

Prioritizing Equity video series: COVID-19 & Native Voices in the Field

On the May 21, 2020, Prioritizing Equity webinar, Aletha Maybank, MD, MPH, AMA chief health equity officer, speaks with a panel of leading Native voices on how the COVID-19 pandemic has highlighted the deeply rooted inequities that impact Native communities across the country.

Moderator

Aletha Maybank, MD, MPH, AMA chief health equity officer

Panelists

Mary Owen, MD

Director for the Center of American Indian and Minority Health and assistant professor in the Department of Family Medicine and Biobehavioral Health at the University of Minnesota.

Dr. Owen practices at Fond du Lac Nation clinic in Duluth, Minnesota.

Tlingit Tribe

Donald Warne, MD, MPH

Associate dean of diversity, equity and inclusion as well as the director of the Indians Into Medicine (INMED) and Master of Public Health programs, and professor of family and community medicine at the School of Medicine and Health Sciences at the University of North Dakota.

He also serves as the Senior Policy Advisor to the Great Plains Tribal Chairmen's Health Board in Rapid City, SD.

Dr. Warne is a member of the Oglala Lakota tribe from Pine Ridge, SD and comes from a long line of traditional healers and medicine men.

Oglala Lakota Tribe

Shannon Zullo, MD

Medical Student Section Representative on the AMA Minority Affairs Section Governing Council.

She grew up on the Navajo Nation in Chinle, Arizona, and recently graduated from the University of Arizona College of Medicine. She will begin her residency in internal medicine later this year at the University of North Carolina, Chapel Hill, followed by a dermatology residency at the University of California, San Francisco.

Navajo Tribe

Edgar Villanueva

Chair of the board of directors of Native Americans in Philanthropy and board member of the Andrus Family Fund.

He is a renowned expert in social justice philanthropy.

Lumbee Tribe

Transcript

May 21, 2020

Dr. Maybank: Good evening, everyone. Welcome to the next edition of Prioritizing Equity. My name is Dr. Aletha Maybank, and I am chief health equity officer at the American Medical Association and with the Center for Health Equity. I just want to thank everyone for joining us tonight and thank our wonderful panel. I'm really looking forward to the conversation this evening. Just a few updates in terms of what we're doing at the Center for Health Equity. Just want to remind people that we have our health equity resource center for COVID on the AMA website and we'll make sure we put all of these links in the chat so that you have access to them. Please also feel free to put your questions as they come along too.

Yesterday, just for those who don't know, the AMA hosted a tribute to medical students, the 30,000 or

so who graduated across the country, to really honor their future in the workforce as well as some of their work that they've been doing on the front lines. So please feel free to check that out. We'll also put that as a link. Last week we had a great conversation with Latinx physicians to talk about their experience and what has been happening as it relates to just experience in the front lines but also experience on the policy and advocacy space as well. Next week we will have our next edition, which is going to be the root cause, Prioritizing Equity, and really talking about the impact of racism and it being a fundamental cause of why inequities exist. We have an esteemed panel for that as well.

One more announcement that we will also put as a link. Many of you who are in public health are very familiar with the 10 Essential Public Health Services. It is the 20th anniversary and there has been a taskforce that has been convened to think about how to revise the public health services, which I think is really important at this time. And folks are really starting to understand the value of the public health infrastructure and how it really needs to be supported. So there is an opportunity for comment from the public to comment on these potential revisions that are coming up. We will put the information and link also in the chat box so that you have access to it.

Getting to today's panel, we are here to explore ways in which COVID uniquely impacts Native communities across the country. My experience even just in talking about data and just experience even before this work, I've been in equity work for a while, that Native communities have been rendered invisible over time. Not that they are really invisible, but just rendered invisible. Throughout history, whether it's taking of their land and through mass genocide, but we also know more recently the stories and the data also have been really invisible as well as we've tried to seek out answers and solutions and just better understanding. So we're really grateful for the panelists that are joining us here today to really help make those injustices visible.

I would like to start off, I do this actually in my presentations. This came to my attention. I give land acknowledgements usually when I go to different places across the country when we were able to move about across the country as well as acknowledging our ancestors that were also enslaved. So I definitely want to make sure that we just take the time to acknowledge the land that we are meeting on in our different places and pay respects to indigenous peoples of each of our respective locations who have been thriving for centuries before now. We honor not only the heritage of Native peoples but their continuing efforts to advance Native ways of life and living that we may use our minds in exchange of ideas and understanding and learning here today.

On our panel today we have Dr. Mary Owen. If you could just raise your hand so folks have a sense—they see your name, but if you could just raise your hand, that'd be great, who is director of the Center for American Indian and Minority Health and assistant professor in the Department of Family Medicine and Biobehavioral Health at the University of Minnesota. She is also practicing at the Fond du Lac Nation Clinic in Duluth, Minnesota.

We have Dr. Donald Warne, who we have had, I don't know if it's on this show, but we've definitely

had you on another one of our shows before, who is associate dean of Diversity and Equity and Inclusion as well as the director of the Indians into Medicine, among other titles, at the University of North Dakota. He also serves as senior policy advisor to the Great Plains Tribal Chairmen's Health Board in Rapid City, South Dakota.

We have Dr. Shannon Zullo, Medical Student Section representative on the AMA Minority Affairs Section governing council. She is currently at the University of North Carolina at Chapel Hill as an intern in internal medicine. Then she's going to be starting a dermatology residency this coming year at the University of California San Francisco. So congratulations to you. Very proud of you.

