Arizona Health Care Cost Containment System (AHCCCS)

FY 2026 Division Budget Request (Due to DBF-Budget by June 30, 2024)

Division: Arizona Advisory Council on Indian Health Care (AACIHC)

Title of Request: AACIHC SFY26 Operating Budget

Request (Addition) Amount: $436,580.50

AACIHC SFY26 Budget Request (Increase)	
Salary	$296,430
ERE	$103,750.5
Professional and Outside Services	$0
Travel	$2,400
Other Operating Expenses	$34,000
Equipment	$0
Total Request for SFY25	**$436,580.50**

Breakdown: (Total increase request of $436,580.50)

- **Total Salary and ERE = Increase of $400,180.50**
  - **Salary:** $296,430 (4 new positions)
  - **ERE:** $103,750.50 (4 new positions)
    - Calculated at 35% of salary per AHCCCS DBF for SFY26
- **Travel = Increase of $2,400**
  - Additional travel is required to support tribal health departments, IHS and 638 facilities, Community Health Representative Organizations, and other community organizations serving American Indian and Alaska Native communities in Arizona. The AACIHC provides vital training to both health care providers and community members alike in health system navigation, and health prevention and disease management education. Additionally, providing technical assistance to Tribes is necessary to fulfill the agency mission as outlined in A.R.S. 36-2902.02.
  - There are 22 federally-recognized Tribes in Arizona, scattered throughout the entire State. Travel is not always feasible as a day trip. Per Google maps, examples of ***one-way mileage and associated travel time*** from the 801 E Jefferson location in Phoenix, Arizona to different areas of tribal Nations include:
    - Hualapai Tribe: 205 miles (3.5 hours) to 270 miles (4.5 hours) one-way
    - Navajo Nation (Window Rock): 283 miles (4.5 hours) to 333 miles (5 hours) one-way
    - Navajo Nation (Tuba City): 225 miles (3.5 hours) to 261 miles (4.5 hours) one-way
    - Hopi Tribe: 240 miles (3 hours and 40 minutes) to 299 miles (5 hours) one-way
    - Tohono O'odham Tribe: 126 miles (2 hours and 15 minutes) one-way
    - San Carlos Apache Tribe: 133 miles (2.5 hours) to 184 miles (3 hours and 15 minutes) one-way

        - Cocopah Tribe: 198 miles (3 hours and 4 minutes) one-way
        - Quechan Tribe of the Fort Yuma Indian Reservation: 189 miles (2 hours and 52 minutes) one-way
    - Additional funding is requested for gas, hotel for an overnight stay, and meals reimbursement for the staff who provide outreach and education to tribal communities.
- **Other Operating Expenses = Increase of $34,000**
    - This will cover things like the following:
        - Per Full Time Employee cost for two monitors, one laptop, software (i.e., Office 365), and VO stipends;
        - Cost of hosting meetings for Tribal leaders and stakeholders around the State on a quarterly basis. Anticipated cost is $3,500 per event. ($14,000 per year)
        - Cost of conference attendance for presenting work and soliciting feedback of tribal stakeholders (even when your agency submits an abstract submission for a conference that is accepted, you have to pay the conference fee in order to present the information there) for key staff;
        - Cell phone cost and operation for work (cell phones are necessary for agency staff due to the mobile nature of our work and presence at community events);
        - Office and miscellaneous supplies; and
        - Educational materials to provide to the community to enhance health literacy and the work of CHRs in Tribal communities, as these two aspects are key in preventative medicine. Additional expenditures upfront for preventative services can translate to significant cost savings on the Medicaid side of the house. This also includes the cost of renting space when we need to host community forums and educational events for members of Arizona Tribes.

Description of problem or issue and how this furthers the agency mission or goals:

The AACIHC promotes and supports the overall health and wellness of Arizona residents, in particular historically underserved and marginalized Tribal communities.

Currently over half of the agency's budget and provided services are funded by grants. These grants are set to end in 2024 and 2025. The agency is one of the lowest funded in the State, and consequently does not have discretionary funds available to absorb the cost of funding those efforts once the grants expire. This may result in the cessation of providing such services to Tribal communities.

Ceasing services would not be ideal.

Health disparities in Arizona are already extremely disproportionate for American Indian and Alaska Native populations. They have consistently been disproportionate throughout the State's history. Thanks to herculean efforts from multiple organizations, including the AACIHC, to reduce health disparities and inequities, some improvement in life expectancy and disease management is beginning to occur. However, a cessation in health education efforts could result in not just a potential backslide, but if preventable conditions and chronic disease rates begin to increase, then it could cost the State and Federal

governments additional monies to cover the health care for these conditions.

