant concerns regarding the mental health condition of patients and community members during the pandemic.

An understanding of behavioral issues among AI/ANs benefits from an understanding of the concept of historical trauma. According to Maria Yellow Horse Brave Heart, Ph.D., associate professor of psychiatry and behavioral sciences and director of Native American & Disparities Research at the University of New Mexico, historical trauma may be defined as “the cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma.”¹⁸

For example, a survey of Native Americans who were generations removed from many of the traumas experienced by their ancestors found that “36% had daily thoughts about the loss of traditional language in their community and 34% experienced daily thoughts about the loss of culture. Additionally, 24% reported feeling angry regarding historical losses, and 49% had disturbing thoughts related to these losses. Almost half (46%) of the participants had daily thoughts about

alcohol dependency and its impact on their community. Further, 22% of the respondents indicated they felt discomfort with white people, and 35% were distrustful of the intentions of the dominant white culture due to the historical losses the Native American people had suffered."¹⁹

One Roundtable speaker stressed the need for public health agencies and others to be sensitive to issues of historical trauma in AI/NA communities and to consider these factors in introducing the COVID-19 vaccine in tribal communities by using culturally appropriate ways of reassuring citizens that the vaccine is safe and is not going to harm them.

AI/AN people also are facing significant behavioral health issues due to the loss, necessitated by the pandemic, of some important traditions and burial customs that enable families and individuals to mourn and grieve the loss of loved ones and draw strength from family and friends. IHS's Telebehavioral Health Center of Excellence has developed a virtual webinar series on grief and mourning; however, a need was identified for tribes to address this issue collectively on a larger scale.

8 Respect for Tribal Sovereignty

Participants stressed the crucial importance of governments and organizations that are seeking to work with tribal communities first informing and seeking the input of tribal leaders before proceeding with any efforts related to COVID-19 vaccines or other trials, initiatives, or activities involving their people. This communication is an issue of tribal sovereignty, but also of historical trauma rooted in historic incidents in which AI/ANs were coerced to participate in programs without consent. Soliciting the involvement of advisory groups composed of community members and tribal elders (a high-risk group for COVID-19) would also be beneficial.

A Roundtable participant noted an instance in which a tribal community learned when it was announced at a press conference that it would be participating in a COVID-19 vaccine trial, raising fears at least partly rooted in historical trauma that members of the tribe might be used as test subjects for the vaccine. It turned out that the effort related only to the state government's interest in giving the Native American community a seat at the table to discuss effective vaccine distribution when it became available, not the vaccine trial itself. Nonetheless, for cultural and other reasons, consulting with tribal leadership on matters such as these at the beginning of an initiative, not as an afterthought, is of great importance in working with AI/AN communities.

The participant also reported instances in which tribal communities had taken the initiative to set up checkpoints to protect their tribal members from outside risks during the pandemic, only to be faced with opposition to these measures by state governments.



Strength, Resilience and Community Solidarity

The pandemic has hit AI/AN people hard, and tribal communities tend to be overlooked in the allocation of funding and resources. However, people and communities have banded together to find innovative ways to overcome the challenges and barriers, doing the best that they can with the resources they have.

Roundtable speakers stressed that although the struggles and challenges across tribal lands continue to grow during the pandemic, the resilience, strength, and perseverance of native peoples are to be greatly admired.

The cohesion and solidarity of AI/AN communities throughout the U.S. have shown to be an asset in efforts to reduce the spread of COVID-19 and flatten the curve. Participants praised the willingness and determination of many tribal communities to band together to care for their elders and to follow the recommended safety practices of mask wearing, hand washing, social distancing, and sequestering. One speaker noted that many tribes responded immediately to the pandemic with stay-at-home orders, and were, in some cases, the first governments in the U.S. to do so.

These include efforts by tribal leaders to work with state governments to advocate for improved mass testing in tribal communities; plans to create safe isolation facilities for homeless citizens who must be quarantined; organizing gatherings by car, with car-decorating contests and parking-lot bingo to provide safe social activities for tribal elders; pen pal programs to help elders combat loneliness and isolation; ongoing safe home meal deliveries to seniors by volunteers with informational leaflets for residents on topics such as COVID-19 scams; redeployment of community health representatives to serve as contact tracers to support mitigation; and volunteer-organized food distribution events at designated distribution sites and home delivery of elder baskets and food to high-risk groups.