We have Mr. Edgar Villanueva, who is renowned expert in social justice philanthropy. Honestly, I've been following you on social media for a while now, so I'm really happy to have you on the show and hear your expertise. But he currently serves as chair of the Board of Directors of Native Americans in Philanthropy and is a board member of the Andrus Family Fund, a national foundation that works to improve outcomes for vulnerable youth. Thank you all for your time with us today.

I'm going to start off with a question really for all of you, and this is more so just so folks can learn a little bit more about you but also where has your energy and efforts been over the last couple of months. Clearly, that could tie to what you've done before, but would just like you to speak to that and your experience. What are you experiencing as leaders of Native communities to this day? Whomever wants to start is more than welcome to start. I'm going to pick somebody then. I'm going to go with Dr. Zullo. Go ahead, Zullo.

Dr. Zullo: My name is Shannon Zullo. For the folks who are listening from the Navajo Nation, [speaks Navajo]. I am from Chinle, Arizona. On the Navajo Nation we like to introduce ourselves formally so that we know who we are related to and who is family in the conversation, so I just wanted to go ahead and do that. I'm a medical student, or I was a medical student. I just recently graduated from the University of Arizona in Tucson.

This last year I have been incredibly fortunate to serve as a medical student liaison on the Minority Affairs Section Governing Council of the American Medical Association. I have had the honor and the privilege to serve on a wonderful council that uniquely aims to support underrepresented minority physicians and communities such as Native Americans and African Americans and Hispanics. We have been fervently working on back end to try to highlight Native American needs as we've responded to COVID as well as other populations. We've worked very closely with Dr. Maybank and other folks in the AMA in increasing equity. That's what we've been working on.

Then from a personal side, been trying to get ready to move across the country to start my internship at UNC in Chapel Hill.

Dr. Maybank: Yes. Okay, great. We'll come back to that as well. Dr. Warne, do you want to go next?

Dr. Warne: Sure. My name is Donald Warne. I'm Oglala Lakota originally from Pine Ridge, South Dakota. I'm currently working in North Dakota at the University of North Dakota School of Medicine and Health Sciences. Recently, much of our work has been directed toward COVID-19. I wear a number of different hats. In addition to being associate dean and professor of medicine, I'm also the director of the Indians into Medicine or INMED program and director of the public health program at the School of Medicine and Health Sciences. So much of our work both from the medical side and the public health side has now been directed toward COVID-19.

Of course, in a medical school one of our big challenges has been that students can no longer work in the hospital or the clinics until just this past week, so we had to go a couple months without the clinical rotations that we typically do. But on the public health side we've actually been able to partner with the state of North Dakota to hire our master of public health students and other graduate students to be contact tracers. So a lot of our students are actually getting really practical experience and that includes our American Indian graduate students who can work with the tribes and collaborate on doing the contact tracing.

As you know, they talk about the three T's of testing, tracing and treatment. With public health and medicine, we're working along that whole continuum. It's been obviously a lot of work and a lot of stress and a lot of health adversity that we're facing, but it's also, in my little corner of the world, we've had an opportunity to highlight some of the challenges in Indian health and certainly demonstrate the need for an expanded workforce.

Dr. Maybank: Thank you. And Dr. Owen.

Dr. Owen: At the university, my main role is supporting students while also educating the community about Native needs. As Dr. Warne has pointed out, the education piece has been huge. I'm also the incoming president for the Association of American Indian Physicians, and so I've got to play a role in helping our communities understand what's going on and answering questions for our communities mainly as a provider on those calls. Also, trying to help our students, our Native medical students, cope with what's going on and find ways that they can be productive, because they all want to do something. So leading, not leading, actually supporting a taskforce of students to reach out to other youth throughout our communities who we know are dealing with depression and other worse issues.

Oh, and I'm also a clinician one day a week for the Fond du Lac Nation, so I get to see patients, which is a lifeline for me, actually. Keeps me connected. Then working with the University of Minnesota to try to reach out to the 11 tribal nations in Minnesota and find out what needs that are still existing and how we can help meet the needs for them. Minnesota's pretty far ahead as far as its testing and being able to test as many people as possible, but getting that out to our communities isn't—there are lots of different issues, including sovereignty, so trying to negotiate those issues. That's what I've been up to. Thanks.

Dr. Maybank: Thank you. And Mr. Villanueva, how are you? I just also want to frame one of the reasons why I invited you because folks would be like, "But he's not a physician," and that's okay. I'm very big on narrative and the importance of narratives that are pushing away dominant narratives that undermine the opportunity to advance equity. I think you've done a lot of that work in your voice, and so that's one of the reasons why I was really interested in having you on just to explain that context.

Villanueva: Thank you. Hi, everyone. It's an honor to be on. I am Lumbee from North Carolina, so shout out to the Lumbee Tribe and to UNC Chapel Hill where I'm a Tar Heel. So I was glad to hear the university lifted up here. I'm speaking to you tonight from the unseated territory of the Lenape Tribe of New York. I think what I'm bringing to the conversation, I used to work—I was trained in public health, and I ran the North Carolina American Indian Health Board, so I'm used to being a non-physician around a lot of doctors. So I guess it's very comfortable and familiar.

The work that I do is really about, I really like how you framed that, narrative change work, pushing back on myths and misconceptions about Native communities that folks have that are harmful stereotypes often and that invisibility factor that was said at the start of this conversation. I've heard some of my relatives say before that invisibility is like our new genocide because we are not seen in places where decisions are being made about resources or money and investment in our communities, where we're not able to have race-explicit data to really understand the prevalence of disease in our communities. And that data matters when it comes to the allocation of resources.

That's really what I'm focused on is bringing more visibility and shining a light on those disparities that this pandemic has really exposed and organizing resources, money from within the philanthropic sector to support Native-led efforts on the ground to provide emergency resources and relief during this time. Thanks for having me.