American Indian and Alaska Native (AI/AN) populations in Arizona contend with significant disadvantages. Statistics to support this include:

- On Navajo Nation, 30% of families live without running water.
- On Hopi Nation, 75% of families rely on well water that is tainted with high levels of arsenic, verified via a joint study between Hopi Nation and the Environmental Protection Agency (E.P.A.). [1]
- On Hopi Nation[1], the Hopi Environmental Health Project found that even the municipal/piped water had a mean arsenic concentration (11.01 µg/L) in excess of standardized maximum contaminant levels (MCL), which are set by the E.P.A. This was determined to increase the lifetime cancer risk to 9.96 cases per 10,000 individuals[2].
- On Hopi Nation, water is only available for irrigation to 38% of farmland, impeding access to fresh fruits and vegetables.
- Citizens of Tohono O'odham nation have been repeatedly exposed to groundwater contaminated with mine waste. Despite removal in prior years, such as a cleanup in 2008, contamination persists and requires alternate access sources to be obtained. Prior exposures resulted in citizens being exposed to perchlorate, sulfate, and uranium. [3]
- On Navajo Nation, there are more than 200 abandoned uranium mines that have been identified by the EPA[4]. Mines stem from Navajo Nation's willingness to lend help to the U.S. Government in World War II, and many of the mines continued to be in operations until the 1980's. However, upon cessation of operations, many were not properly sealed or secured by the industry that had financially benefited from the Navajo Nation's resources.
- On Navajo Nation, uranium contamination has been found in building materials of existing housing.[4]
- On Navajo Nation, one study found that 27% of the participants, who consisted of women and children, had high levels of uranium in their urine, compared to 5% of the U.S. population as a whole.[5]
- Food insecurity amongst Tribes in Arizona's Apache County is 30%,[6] affecting Fort Apache Tribe, the Zuni Tribe, and Navajo Nation.
- 34% of AI/AN households have no high-speed internet access at home, and almost 16% lack a home computer[7]. This directly impacts the ability of AI/AN families to receive and access important health education information.
- Travel time for many AI/AN individuals living on reservations, to their nearest healthcare facility capable of specialty treatment, is significant. Statistics include the following:

[1] In Arizona Water Ruling, the Hopi Tribe Sees Limits on Its Future — ProPublica
[2] Drinking water and health assessment in a Northern Arizona community - PMC (nih.gov)
[3] EPA Announces Final Cleanup Plan for Drinking Water Aquifer on Tohono O'odham Nation | US EPA
[4] Navajo Nation Still Shows Uranium Exposure Today, Decades After Atomic Age Mining (cpr.org)
[5] Uranium Exposure in American Indian Communities: Health, Policy, and the Way Forward | Environmental Health Perspectives | Vol. 129, No. 3 (nih.gov)
[6] Restoring Food Sovereignty for Native American Communities - Tribal Health
[7] The Condition of Native American Students (nsba.org)

- Travel time for enrolled AI/AN individuals to the nearest hematologist/oncologist (calculated by reviewing sites with at least one hematologist/oncologist billing Medicare in the year prior to the study), averages as follows:[8]
  - Navajo Nation: 187 miles (3.5 hours) to Tuba City Regional Health Care Corporation
  - Fort Apache Reservation: 34.8 miles (47 minutes) to Summit Healthcare Association
  - Gila River Indian Reservation: 42.3 miles (41 minutes) to Ironwood Cancer and Research Centers
  - San Carlos Reservation: 24.9 miles (31 minutes) to San Carlos Apache Healthcare Corporations
  - Tohono O'odham Nation: 135 miles (2 hours and 15 minutes) to Ironwood Cancer and Research Centers
- As of 2023, there are only 4 Indian Health Services (IHS) facilities and 2 Tribal Health facilities that offer Labor and Delivery services. Due to this severe shortage both on and off tribal lands, tribal members often have to travel **extremely far distances** for basic prenatal services and for delivery services. Travel distances, depending on which reservation an AI/AN mother is traveling from, can average anywhere between 100 and 200 miles roundtrip.

The above list represents only a subset of the disadvantageous social determinants of health (SDOH) that affect AI/AN individuals within Arizona. To list all the SDOH outside of the control of AI/AN communities would require a considerably longer budget proposal.

These SDOH affect lifetime risk for the development of serious, and costly to treat, health conditions. They also place AI/AN individuals at higher risk of injury and illness.

For instance, addressing the necessary need for water access requires driving long distances on undeveloped roads, collecting water in tanks (a risky activity for elders or anyone who is not in possession of incredibly good health and fitness), and then carefully rationing water for cleaning, cooking, and consumption activities.[9] Without easy access to running water for basic handwashing, hygiene, and cleaning, it is little wonder that AI/AN communities were subject to some of the highest COVID-19 infections in the nation. [9]It placed them at higher risk.

Exposure to arsenic results in a heightened lifetime risk of cancer development, contributes to cognitive developmental disorders (impacting youth and dementia/Alzheimer's rates), and is even linked to type II diabetes. Uranium exposure contributes to heightened cancer risk and odds of kidney failure.

Prolonged travel times makes it not only more difficult to block out time for healthcare appointments, but it also makes securing transportation less likely. This is without taking into account undeveloped, dirt roads that many families must contend with, before even making it to paved thoroughfares. These roads are often flooded. At the time this proposal is being written in June of 2024, there are completely flooded portions of Navajo Nation that required individuals to stay in place until it recedes. Missed healthcare

[8] Access to cancer care in Native American reservations in the US | Published in International Journal of Cancer Care and Delivery (binayfoundation.org)
[9] Navajo Water Project

appointments can result in the worsening of chronic conditions and in newly developed conditions being missed in their early, more treatable, *less costly* stages.