Conclusion

COVID-19 has magnified the socioeconomic and healthcare inequities that have beset AI/ANs for generations. Yet, faced with the disproportionate hardships wrought by this pandemic, tribal communities have shown exceptional cohesion, resourcefulness and determination in following recommended public health safety practices to control the spread of infections, putting the welfare of their communities first, and making special efforts to protect their most vulnerable members, including elders and homeless individuals.

Despite this resilience, AI/AN communities continue to face uphill battles during the pandemic stemming from a constellation of factors, including a chronic disease burden that exceeds national averages and increases the risk of severe illness and death due to COVID-19, combined with underfunding of health services; lack of infrastructure, including running water, electricity and broadband connectivity; issues of historical trauma; significant behavioral health concerns; data inaccuracies that under-represent AI/ANs and the pandemic's effect on tribal populations; and problems of access to accurate and high-quality data about individual tribes for crucial decision-making. Further, cultural literacy training is needed to help healthcare professionals provide culturally congruent care to patients who are separated from their communities and loved ones during hospitalization for COVID-19. Also critical is the need for outside organizations and governments interested in working with tribal communities to respect tribal sovereignty by collaborating and consulting from the outset with tribal leaders on programs and initiatives.



Endnotes

- 1 <https://www.cdc.gov/mmwr/volumes/69/wr/mm6934e1.htm>
- 2 Rodriguez-Lonebear, D. American Indian Reservations and COVID-19: Correlates of Early Infection Rates in the Pandemic, *Journal of Public Health Management and Practice*, July/August 2020.
- 3 <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>
- 4 COVID-19 case rate by select tribal nations and states, Johns Hopkins Center for American Indian Health, June 5, 2020.
- 5 *ibid*
- 6 COVID-19 case rate by select tribal nations and states, Johns Hopkins Center for American Indian Health
- 7 <https://news.harvard.edu/gazette/story/2020/05/the-impact-of-covid-19-on-native-american-communities/>
- 8 Weahkee, Michael D. (2020). Supporting Native American Communities – Managing COVID-19 Through Indian Health Services [Presentation] Supporting Native American Communities Combating the COVID-19 Pandemic, Virtual Roundtable, eHealth Initiative Foundation, Washington, D.C., August 25, 2020.
- 9 *ibid*
- 10 Toedt, Michael (2020). Supporting Native American Communities – Managing COVID-19 Through Indian Health Services [Presentation] Supporting Native American Communities Combating the COVID-19 Pandemic, Virtual Roundtable, eHealth Initiative Foundation, Washington, D.C., August 25, 2020.
- 11 <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew,For%20additional%20information%2C%20see%20below.>
- 12 https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/IHSPProfile.pdf
- 13 Crevier, F. (2020) Challenges Facing Native American Communities [Power Point presentation] Supporting Native American Communities Combating the COVID-19 Pandemic, Virtual Roundtable, eHealth Initiative Foundation, Washington, D.C., August 25, 2020.
- 14 <https://www.bia.gov/as-ia/opa/online-press-release/cares-act-provides-critical-assistance-tribal-governments>
- 15 <https://www.indianz.com/News/2020/06/29/judge-covid19-relief-tribes-ancs.asp>
- 16 Crevier, F.
- 17 <https://www.klcc.org/post/native-americans-fear-latest-census-deadline-means-yet-another-undercount>
- 18 https://www.ihs.gov/sites/telebehavioral/themes/responsive2017/display_objects/documents/slides/historicaltrauma/htreturnsacredpath0513.pdf
- 19 Whitbeck, L. B. Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology*, 33(3-4), 119–130, 2004.

About eHealth Initiative & Foundation

eHealth Initiative Foundation (eHI) convenes executives from every stakeholder group in healthcare to discuss, identify and share best practices to transform the delivery of healthcare using technology and innovation. eHI, along with its coalition of members, focuses on education, research, and advocacy to promote the use and sharing of data to improve health care. Our vision is to harmonize new technology and care models in a way that improves population health and consumer experiences. eHI has become a go-to resource for the industry through its eHealth Resource Center. For more information, visit ehidc.org.

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