Dr. Maybank: Absolutely. Let's build on what you said about the data part, and we'll start there and digging deeper into a conversation. We have been involved in terms of AMA. Many people have been involved and been working on a couple months ago recognizing that there was just no race and ethnicity data that was being presented across the country when they were talking about COVID cases, deaths, hospitalizations, whatever it is. So lots of advocacy efforts to the federal government, federal level, to the CDC and to local health departments as well across the country of the importance of, to your point, we need to see the data. We need to know what's happening in order to know about solutions.

Then there was also just more so from those of us who are in equity space just knowing that the data was going to show something that we were very clear what it was going to show. We knew these inequities were probably going to show up, but we needed to see them. What I've noticed though as we were working on trying to collect and have an understanding of what's happening nationally, especially at the state level on my team, and even if race and ethnicity data are presented, oftentimes Native American data, one, it's nonexistent or it's othered.

I wanted to just have a conversation and hear a little bit more about the impact of being othered in data of people itself, the systems and resources, but even for your own selves in terms of advocacy and how that feels to you. That's my question. This is really an open opportunity where any of you can answer, and all of you can answer if you choose.

Dr. Owen: I'm really—go ahead, Don.

Dr. Warne: No. I was just going to say that is a big challenge because we're not included in all the datasets. I think as a starting point just to understand the datasets that are involved, if you look at Census data, for example, there's over five million self-identified American Indians and Alaska Natives. If you look at Indian Health Service data, there's about two million users. So actually, the majority of American Indians are not using IHS, and they're not captured in that dataset. Then there's other datasets, even some of the national surveys like BRFSS, the Behavioral Risk Factor Surveillance System. We're just notoriously underrepresented in BRFSS datasets.

When we're thinking about data, it's actually a much bigger issue because a multitude of datasets, including tribal data, and very rarely are those datasets cross-walked to provide an accurate picture of our health inequities. I agree with you, Dr. Maybank, we have to have good data really to characterize those inequities. I think COVID is shining a light on some of those data challenges that were existing already, but now with the lack of accurate reporting of racial data related to COVID-19 infections, it's just making the challenge of addressing equity even more difficult.

Dr. Owen: It's not just the lack of reporting of the data. It's also lack of an infrastructure to collect the data. We have IHS system and we have our own tribal health and then we have these GLITECs now, or these Great Lakes Inter-Tribal Epidemiology—well, I'm sorry. That's a specific one, but the epicenters. Then we have missed data like for the urban centers, how many. I'm curious. New York City has the largest number of Native Americans in the country. Where's the data there on the people who were impacted? How many of those folks were Native? We're not going to see that out of these urban centers.

Dr. Maybank: Yeah. To that point—

Dr. Zullo: I also think that—

Dr. Maybank: That kind of triggered my mind, this past week—oops, can you all hear me? I'm sorry, my connection is not great today.

Dr. Owen: We can hear you now.

Dr. Warne: Yeah, I can hear you. There was a little lag. Now I can hear you.

Dr. Maybank: Okay. Yeah. I don't know what's going on in Brooklyn today, but for some reason my connection isn't that great. I was saying New York City released data last week and in that data, I don't know if, Edgar, you saw that data or Dr. Owen, if you saw the data. But definitely to me it was like, Native American not there. Then I looked in the other column and the other description, and that's where they were inclusive of Native data but more so as a well, we don't have it, so we don't know how to present it type of deal. I definitely echo what you're saying and understand, Dr. Owen, what you just expressed and shared. Others to that question about othering?

Dr. Owen: Yeah. 70% of us at least are urban now, so that's a huge loss for us.

Dr. Maybank: Right.

Dr. Zullo: I think it's also very difficult, too, in a lot of our populations because there's a lot of historical traumas there. There's a lot of medical mistrust historically. I think it's really difficult sometimes to gain that trust from the population, especially if you're not a member of the community, in order to get data like that.

Because I mean, I can tell you countless times when family members have told me they felt like guinea pigs in the medical system on the reservation because we often have a revolving door of physicians who are coming to the reservation for a short time or non-Native folks come and do research but we never find out the results of the research. Or in some cases maybe the research is not being presented in a, I don't know, culturally competent way in which all of the different aspects of the interpretation are not taking into consideration the socioeconomic and disproportionate disparities among Native Americans.

I mean, I think a lot of times the research is not flattering, and there's this trope that Native Americans have a lot of alcoholism or even that we smoke or gamble because of the casinos. I just don't feel like those things are true, and there's a lot of stereotypes and a lot of misrepresentation out there that the data would be really important and help me to alleviate and clarify these things. But I think unless it's in responsible hands and people who actually understand the population, sometimes that data is misinterpreted.

Dr. Maybank: Absolutely. This last week—

Villanueva: I'm going to add to that. I often think about—

Dr. Maybank: Data 4 Black Lives issued a report—go ahead, Edgar. Something is messed up with my connection, so go ahead.

Villanueva: I'll just add to that. I mean, I often think about this idea of otherizing, being in the other box as there's so many complex layers of oppression that are wrapped up in that. First of all, Native Americans, we are the only ethnicity or race in this country that has to prove that we are who we say we are. We have to prove that. No one else really has to prove that. Then so when you are in the position to have to prove that and then you don't even see your box show up when you're collecting data, and I'm old enough to remember in school check for black, white or other. I was the only one in that other box because I grew up in a city.