Chronic conditions are also difficult to manage nutritionally, due to many reservations existing within food deserts, which are areas lacking farmer's markets, grocery stores, and a lack of access to fresh produce. AI/AN individuals not only have less access to food, but they pay higher prices for lower quality meals at fast-food restaurants and convenience stores as a result. This contributes to difficulties in management of chronic conditions like diabetes, and in the development of food-susceptible conditions such as heart disease, hypertension, and stroke risk. This also strongly contributes to obesity rates, which put AI/AN individuals at higher risk of many other chronic conditions that could be preventable through health education campaigns.

Tribal communities, like other BIPOC communities, are amongst the first to suffer ill effects of any outbreak of infectious disease, due to the additional difficulties experienced in daily life when it comes to safe-water access, distance from healthcare facilities, food deserts, and the significant health problems already existing within the population that put them at higher risk. They additionally suffer higher rates of chronic and acute illnesses alike. Treatment can be costly when it is addressed after-the-fact (retroactively) as opposed to using a preventative approach (proactively) through health education, which the AACIHC can provide.

The impact of these daily challenges on the health of AI/AN individuals is backed by data.

For instance, in 2020, the State of Arizona experienced an overall decline in life expectancy, which was *significantly higher than the U.S. overall*; 2.8 years in Arizona vs 2.1 years nationally.[10] However, the decrease in life expectancy ***was not uniform across all demographics***, with ***American Indians experiencing a decrease in life expectancy of approximately eight (8) years.***

- There are a variety of factors that contributed to this, including higher rates of chronic health conditions, lifestyle health-related risk factors, social determinants of health, and location of residences.

Unfortunately, this trend continued. The 2021 Data Book published by ADHS, titled, *Health Status Profile of American Indians in Arizona*, showed that, on average, **AI/AN individuals were, on average, 15 years younger at their time of death when compared to all other racial/ethnic groups in the state.** Additionally, AI/AN individuals in 2021 had higher mortality from alcohol-induced causes, chronic liver disease and cirrhosis, COVID-19, septicemia, diabetes, assault, influenza and pneumonia, motor vehicle accidents, early syphilis, and unintentional injuries.[10][11] AI/AN individuals also ranked worse on measures of maternal lifestyle and health, as well as in utilization of prenatal care,[11] which, given the severe shortage of labor and delivery services, and maternal health services, in AI/AN communities, is no surprise.

[10] Arizona Department of Health Services. (2021). *Leading Causes of Death and Health Disparities Among the American Indian and Alaska Native Population in Arizona*. https://www.azdhs.gov/documents/director/tribal-liaison/2021-american-indian-status-report.pdf

[11] Health Status Profile of American Indians in 2021

Deaths due to certain lifestyle preventable conditions were significantly higher for American Indians/Alaskan Natives (AI/AN) compared to all other racial ethnic groups. This held true for diabetes, chronic liver disease/cirrhosis, motor vehicle accidents, and self-harm (suicide) and unintentional accidents. Native Americans are also amongst the highest prevalence of hypertension in the United States as a whole.[11]

The key we want to highlight, is that deaths were due to ***lifestyle preventable conditions***.

This means that we can intervene. Through health education and outreach conducted by our agency, we can help to save and improve the quality of lives amongst one of Arizona's most underserved and vulnerable communities, while reducing the cost burden of the State in treating these conditions.

Additional disparities from the ADHS 2021 report findings, specific to our AI/AN populations in Arizona, include:

- Higher prevalence of diabetes, pre-diabetes, and high cholesterol;
- Higher prevalence of sexually transmitted diseases (early syphilis, gonorrhea, chlamydia) and HIV/AIDS;
- Higher rates of obesity and physical inactivity;
- Higher prevalence of smoking and smokeless tobacco use;
- Higher rates of teen pregnancy and ***poor neonatal/infant health outcomes***, with ***lower utilization*** of prenatal care services;
- Lower levels of educational attainment;
- Lower overall income and higher poverty levels; and
- Higher levels of unemployment. [1110]

The ADHS 2021 report findings can be found here:

- https://www.azdhs.gov/documents/director/tribal-liaison/2021-american-indian-status-report.pdf

Per a review of Medicaid claims in Arizona, for AI/AN populations, we found the following disparities in an epidemiological analysis of COVID-19 outcomes and severity levels:[12]

- AI/AN Medicaid members with diabetes were 14 times more likely to develop pneumonia due to COVID.[12]
- Once pneumonia developed, AI/AN Medicaid members were 125 times more likely to experience respiratory failure.[12]
- AI/AN Medicaid members with hypertension were 4 times more likely to experience a severe COVID case (as defined by going on to develop bronchitis, acute respiratory infection, pneumonia, respiratory failure or death) and were 20.47 times more likely to develop pneumonia.[12]
- AI/AN Medicaid members with the social determinant of health of lack of exercise were 3 times more likely to develop pneumonia.[12]

[12] Garman, K. (2023). *COVID-19 Within 2020 - 2023 Social Determinants and Pre-existing Conditions Affecting Risk of Increased COVID Severity Amongst Tribal Populations in Arizona* [Unpublished raw data analysis]. Retrieved from Arizona Health Care Cost Containment System Medicaid Data.