Just the layers of oppression and the internalized mental trauma of being in this box of other causes an inherent identity crisis in some ways that I think contributes to mental health and a struggle to be connected to culture, which we know from research that that's a protective factor for us to be in contact with our culture and communities. It's just layers and layers and I feel like when we are left out of data collection processes, when we do not identify and pull out Native as an identifier for health care data collection processes, it's just another re-traumatization and a message of we don't matter, that we are invisible. We hear often in my space of philanthropy that the N is too small, that we're statistically insignificant. These are just extra battles that we have to face as a community to get the resources and access to care we need.

Dr. Maybank: So what is needed—

Dr. Owen: I think this is also playing out—

Dr. Maybank: Go ahead. There's a delay for me. You all are good, but go ahead. Go ahead.

Dr. Owen: Excuse me, Dr. Maybank. I'm actually jumping your questions a little bit, okay. The data issue and the trust issue—

Dr. Maybank: It's all good. It's all good.

Dr. Owen: That Dr. Zullo talked about impacts us right now with COVID in that, and I've talked with Dr. Warne about this because we're just across the border in trying to get this surveillance testing and contact tracing done with our communities. Because of that distrust that Dr. Zullo talked about, how is that going to go? Some people are not going to answer the phone when they get a call to do the surveillance and to find out whether or not they should be testing and then find out where this disease is in our communities.

Dr. Owen: The state of Minnesota has been trying to approach this, but it hasn't been taken very well because we know that a phone call to our communities, one, from a government worker in the first place isn't going to work. And then a phone call itself instead of somebody going out directly to work with people who have been traumatized is also not going to work. So it's playing across multiple levels and definitely impacting this pandemic, this long history.

Dr. Maybank: Okay. Can you all hear me?

Dr. Owen: Yes.

Dr. Maybank: Okay, good. Definitely agree with that. To that, what needs to be done to help improve the data collection piece? What do you need from people in terms of advocacy and in terms of systems? Because this is a moment in time where we are advocating. There's a lot of folks advocating, but maybe we need to be a lot more explicit in the nuances of what's happening. Any thoughts and ideas around that? If you were to tell people, this is what we need from you, whomever it is, what is it in terms of this data collection piece?

Dr. Warne: Yeah. I can take a stab at that.

Dr. Zullo: I think it's kind of a lot—

Dr. Warne: One of the challenges—

Dr. Maybank: Okay. We'll start with—Dr. Warne, you go first.

Dr. Warne: Okay, very good.

Dr. Maybank: Dr. Warne, you go first.

Dr. Warne: What's been mentioned, some of the challenges related to trust and certainly having control over the data is a big issue, so there's no simple solution. There's a multitude of things that need to occur. One is the tribes need to have more control over their own data, but the challenge there is how do we aggregate national data if it's coming in a piecemeal fashion. What we really need is more tribal control nationally over their own data, but then having the ability to crosswalk it and compare it to other datasets. That's going to be a long-term solution.

I think in the short run one of the challenges that we face, that Dr. Owen even described, is that we have data within the Indian Health Service, but the tribally run programs and the urban Indian health programs, it's optional whether or not they report those data to the Indian Health Service. So even within IHS we don't capture all of the IHS tribal and urban Indian health data. So there's no simple solution, but again I think what is happening with the pandemic is it's highlighting a lot of these concerns. And we can see how that has to do with outcomes.

Dr. Maybank: Got it. Dr. Zullo, you were going to say something?

Dr. Zullo: Yes. I think even from a more basic standpoint on an individual community type level, I think it's really important that whoever chooses to go out to try to collect this data be very explicit with the folks that they're collecting the data from. You need to actually take the time to explain to people, this is why we need to understand this data. I know that you're worried about it. I'm going to take good care of it, but also it's important because we need to show that this need exists. We need to show that we're affected disproportionately from this condition so that we can get funding. We can get help from people on the outside or we can show—

Because I think that is one of the more important things that I've learned in my career as my medical student but also as a researcher and also in advocacy, unless you have the data to show a need for something, you can't get support. You can't get policy pushed forward because we don't have the data points. We can't say what diseases are common or what access to care deficiencies are there. I think it's really important on a basic level to really garner that trust with the community and explain why you need that information, but also to say, "We're going to take good care of it, and we're going to use it for the right reasons, but we need this information to help you."

Dr. Maybank: Right. That's for the patient aspect of it, but then, so this is a comment that I've heard from physicians, "But it's COVID, so we can't have the physician focus on collecting data. They have so many other things to do." I'm not saying I advocate for that thought, but to me that's not how we address it.

As a medical student and then Dr. Owen, as somebody who engages with students as well, what do you say to physicians and students especially, why it is important to have this data and how to build that into their way of being as they move through med school? So even in med school but even when they become full physicians, they're embodying this urgency to have this data and advocating no matter what their background is to make sure that this data is collected and they as physicians and med students are taking that responsibility on. How do we overcome that barrier in the conversation?

Dr. Owen: Well, a couple of things. First of all, most med students, I mean Dr. Zullo is a good example, most med students are already on board with this. We recognize the importance of it, so I think it's more convincing our communities. If we're going to convince our communities, we have to do that by trusted people. So we should be using our trusted community elders and traditional people to

help inform that, so we need to be talking with them, building community with them to help convey the importance of this information.

Then the other thing, like Dr. Warne said, we need to be in the driver's seat. If you're talking about anything that impacts us, we have to be involved. Fond du Lac Nation, for instance, has its own IRB and is doing tremendous work about protecting its community. Anything you do with them, they are going to have the say-so on whether or not it gets out any further than within their community. That's absolutely what universities and NIH, all the other programs need to do is support that kind of work and even bring people together. Right, Don, or Dr. Warne, if we're able to bring different IHS and tribal units together, then we can start talking about how important it is that we share the data, but that's not happening right now. So the government, the NIH, other institutions could help us with that.