- AI/AN Medicaid members with the social determinant of health of secondhand smoke exposure were 2.65 times more likely to develop pneumonia and 3 times more likely to experience respiratory failure.[12]
- AI/AN Medicaid members with the social determinant of health smoking/nicotine use were 4.58 times more likely to develop pneumonia and 3.5 times more likely to experience respiratory failure.[12]

National spotlight has been shone upon the considerable disparities in health amongst racial and ethnic minorities existing within the United States as a whole. There is a growing realization amongst governmental agencies, healthcare researchers, clinicians, and advocates that a focus on health care disparities is an important aspect of not just improving healthcare outcomes, but in ***reducing the overall cost burden associated with preventable and lifestyle associated conditions***.

Since Arizona's AI/AN population has been so disproportionately affected by these disparities, it would stand to reason that increasing funds to provide education from a centralized agency, working to target the unique needs in a culturally and linguistically appropriate manner, would aid in reducing the prevalence of these conditions in AI/AN populations and assist in overall cost savings to the state.

Impact on historically underserved, marginalized, or adversely affected groups:

Members of Tribes in Arizona are historically underserved and marginalized members of our communities. As described earlier in this SFY26 budget increase request, Tribes in Arizona continue to face significant health disparities, ones that already existed and then were further exacerbated by the COVID-19 pandemic. These persist in 2024.

The AACIHC seeks to accomplish meaningful work to alleviate this burden.

The mission of the AACIHC is to serve as a resource for all Tribal governments and the State of Arizona by *supporting* prevention, training, education, workforce development, policy and legislation to meet the unique health care needs of American Indian and Alaska Native (AI/AN) populations in Arizona. We seek to educate and advocate for improved health outcomes.

As described in the earlier sections of this SFY26 budget increase proposal, this mission is greatly needed to ensure equitable health outcomes for AI/AN communities within Arizona.

The Arizona Advisory Council on Indian Health Care (AACIHC) is uniquely positioned to fill the role. As a trusted messenger for AI/AN communities we are able to act as a bridge between governmental organizations and tribal communities to provide key health education messages. Our work has been moving the dial towards health equity.

However, much of our health education efforts are supported by grant funding, which is set to end in 2024

and 2025.

Grant Expirations:

- COVID-19 Health Disparities Grant – ~~May 31, 2024~~ Extended via a No Cost Extension to December 31, 2024
- Arizona Health Improvement Plan (AZHIP) – July 30, 2024
- CDC-CCR Grant – ~~August 30, 2024~~ Awaiting confirmation for a No Cost Extension, which would extend this grant to August 30, 2025
- Arizona Health Area Education Center (AHEC) – August 31, 2026

Continuance of the mission of the central AACIHC team, which has provided necessary supports for all of these efforts**, *and the expansion to include health educators and a training officer in SFY26*,** will allow this important work in Tribal communities in Arizona to continue uninterrupted, even once the current COVID-19 related-grants and AZHIP grants expire.

The addition of these three (3) Health Educators and (1) Training Officer, would allow the AACIHC to have enough staffing to continue hosting currently operating coalitions and workgroups intended to share information and address health disparities, to continue with providing technical and educational advisement components to Tribal CHR groups, to continue in our creation of educational public health materials and provision of trainings, and to provide valuable technical assistance to tribal stakeholders seeking out grant opportunities.

Thus far our agency has been able to, with the assistance of health education and training roles provided specifically by grants, accomplish the following:

- Partnered with AHCCCS to review over 21 *million* lines of health care claims, for 211,208 American Indian and Alaskan Native individuals, drawing relationships between infectious diseases, like COVID-19, and chronic disease conditions, and corresponding social determinants of health.
    - These analyses have been used to create health education campaigns and to provide information back to Tribes and tribal partners regarding risk factors, specific for indigenous peoples in Arizona. It has greatly advised education and outreach efforts.
- Created over 220 informational infographics, posters, and pamphlets on a variety of health related topics, ranging from protective measures to take during a pandemic, health literacy items (i.e. explaining the different type of face masks available, why different ones are used in different situations, explaining what a virus is and how it can be transmitted, explaining what different chronic health conditions are and causative factors, etc.), an epidemiology 101 series, and health and wellness (i.e. exercise programs for at home, nutritional fun facts, etc.) infographics.