Dr. Maybank: Got it. Mr. Villanueva, do you have anything to add to that?

Villanueva: I mean just two thoughts. At a macro level, we definitely need more funding. Indian Health Service is grossly underfunded. There used to be a saying like, don't get sick after June because you didn't even know if the clinics were going to be open and be able to provide service. So we need more funding in the Indian Health Service. We are one of the only populations that are supposed to be guaranteed health care in this country through a treaty, through constitutional work, and so the country needs to honor those treaties and those commitments to our communities and fund adequately health care.

Then we must also just acknowledge that implicit bias is still something that's just a part of what's going on here. I just read a story, I think, yesterday where a black man passed away from COVID because he went in, had the full symptoms and did not get tested. Early research is showing that people of color are not getting the same type of treatment when they do come in presenting the COVID symptoms. Then if you're white, you're much more likely to get tested. We saw that early on with folks who were testing positive, folks with resources, white, celebrity were the folks who had access to testing and were able to know their status.

We have to continue through medical education, through practice in our health care systems, work with physicians around implicit bias in treatment. And then of course we just need to provide all the resources that we need to have the systems, as folks were saying here, to collect data, to share data and to provide adequate health care across Indian country and in our urban centers.

Dr. Maybank: Thank you. And you highlight something for me that the audience may not be in tune to, but what is the experience on reservations right now as well as in Indian Health Service and what you're being exposed to, Dr. Owen and Dr. Zulu, Zullo, sorry, and Dr. Warne? What are you all seeing on reservations?

Dr. Owen: Well, I work for the Fond du Lac Nation, and COVID-19 has not fully hit up into the tribal nations of Minnesota. It's starting to. It's interesting because some tribes can absolutely keep

anybody out. Like Red Lake, they closed their borders. Nobody's coming in. And yet there's word that there is at least one case there, and we'll see where that goes. It just makes me think about South Dakota trying to do the same thing and having to fight against a governor who isn't protecting her people while the tribal leaders there are trying to protect theirs. It's quite interesting, but we have not seen it's full impact here yet.

I know the tribes are extremely worried. The bigger impact is what it's done to the economy and the long-term impact that social determinants are going to play on our health outcomes. Because casinos shut down, fishing, tourism, all those things shut down are going to—and people don't realize because of the health system underfunding, as Dr. Villanueva pointed to, we have to subsidize so many of those social determinants of health, housing, water, infrastructure, all that with the casino fund. So it's hugely important and going to be devastating to the tribes. Thank you.

Dr. Maybank: Thank you. Dr. Zullo?

Dr. Zullo: So from my perspective, I'm approaching this more as a medical student graduating but also preparing and gearing up to become an internal medicine doctor, essentially, for a year. But from my perspective in growing up on the reservation and still having a majority of my extended family live there, the Navajo Nation has been hit particularly hard by COVID-19, as we've all seen. It's honestly, it's been really surreal because I see my hometown, I see my reservation communities on TV every night, and not for good reason. It's just, it's very, very sad, and it's heartbreaking to see what it's doing on the reservation in the communities, in my own home community.

The social determinants of health, we all talk about there's a lot of issues on reservations, but I think with the Navajo Nation we're being particularly hit hard because of the lack of infrastructure. There's up to 30% of homes don't have running water, and a good majority of those homes don't have electricity. There's a disproportionate amount of people who live in houses too, so there's many homes that are multiple generations living in a home. You got grandma and grandpa and mom and dad and then the kids and then grandkids even. So it's really difficult, and I think it was the perfect setup to being a tinderbox for something like this to occur just from the lack of infrastructure.

I mean if you think about it, going back to talking about those multi-generational homes, you can have up to eight to 10 people living in a home that is maybe only two rooms. You've got your bedroom space and your living room and cooking area. Hypothetically, one person gets COVID, it's incredibly difficult to quarantine that person from the rest of the family. I think that that's kind of the situation that we're seeing there.

Then also, just from the poverty and unemployment rates, we have unemployment rates on reservations, at least on Navajo, of 50% or more. So many people actually have to travel quite a ways to go to work. Growing up, my mom drove 140 miles every day, an hour each way, to get to work. That's just to have that opportunity. Native American people are very hard working people. It's just really that the opportunities are not there.

But going back to all of this travel, being in a very rural area like that, especially on Navajo Nation, we're in a tremendous food and supply desert. There are only 13 grocery stores on the reservation. So when you think about that and you think about those locations and those towns where those grocery stores are, you have to realize that that one grocery store is serving the needs of entire community. So you have all these folks coming in to this one location trying to do what everyone else in America is trying to do. They're trying to survive. They're trying to prepare and trying to shelter in place. But what happens when you drive an hour to get to this grocery store and they don't have enough groceries, or they don't have toilet paper for everyone has been sort of hoarding. It's a really difficult situation to be in, and it's really heartbreaking.

I think that for someone like me who at this point has been in school for so long, I was afraid, honestly. I was afraid when I knew that this was an upper respiratory virus that could potentially spread, could potentially become an epidemic or a pandemic, and I was afraid for my people because I knew what that life was like. I knew what it was like to not have indoor plumbing and use an outhouse. As for water, there are some people who only get water delivered to their home once a month. So when we tell people that they need to wash their hands, they need to wash their clothes, they need to wash the surfaces in their house, that is a very rare resource in their house to have that water because maybe they don't have the car to travel to go to the pump in the community to get water.

Dr. Maybank: Thank you.

Dr. Warne: We're seeing similar things in the Northern Plains. Yeah, similar things in the Northern Plains because we have very rural and impoverished communities very similar to Navajo Nation. I think Navajo was very unfortunate. We can trace one large gathering with a lot of people that came together and a lot of the cases seem to have come from that, but every single reservation that has similar dynamics is at the same type of risk. I work closely with the Northern Plains Tribal Epidemiology Center, the Tribal Chairmen's Health Board out of Rapid City. We had a meeting today, and our numbers on reservations are going to straight up. It's exponential growth now.

What I'm afraid of is that the pattern of spread that we saw in Navajo is also going to occur in other reservations, and it really is just reflective of a lack of infrastructure. It's decades and decades of neglect and lack of investment in the infrastructure that we need just to keep people healthy. So we also have multi-generational housing, inadequate housing. It's impossible to quarantine and isolate in those circumstances. Then when you have a great deal of poverty and less access to public health

services, less access to testing, less public health workers to do the contact tracing. And most of our reservations, we don't have an ICU. We don't have ventilators, so we have to try to get coordination with the private sector.

What we're seeing through the pandemic is the outcomes of generations and generations of neglect. And what Mr. Villanueva said is correct. We have a treaty right to health services. We're the only population that actually has a treaty right to health care, but clearly the federal government for decades has been in breach of contract because they're not fulfilling their end of those treaties. And this is the outcome. When you don't invest in public health infrastructure, populations are at risk and people suffer and die as a result.

Dr. Maybank: Absolutely. I guess to that point and kind of building on that again is the CARES Act. We know money has not been distributed in the way that it had been promised or intended and just wanted to talk, what is the impact of that on systems now? Clearly, we've all and you all have highlighted this is existing before COVID and it's already a breakdown in infrastructure, but now with the CARES Act and the monies not being distributed, now what? How is this impacting our systems and our ability to respond to the crisis in real time?

Dr. Owen: I want to talk about a couple things I've noticed. It's not just the infrastructure that the lack of funding makes us suffer from. It's also we can't have the same competitiveness for health care providers. So for instance, in the area that Dr. Warne and I live in and take care of patients in, there's a 48-52% vacancy rate for physicians. So there's always this need, this constant need. And if any of them gets wiped out, then who's going to replace them in the time of COVID? There's that piece.

As far as the CARES money, one, it took Donald Trump going down to Navajo Nation how many weeks later to say that these monies are now going to be released. So he didn't do anything special. All he did was try to break a few roadblocks to get the monies that were already promised. Look how much it had already been impacted, the Navajo Nation. Then on top of it, CARES money weren't the only monies appropriated. There were also monies appropriated through the CDC. However, those money as well as CARES money, the tribes are having to be overzealous, while the CDC monies, I'm applying for grants for.

So their administrators and a lot of providers, or not providers, but a lot of people working within the clinics are tied up trying to write for grants and then trying to make sure that those grant monies are absolutely adhered to. Because if they get audited, which has happened, the federal government all of a sudden pulls back from a needy system. So they are spending an inordinate amount of time to get some of those monies even released. Then they're often coming so late. So a couple points. Thanks.

Dr. Maybank: Thank you. Anybody else want to make any further points related to that?

Villanueva: I'll just make one.

Dr. Maybank: Go ahead.

Villanueva: We had to fight to get funding in the first place in the stimulus packages. It wasn't an automatic thing. So just to be included in the emergency funding was a fight in itself. When we were included, it was an insufficient response—

Dr. Owen: Must be Brooklyn.

Villanueva: I think I might've froze up.

Dr. Maybank: It must be Brooklyn.

Villanueva: Can you guys hear me?

Dr. Maybank: We can hear you. I can hear you.

Dr. Owen: Yeah. We can hear you.

Dr. Maybank: I can hear you.

Villanueva: You can hear me. Okay. So yeah.

Dr. Maybank: I think we could—

Villanueva: You can hear me, okay. I paused my camera for just a moment. That may help a little bit. But yeah, I think just in terms of the CARES package, I just wanted to just make the point that it was a fight to be included from the gate. From the very beginning, the Trump administration did not want to include us. When we did get included for money to go to tribes, it was an insufficient response.

The amount of money that has to be spread over 570-plus tribes already into a system that was starving for resources and then all of the barriers of getting the money. I haven't even heard that the money has gotten to tribes yet, and so lives are on the line. That's what's at stake here every single day that it takes for the resources to be, I like to say, liberated and to get to community means more lives are on the line that we're losing every day because of the lack of having the sufficient resources we need to care for people.

Dr. Maybank: Absolutely. Can you speak to that in terms of this has to go back to narrative and solutions? We advocate a lot. I advocate a lot the importance of having a racial equity lens as we talk in our space, especially within the health care context, and sometimes that translates and other times it absolutely does not. I just wondered if you could just talk a little bit more about what that means and

also around your term of decolonizing wealth and how it's important in this time?

Villanueva: Yeah, absolutely. I mean, I think what it really comes down to is understanding the history of what has transpired in this country, the history of colonization, the history of extraction from indigenous communities and other communities of color that have led to our current situation where we see disparities across health, across income, across all the socioeconomic determinants of health. There's a reason that we got here. There's a reason that our communities are in poverty because of very intentional policies that have been put in place over many, many years that continue to hold us in poverty. There's so many laws. Indian law is a very fascinating field of study, to understand all the legal things that went into place to put us in the situation that we are today.