  - Tribes and partner organizations serving indigenous peoples can request to collaborate on the creation of such materials for their use.
  - In the creation of these infographics, we have partnered with physicians, personal trainers, public health experts, infectious disease experts, and health insurance subject matter experts.
- Started a technical support training series for community members seeking to learn more about health topics, such as managing chronic diseases, health and wellness (e.g. nutrition and exercise), navigating the healthcare system, health insurance, and general health literacy topics (e.g. how vaccines work, what are viruses and how do they transmit from person-to-person, what is Personal Protective Equipment and how can you use it in your daily life?) etc., and health care providers serving the American Indian and Alaska Native (AI/AN) community. In the first 2 and a half weeks of the sessions, we have provided training to 173 individuals.
- Created multiple health education toolkits available on the AACIHC's website:
  - Health Education Toolkit: https://aacihc.az.gov/health-education-toolkit
  - Tribal Pandemic Toolkit: https://aacihc.az.gov/tribal-pandemic-toolkit
  - Epidemiology Toolkit: https://aacihc.az.gov/epidemiology-toolkit
- Successfully planned and hosted three (3) Community Health Representative Annual Summits, providing education to over 200 participants per conference.
- Coordinated over 48 trainings for Community Health Representatives, and trained over 684 participants.
- Facilitated over 24 CHR Directors Meetings.
- Established partnerships with over 34 external partners, including 19 Tribal CHR Programs within Arizona, along with colleges, hospitals, and I/T/U's.
- Established the Tribal Pandemic Coalition, with over 60 representatives from a variety of tribal, healthcare, and state agency stakeholders, and facilitated quarterly meetings since 2022.
- Held the very successful Tribal Health Literacy Summit: Navigating Pandemics Together in March of 2024, with 184 participants.
- Held a very successful statewide Tribal Epidemiology Summit, with 116 participants, in May of 2024.
- Established a comprehensive workshop on Tribal Data Sovereignty and hosted four sessions, through the Arizona Health Improvement Plan (AZHIP).
- Commissioned a Health and Housing Assessment Amongst Tribal Communities in Arizona, for 2023/2024.
- Facilitated clinical placement and student stipends for over 80 graduate and undergraduate health professions students in nursing, dentistry, medicine, primary care, allied health professions and physician assisting, in the second year of the American Indian Health -Area Health Education Center (AIH-AHEC), which the AACIHC runs.
- Facilitated training and/or certification for over 60 health care professionals within their professional discipline, impacting both their career growth as well as the communities' resources, through the Arizona AHEAD (Advancing Health Equity and Reducing Disparities) program.

- Outreached over a thousand Indigenous youth in collaboration with the AHEC's two partners, Gila River Health Care and San Carlos Apache Health Care, to promote healthcare careers and exploration among Indigenous youth, K-8, as well as through a more structured program for high school and undergraduate students.
- Agency staff have been invited to speak and present at over 24 national and state-wide conferences, providing over 30 educational presentations at these conferences, along with 4 poster presentations.

These accomplishments have significantly impacted Tribes in Arizona, and AI/AN individuals who have been historically underserved and marginalized members of our communities. The work of the AACIHC is also significant on a national level, in that it provides a model for other states, by showing the State of Arizona's innovative approach to addressing health disparities, while also proving that the state takes its duty to help reverse health inequities existing within historically underserved communities seriously.

How has feedback been incorporated from groups directly impacted by the proposal?

Ensuring that the voices of the 22 Tribal communities in Arizona are heard is of the utmost importance to the AACIHC.

The Arizona Advisory Council on Indian Health Care, established by A.R.S. 26-2902.01, provides a voice to the leaders within Tribal communities and to members of Tribal communities, so as to represent them when it comes to shaping and advocating for health policy. Representatives to the council are chosen by contacting each Tribe to solicit names of individuals who would best serve the interests of the Tribe and American Indian peoples within Arizona. This allows the council to provide representation of Tribal communities.

The council consists of:

- Up to 22 representatives from federally recognized American Indian Tribes in the State, who are recommended by the Tribe and then become appointed by the Governor;
- 1 representative from the Inter Tribal Council of Arizona (ITCA)
- 1 representative from an Urban Indian Health Organization
- 1 representative from AHCCCS (usually the Tribal Liaison)
- 1 representative from ADHS (usually the Tribal Liaison)
- 1 representative from DES (usually the Tribal Liaison)
- 1 representative from the Arizona early childhood development and health board

This proposal has been discussed with various members of the council and with Tribal community members as our various agency staff have gone out into the community to discuss needs. The identified need has been a continuance of health education efforts once the grants, and grant funded positions, have expired. Another community request has been for further technical assistance, in the form of training, on grant applications pertaining to health services and addressing health disparities.

In addition, every member of our agency, including those working under grant-funded positions, directly interfaces and communicates with Tribal members, Tribal leaders, and other stakeholders working with Tribes (i.e. CHR organizations, IHS and 638 providers, urban Indian health organizations, health plans, etc.), both through meetings (virtual and in-person) and through community engagement events (i.e. council meetings, seminars, conferences, welcome-back events, informational sessions, etc.).

Our agency has established and runs a Tribal Pandemic Coalition, which is being transitioned into a Tribal Health Coalition, and also hosts the Tribal Community Health Representative (CHR) Director's meetings. These two forums provide regular communication with representatives from 11 Tribes in the Tribal Health Coalition, and 10 Tribes in the Tribal CHR Directors meetings. Additionally, our policy and legislative areas have established regular meetings with several Tribal Public Health departments to discuss areas of need and collaboration.

Feedback from the Advisory Council, community members, the I/T/U system, the Tribal Health Coalition, CHR Directors meetings, and Tribal Public Health Departments is continually considered by AACIHC leadership and the Advisory Council when determining health educational campaigns, outreach efforts, technical assistance programs, and legislative and administrative advocacy efforts.