Decolonizing wealth is just really simply acknowledging that there's a history of the way that wealth has been built in this country on the backs of indigenous people and on the backs of other people of color and thinking about who holds power now, who holds resources, who holds the microphone, who holds the decision making power about how resources are deployed. For me, decolonizing wealth is actually reallocating wealth in a way that is simply respectful to that history, understanding that we are hurting the most. People of color, indigenous folks are the canary in the coal mine. So when we decolonize wealth or we bring a racial equity lens to our work, whatever that may be, it means we're going to prioritize indigenous communities and other communities of color because we have been the ones who have been put at the margins for so long.

In that, I think there's an indigenous lesson that everyone should understand when we say all my relations. When we prioritize at the margins, when we center indigenous communities in our efforts, we're not taking away from anyone else. By focusing explicitly on communities of color, we are helping everyone. We're closing a gap, a tide that's going to lift all boats. It's just a matter of understanding history and racializing that history and then designing solutions and bringing that into our current day work of prioritizing these communities in a way that is respectful of the harm that has been done so that we can all heal together.

Dr. Maybank: Thank you. That was really helpful and hopefully helpful to the audience as well, because I get asked that question quite often. And I hope you all are able to hear me. There are actually quite a few questions. Let me see if I can get a few in while we have this time. One is going back to Dr. Owen. When you talked about a high vacancy rate in the overall IHS and especially in your area, and we mentioned this a little bit actually before the Zoom call started, what are the challenges that exist in recruiting and retaining physicians, and you could say med students as well, in med school but also within the IHS as well?

Dr. Owen: Well, the issue that I was speaking to specifically was that if there are low numbers of Native doctors, there are even lower numbers representatively of Native academics like Dr. Warne and myself. So if we don't have representation, we tend not to be thought about. Just, that's the same problem with being an other. If people don't see us at the table, they don't always think about us. It's

kind of a human instinct almost. The other issue is that just like the US government hasn't held up its responsibility as far as our health system, it has done the same neglect of our education system. We're seeing suffering from that.

Our high school graduation rates are quite low around the nation, and in some communities, like for instance Duluth where I live, it's down to 50%. If you have a high school graduation that is that low, how many of those students go on to college? And then how many of those because of tons and tons of other issues end up going further from there and getting through college and then being able to apply to medical school to take care of our communities? There's this drop off that continues to harm our communities. That's part of it. That's just the Native representation.

The other piece is that we've never had the same on par funding of our physician labor force that other private systems have had. On top of it, you're going to communities that are underserved and face the issues that Dr. Zullo and Dr. Warne talked about. They're very rural. They don't have all those pretty services. So unless you're from that area, and that's the beauty of recruiting more Native people, you don't have the drive to be there. Most of us want to go home to our tribal homeland no matter what it looks like to the rest of the nation. So the more of us we educate, the better off we'll be. But it's difficult also to get others to understand that piece.

Dr. Maybank: Dr. Warne, do you want to comment at all? I didn't know if you were about to. It's up to you.

Dr. Warne: Sure, yeah. Just had a couple thoughts. I completely agree the challenge of developing our own workforce is tremendous because of the educational disparities as well. So what we do at University of North Dakota, we have a couple of programs. One is the Indians into Medicine, or INMED, program. That's been around since 1973, so our current students who just finished their first year, they're the 50-year anniversary class of INMED. And we now have around 240 or so physicians who graduate through INMED programming. That's over a 50-year period, but that alone clearly is not enough. We need more investment in infrastructure, whether it's educational or any other type of social program or health program, to try to increase the numbers of people working in these spaces that will actually go home and work with their communities where they're needed the most.

Another outcome, just real briefly, with the lack of investment and lack of infrastructure, we have a lot of poverty-related illnesses like diabetes, which puts us at higher risk for bad outcomes with things like COVID-19. So the average age of death for American Indians in North Dakota is in the mid-50s, average age of death mid-50s.

Dr. Maybank: Wow.

Dr. Warne: For the white population, it's mid-70s.

Dr. Maybank: Wow.

Dr. Warne: So in many ways we have Third World health conditions, and I'm hoping that if there is a silver lining, perhaps COVID-19 will shine a spotlight on the need to invest in our own populations right here.

Dr. Maybank: Thank you. We have still a little bit more time. Let's see if we can get one more question here. There was—sorry. Someone asked about the Census and how is Census data collection going on Navajo Nation or any of the nations during this time of COVID? Are any of you connected in and aware on some of the efforts that are happening?

Villanueva: I can say that I know the efforts are happening. From an urban perspective, I can speak to what I know there. I'm going to go off my camera so that it comes through clearly. The National Urban Indian Family Coalition is one organization that has been working with the urban centers in 10 metro areas across the US to do Census education, outreach and collection. So I do know of at least one effort that is focused on collecting Census and supporting our communities in urban centers to do Census work.

Dr. Maybank: Thank you. Somebody else was going to respond.

Dr. Zullo: As far as I know from just national news, and I think also just with the COVID response and everything that's been going on pandemic wise, I think as far as I understood, the Census was going to be pushed back a little bit further in time. I think that'll probably remain true, especially with Navajo Nation and other tribal entities, just because that's often a boots on the ground kind of job. So I think in order to protect people, delaying it is probably the best course of action there.

Dr. Maybank: Thank you. As we're coming to the end, these things always go by way more quickly than I want them to. And usually there are lots of questions, and I can't get to them. But that's all right. We pay attention to them and we do follow up on the questions and action. Just as we're closing out here, just wanted to hear from you all. What would be most helpful from anybody who may be listening in today in terms of helping to support and advance equity in this current time and this current moment and justice for Native communities?

It's a broad question, but I want you to be able to just take it wherever you feel is important. What is that one or two things that you would like to see happen over the next couple of months, and not even just the months, our lifetimes really? I kind of pick on you, Dr. Zullo, because you're the med student, so I'm going to go to you first.