Proposed solution to the problem or issue:
To sustain the services we are currently providing through grant funded positions, we are requesting three health educator positions. To expand technical assistance programs in tribal communities we are also requesting one training officer 3 position. This is per our charge in A.R.S. 36-2902.02, which states, "The staff shall provide technical assistance to tribal governments on tribal health care initiatives." The training officer position can also assist health educators in the design and implementation of training modules.

Position Justifications:

1.	Health Educator	Grade 20	$72,410
2.	Health Educator	Grade 20	$72,410
3.	Health Educator	Grade 20	$72,410
4.	Training Officer 3	Grade 21	$79,200

Total for new positions: $296,430

$296,430 – for new positions only – not including the Director, Business Operations Administrator, Legislative Specialist, Community Outreach Coordinator, Senior Epidemiologist, Executive Project Coordinator, or Executive Assistant positions. These four positions (health educators and training officer) are requested as State General Fund staffing additions to our existing staff. ERE calculated based off 35% of total salary, per discussion with AHCCCS DBF team.

The AACIHC is uniquely situated to:

1) Provide direct health education to members of Arizona Tribes, to Community Health Representatives (CHR's) working in tribal communities, and to individuals working in tribal public health, through the creation of educational materials, in-person and online trainings, one-on-one sessions, and participation in community events. Materials we create for Tribal populations can also

be utilized by other State agencies for their educational efforts. Currently, our grants fund these valuable services, which ultimately saves the State money. However, once grants expire, we will no longer have funding to continue things like updating pre-existing materials, creating new materials, providing training sessions to the public, and updating/maintaining our website. If granted the three health educator positions, they will be able to perform these functions.

2) Provide technical assistance to tribal governments, tribal health departments, and IHS, Tribal 638's, and urban Indian health organizations (I/T/U's) on grant applications for health care initiatives. This will help in bringing in additional dollars to the State as a whole, and assist Tribes by helping to secure funds to further address health inequities through the I/T/U system and tribal public health departments. This should ideally translate to a reduction in the development of newly diagnosed chronic health conditions amongst AI/AN populations, and in helping to ensure proper disease management amongst the AI/AN population currently living with health conditions that, when not treated, are costly to the healthcare system as a whole. Tribes currently lack key infrastructure and capacity building employees when it comes to applying for grants, and this would help to fill this role.

New Position Request	Job Code	Job Code Title	Schedule	Grade	Annual Min	Annual Mid	Annual Max
Health Educator	AUN04426	**HEALTH EDUCATOR**	AREG	20	$40,496	$56,453	**$72,410**
Health Educator	AUN04426	**HEALTH EDUCATOR**	AREG	20	$40,496	$56,453	**$72,410**
Health Educator	AUN04426	**HEALTH EDUCATOR**	AREG	20	$40,496	$56,453	**$72,410**
Training Officer 3	AUN04866	**TRAINING OFFICER 3**	AREG	21	$43,981	$61,591	**$79,200**

We are requesting funding for the top of the range, so as to get and retain the best talent possible for these positions. It is extremely difficult to attract and retain talent, with experience working within Tribal communities, and we need to adjust our offered pay scales accordingly to keep the positions attractive.

Performance Measures to quantify the success of the solution:

AHCCCS Strategic Goal(s):

- While the AACIHC is a separate State agency, we do align with AHCCCS in the following goal: Providing equitable access to high-quality, whole-person centered care. We are working to improve health outcomes for AI/AN individuals within Arizona, and are working to ensure that all AI/AN individuals within Arizona have access to services, education on how to obtain those services, and the health literacy and health education skills to understand the system they are accessing.

AACIHC Strategic Goal(s)

- Helping to reduce health disparities through educational efforts and legislative and administrative advocacy.

ARIZONA ADVISORY COUNCIL ON INDIAN HEALTH CARE

Of the 7 strategic plan goals that our agency has proposed, that are AACIHC-specific, the addition of three (3) health educators and one (1) training officer aligns with and provides direct ability to accomplish three of our strategic goals, for the SFY25 to SFY27 Strategic Plan. They are as follows:

Goal 1 - Provide technical assistance and support on Medicaid, health care policies and laws, and operational assistance for standing up health care programs for Tribes and Urban Indian health organizations.

We do this by collaborating with tribal governments, tribal organizations and urban Indian health care organizations in this state to ensure representation in shaping Medicaid and health care policies and laws that impact the populations they serve.

Objectives of AACIHC Strategic Plan Goal 1:

- Providing technical assistance and/or connecting tribal programs with trusted resources to support their tribal health care infrastructure.]
- Provide "Office Hours" - a designated time for Tribes to call for assistance from our agency staff.

Goal 3 - AACIHC as a trusted resource for information, education and relevant data on AI/AN health disparities.

Objectives of AACIHC Strategic Plan Goal 3:

- Host informational and training sessions about our programs.
- Establish easily accessible toolkits that support the mission of the AACIHC.
- Engage current followers and grow network of followers on social media accounts
- Engage partners through various workgroups, inclusive of all 22 Tribes and organizations working with AI/AN communities.
- Establish and support data related initiatives in state, local, and national data workgroups.
- Create a process for sharing events and activities among Tribal Communities and AACIHC activities that can be used to create content for social media and website updates

Goal 5 – Develop sustainable initiatives to increase assistance for Tribes/Urban Programs.

Objectives of AACIHC Strategic Plan Goal 5:

- Identify grant funds that meet AACIHC's Mission and Vision and benefit our Tribal stakeholders.
- Expand our partnership network for assistance in obtaining letters of support for grant funding and/or policy advocacy.
- Nurture and Leverage partnerships and networks towards inclusive and comprehensive communication.

Proposed Performance Measure(s):

Performance measures will be three-fold:

1. Epidemiological Measurements
2. Programmatic Activity Tracking as Achievement Indicators
3. Evaluation of Success of Programmatic Activities

(1) Epidemiological Measurements

The AACIHC does not provision direct health care. However, we engage in health education activities with underserved communities, serving as trusted messengers for providing training and disseminating information. The ultimate goal is to narrow the gap in health inequities between AI/AN populations and all other demographics.

There is a known and inevitable delay between health education campaigns and when measurable results are available regarding the success of campaigns. The success is often not observable for several years, making the measurement of the success of education campaigns challenging.

To do this, we intend to look at publicly available rates of chronic disease in American Indian and Alaskan Natives (AI/AN), and through our partnership with AHCCCS, compare rates of chronic disease between our first data set of Medicaid claims (from 2020 to 2023) to a second data set pulled from 2024 to 2026.

The performance measure will be the publication of an annual report of the health inequities noted amongst AI/AN populations and changes between years, linked to other health indicators as noted by our epidemiological analysis.

(2) Programmatic Activity Tracking as Achievement Indicators

Programmatic activities shall be tracked using metrics based off the number of trainings created and delivered, number of individuals reached, number of Tribes reached, number of I/T/U's reached, number of materials created, and number of surveys (along with data obtained from community surveys). This metrics breakdown is further detailed below.

- Community Reach
    - Number of individuals, Tribes, CHR organizations and workers, clinicians, and students reached through all programs
    - Social media metrics from educational campaigns
    - Number of materials provided to community members
    - Number of conferences and public presentations delivered

- Health Disparity Reductions for Chronic Disease
    - Report published on impact of health education campaigns, to be done in conjunction with performance measure 1, epidemiological measurements.

- Technical Assistance Provided

  - Number of trainings created and delivered on technical support topics, such as standing up billing/reimbursement activities, grant application support to Tribes and organizations serving tribal communities, training provided to support the design and implementation of medical and public health care delivery and financing systems for Tribes and urban Indian health organizations in this state, along with other technical support-related topics.
  - Number of one-on-one sessions with Tribes and I/T/U systems to provide technical support
  - Number of providers trained

- Health Education and System Navigation Trainings
  - Number of trainings created and delivered on health education topics, such as chronic disease, acute disease, health and wellness, prevention measures for common conditions, health literacy, and scientific foundations of disease prevention (i.e. How vaccines work, mask wearing 101, virology 101, the chain of infection, etc.)
  - Number of trainings created and delivered on system navigation (i.e. health insurance 101, how to use health insurance, understanding HIPAA, etc.)
  - Number of individuals and providers trained

- Health Education and System Navigation Materials
  - Number of materials (i.e. pamphlets, infographics, videos, social media campaigns, and FAQs) created to provide health education on chronic disease, acute disease, health and wellness topics, and prevention measures for common conditions, along with education on system navigation to the community and providers. Metrics shall be tracked by topic.

- Workforce Trainings
  - Number of trainings delivered to AI/AN workforce and students
  - Number of clinical practitioners and students provided training and enrichment opportunities

- Community Surveys:
  - There will be community surveys utilized to measure success and utilization rates of health services.

- Training Surveys
  - Pre-test surveys and post-training retrospective surveys shall be delivered for key trainings and workshops, to assess participant perceived changes in knowledge, self-efficacy, and intention to take action to improve mitigable health risk factors, related to the training topics. Other surveys will be delivered to test increase in knowledge base on the training topic

- Health Education Kits
  - Number of kits created and items within kits to further tangible educational opportunities. Many individuals live in rural areas where internet access is not high-speed or available at all. Health education kits provide vital education to individuals in these areas.
  - Number of Individuals Reached

(3) Evaluation of Success of Programmatic Activities

Evaluation findings shall be published in an annual report, comparing the programmatic activities and community reach, with the data summaries yielded as a result of training participant confidence and community surveys. This shall include any changes in chronic and acute disease findings noted from accessible data sources, with the caveat that delays in public health education campaigns often take time to show up in data sources. This is particularly noteworthy due to Medicaid programmatic structures and timely filing guidelines outlined in ARS §36-2904 (G),), which permit health care claims to be submitted up to six months after the initial date of service, and an additional six months for a final 'clean claim' to be submitted. This can create up to a twelve month delay in the submission of measurable data points, for measuring the success of public health campaigns. This is further compounded by the ARS caveat permitting IHS and 638 clinics and facilities to take up to twelve months to submit their initial claim.

Evaluation shall also include the tenets of community based participatory research and evaluation (CBPR)[13] and the nine principles of CBPR offered by LaVeaux and Christopher (2010)[13] for conducting research with, by, and for tribal communities. CDC Evaluation Framework[14] shall be utilized in the assessment of public health education outreach efforts.