Dr. Zullo: Kind of used to it. No. I think that the really sort of heartening thing about this whole pandemic and this whole terrible situation, especially for Navajo Nation, has been that people, community members, other organizations, volunteers, nonprofits, have really stepped up to try to

help. I think just going back to talking about the rural-ness of the community, the lack of resources as far as grocery stores, as far as getting any kind of supplies on the reservation, all of those donations, all of those people who are out there making masks and donating them and sending them in to people to go out to our communities, we truly thank you.

I think the other thing also that I really wanted to mention too was the medical community has really kind of stepped up too to try to help, especially the UCSF HEAL program who sent seven physicians and 14 additional health workers, nurses and allied care folks, and then Doctors With Borders, who recently sent nine physicians to the reservation. We cannot thank you enough. Just know that when you come out and you help us as a people, we truly appreciate it. We really do. Because like Dr. Owen said, like Dr. Warne said, the resources are not there. In medicine and everything else, we just don't have enough physicians. We don't have enough PPE. We don't have enough ICU units. We don't have enough ventilators. So anytime that anyone out there can really give a helping hand, we really appreciate it.

The one kind of anecdote I really wanted to leave it on, especially from my perspective, was in World War II, the Navajo code talkers were a huge turning point for that war. We gave everything we had. I think that a lot of people don't know that Native Americans actually serve in the armed forces disproportionately higher per capita than any other ethnicity or racial group in the US. With that in mind, we serve our country, and so we don't ever really ask for help. Then I think that's a big issue too is we're very quiet. We're very resilient. We're very stoic people, but we need your help. We need the help of the medical community and we need the help of the rest of the country to really help us through this. I'll just leave it at that, but any help that we get, we are incredibly thankful.

Dr. Maybank: Thank you. Dr. Owen?

Dr. Owen: Well, I'll have to push back, Dr. Zullo. Not all of us are stoic. My tribe behind me in this little image here, they are not known for being stoic, so don't cross them.

Dr. Zullo: I know. I don't really fit that stereotype either.

Dr. Owen: I have to agree with everything Dr. Zullo said in that the volunteerism. I was pleasantly surprised when I did a call out in Minnesota to providers on who might be interested in helping if there was a call. We got responses from several doctors, including a radiologist, emergency room physician, a peds intensivist. It was really heartening to hear that. And students have been reaching out to me because of our little center, which also has graduated tons of Native physicians, by the way, Dr. Warne, and trying to find out different ways that they can be involved and volunteer as well.

I will say the other piece that Dr. Zullo mentioned that's really important is not just seeing what's happening with Navajo Nation now, but we're just starting to see the turn. I and Dr. Warne, I'm sure, are doing this work in our colleges, but teaching people about the true history of Native people. There are a couple of really good books out there, Indigenous Peoples' History by Roxanne Dunbar-Ortiz

and Dr. Treuer, one of the Treuer brothers, that just came out, Heartbeat of Wounded Knee. Those are great books that are easy to read and full of good information about who we are as a people, so hopefully this will bring that out of it.

The last point I want to make is that in our state of Minnesota we have, I think, the second Native lieutenant government in the nation. When people think that it doesn't make a difference, let me tell you how it has made a difference. She has been meeting weekly with our tribal leaders. If you think your vote doesn't count, you're wrong. It does count. We've seen the impact of having Native leadership in this state at least. Thank you for the opportunity, Dr. Maybank.

Dr. Maybank: Oh, thank you. Dr. Warne?

Dr. Warne: Yeah. Just very briefly, I agree that on the politics and policy side is very important, and unfortunately we have a lot of elected officials who don't know our issues. And those who know quite often don't care. Certainly, that's reflected in the policies that are made. In terms of what people can do is if you are genuinely concerned about the health and welfare of American Indians and Alaska Natives, look at who we're voting for. Who are we putting into office? Who are the decision makers that are perpetuating some of the challenges?

But on the financial side, we have a National Indian Health Board, nihb.org. We also have regional health boards. I work with the Great Plains Tribal Chairmen's Health Board out of Rapid City, South Dakota. These are nonprofit entities trying to do the best that they can to advocate but also provide regional and national public health programming. They always need resources. So if you're thinking about what you can do from a financial perspective, the health boards need financial help, especially in a time like a pandemic. Then from the politics and policy side, who are we putting into office? Because the lawmakers have a huge impact on our programs.

Dr. Maybank: Thank you. Thank you. And Mr. Villanueva.

Villanueva: I think I would just offer a real time opportunity to support—We at Decolonizing Wealth Project launched a rapid response fund. You can check it out at decolonizingwealth.com/fund. We've raised over a million dollars now to support Native-led organizations and response efforts on the ground. We're supporting several folks down in Navajo and Hopi as well as across the US in tribal and urban communities to get PPE, to pay for food, housing, rent relief, to get water, all of the things that we need right now to get through this. It's not about charity. It really is about solidarity and so we would really appreciate your support. We will get those funds directly to Native-led organizations doing this work to take care of our communities.

Dr. Maybank: Thank you. Well, we're a little over time, but it was well worth it. I just want to thank you all, one, for your leadership, for your commitment, for taking the time out tonight, but also for sharing your stories and your experiences. I talk a lot about how numbers are good for institutions, and we do need numbers. Clearly, we had a whole conversation around data, but stories are really important

too, I think, in terms of moving hearts and capturing the essence of what it means to affirm somebody's and a community's humanity.

So really, thank you all and thank you all, whoever tuned in today and your questions. This will be available to watch afterwards and to share as well, and it will have resources and links listed as well. So thanks a lot, everyone, and have a wonderful evening.

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