Alternatives considered and reasons for rejection:

Additional grant funding to maintain services may be considered. However, while we intend to apply for additional funds as the opportunities present themselves, there are no guarantees.

Without funding for these additional, permanent state-appropriated funded positions within our agency, we will experience a significant reduction in our health education efforts due to lack of staffing. Grant-funding is not guaranteed to continue to support these efforts.

Impact of not funding in FY 2026:

We would have to cease a large proportion of our health education efforts in Tribal communities, including both trainings provided and material creations. Services that would be ceased, or significantly impacted, would include:

- Services provided by the COVID-19 Health Disparities Grant funding, include:

[13] 7. D L, S C. (2009). *Contextualizing CBPR: Key Principles of CBPR meet the Indigenous research context*. Pimatisiwin, 7(1), 1.
[14] CDC. *Framework for Evaluation in Public Health*. Accessed May 8, 2024. https://www.cdc.gov/evaluation/framework/index.htm

  - Creation of initiative-based health educational opportunities for community members through the unique creation of infographics, flyers, fact sheets, training, and health education conferences and workshops geared toward AI/AN community members in Arizona. These are done utilizing learning techniques such as design thinking, taking a distinctive conceptual approach to empowering community members on preventive measures regarding pandemic preparedness.
  - Continuation of regular mobilization and meetings of the Tribal Pandemic Coalition, which is a think-tank that contains a group of individuals making up 11/22 Tribes in Arizona. They serve as stakeholders in tackling pandemic preparedness needs for Tribal Communities and also provide valuable advisement on all health education items created and disseminated for cultural appropriateness. This group is being transition to a health education workgroup, but will need staffing to ensure its successful continuation in the form of health educators.
  - Maintenance and additions/updates to the Tribal Pandemic Toolkit, which contains mitigation and prevention resources to mitigate the spread of COVID-19, Influenza, Sexually Transmitted Illnesses (S.T.I.'s), and other communicable diseases, including information on disease mitigation and how to handle future pandemics through the development of Tribal culturally relevant informational flyers, templates, training, workshops, and videos on pandemic preparedness. The creation of health literacy education is integrated into the toolkit as a request from tribal community members.
  - Maintenance and additions/updates to the Health Education Toolkit, which contains educational materials on health and wellness and mitigable factors for disease prevention.
- Services provided by Arizona Health Improvement Plan (AzHIP) funding, include:
  - Additional identification of public health issues affecting tribal communities, through health assessments delivered to the community; and
  - Reduction in key stakeholder engagements through Tribal Epidemiology Summits and workgroups to discuss public health issues, data sharing, and data sovereignty.
- Services provided by the CDC Community Health Workers for Covid Response and Resilient Communities (CCR) Grant, funding, include:
  - Technical assistance in the form of connecting tribal CHR groups with necessary training opportunities to ensure maintenance of clinical and voluntary certifications, conference and workshop organization and coordination to ensure continued inter-tribal community collaboration, and how to ensure sustainable funding sources to ensure continuance of CHR programs.
  - The creation and delivery of CHR-specific trainings that are formed in collaboration with CHR programs. These trainings focus on public health emergencies, crisis response, chronic diseases, soft skills, and more to benefit the workforce.
  - The cessation of integration manual creations, which are currently done in conjunction with Northern Arizona University Center for Health Equity Research (CHER). If granted positions for health education and training, collaboration with key stakeholders such as NAU could continue. Two examples of manuals created as a part of these collaborations include: Vaccine Development and Public Health Emergency Preparedness and Response.
- Significant reduction in health education provided at community events State-wide.

- A reduced capacity to provide technical assistance to Tribes, CHR organizations, and I/T/U's throughout the state.

Tribal communities are already suffering much higher rates of health disparities and poor health outcomes, when compared to not just white populations, but when compared to all other racial ethnic groups. It is not only vital that we continue the efforts to bridge this gap, but that we increase our efforts to assist Tribal communities.

The cessation of such efforts would be detrimental to our Tribal communities, given the following:

- The pandemic resulted in a decrease in life expectancy of eight (8) years in AI/AN populations in Arizona, specifically, putting us in a national spotlight for poor health outcomes for AI/AN individuals; *and*
- Deaths due to certain lifestyle preventable conditions were significantly higher for American Indians/Alaskan Natives (AI/AN) compared to all other racial ethnic groups, as backed by ADHS and national data; *and*
- The higher rates of orphanhood amongst AI/AN children (i.e. per the CDC, when looking at both primary and secondary caregivers, *1 of every 168 American Indian/Alaska Native children, 1 of every 310 Black children, 1 of every 412 Hispanic children, 1 of every 612 Asian children, and 1 of every 753 White children experienced orphanhood or death of caregivers*), which makes AI/AN children in Arizona especially vulnerable to suffering health disparities, as they may not be receiving health education from primary or secondary caregivers anymore due to the *loss* of those caregivers; *and*
- The higher rates of lifestyle preventable, chronic health conditions, such as type II diabetes, chronic liver disease/cirrhosis, hypertension, obesity, etc.

We thank the Governor's Office and the esteemed members of the Legislature for their consideration.

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