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Date: December 2022

## Overview

In support of the mission of the American Indian and Alaska Native (AIAN) Liaison Committee of the National Association of Insurance Commissioners (NAIC), the Committee agreed to explore three topics with the aim of exploring best practices and fostering an ongoing dialogue on insurance issues.

This paper is intended as a general briefing to explore the COVID-19 response in AIAN communities, including lessons learned, what worked well, and what can be improved upon in the event of another pandemic event.

With the onset of COVID-19 and the rollout of vaccines, the AIAN population acted swiftly and with determination to get their shots. Through the COVID-19 pandemic, AIAN hospitalization and death rates skyrocketed past those of non-Hispanic whites.

Leveraging established systems like the Indian Health Service (IHS) and tribal organizations, AIAN communities urgently administered vaccines. Data from the Centers for Disease Control and Prevention (CDC) showed they achieved the highest vaccination rates of any race or ethnicity. Nationally, 72% of AIAN population of all ages had received at least one dose of a COVID vaccine as of March 28, 2022, with 59% fully vaccinated — having received two doses of the Moderna or Pfizer vaccine or one dose of the Johnson & Johnson.<sup>1</sup>

As of August 30, 2022, 68% of overall Americans have been vaccinated.<sup>2</sup> However, there continues to be 17 states with less than 60% fully vaccinated.<sup>3</sup> Are there lessons to be learned, or practices to be improved upon, from the AIAN response when it comes to early vaccination rates?

## AIAN Population and the Disparate Impact of COVID-19

AIAN people represent 2.9% of the U.S. population.<sup>4</sup> AIAN people live across the country, but are concentrated in certain states, with roughly half living in seven states (CA, OK, AZ, TX, NM, WA, and NY).<sup>5</sup> In looking at the percent of population, five states have AIAN as the second largest racial or ethnic group after Whites (AK, NM, SD, MT and ND).<sup>6</sup> Approximately 70% of the AIAN populations live in urban areas.<sup>7</sup> Under treaties and laws, the federal government has a unique responsibility to provide health care services to AIAN people.

The COVID-19 impact has been devastating for tribal communities and further compounded by not being able to exercise cultural practices, follow values and traditions, and the grief of loss.

The AIAN populations have a long history of pandemics. COVID-19 is only the latest in a string of deadly infectious diseases, including tuberculosis and the Spanish flu of 1918, that have disproportionately killed and sickened AIAN people. During the 1918 flu pandemic, more than 80% of deaths in Alaska were among

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<sup>1</sup> <https://khn.org/news/article/native-americans-covid-vaccine-booster-numbers-lag/>

<sup>2</sup> [https://covid.cdc.gov/covid-data-tracker/#vaccinations\\_vacc-people-additional-dose-totalpop](https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-people-additional-dose-totalpop)

<sup>3</sup> <https://www.npr.org/sections/health-shots/2021/01/28/960901166/how-is-the-covid-19-vaccination-campaign-going-in-your-state>

<sup>4</sup> [How the Native American population changed since the last census \(usafacts.org\)](https://www.usafacts.org/articles/indian-population/2019/08/20/How-the-Native-American-population-changed-since-the-last-census)

<sup>5</sup> [COVID-19 Presents Significant Risks for American Indian and Alaska Native People | KFF](https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-presents-significant-risks-for-american-indian-and-alaska-native-people/)

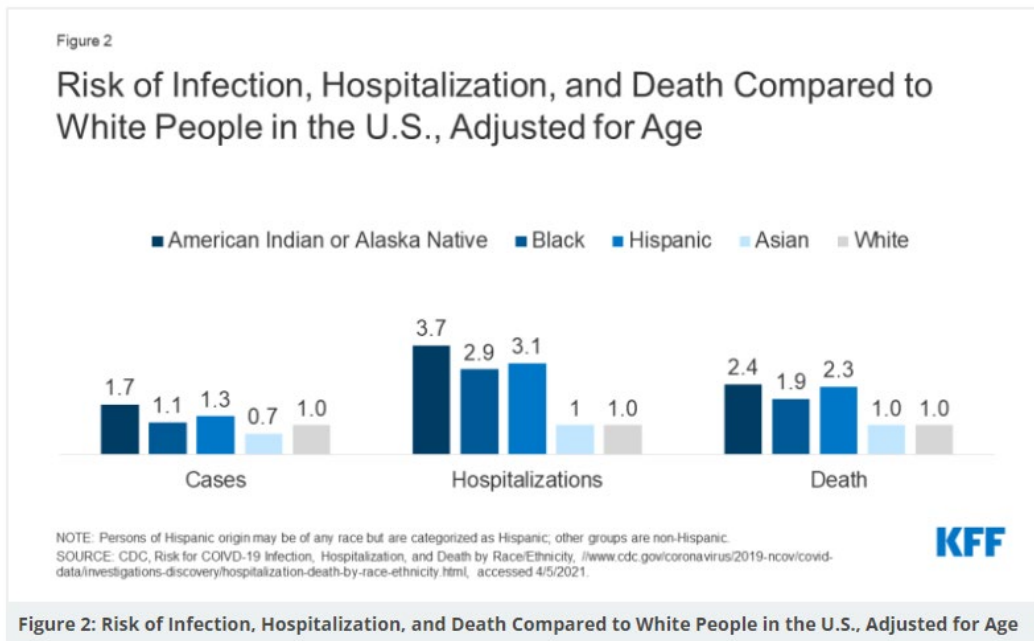
<sup>6</sup> [2020 Census: Native population increased by 86.5 percent - ICT \(indiancountrytoday.com\)](https://www.indiancountrytoday.com/news/2020-census-native-population-increased-by-86-5-percent-ict/)

<sup>7</sup> [Urban Indian Health Program | Fact Sheets \(ihs.gov\)](https://www.ihs.gov/urban-indian-health-program/fact-sheets/)

Native people. American Indians died at four to five times the rate of other Americans during the H1N1 flu epidemic of 2009. These pandemics caused massive social and cultural upheaval – decimating tribal communities and leaving survivors to experience major, lasting disruptions. These pandemics caused massive social and cultural upheaval – decimating tribal communities and leaving survivors to experience major, lasting disruptions.<sup>8</sup>

AIAN people face an increased risk of exposure to the virus due to underlying social and economic factors and have higher rates of health conditions that put them at increased risk for serious illness if they contract COVID-19.<sup>9</sup>

- Nearly one quarter, or 23%, of AIAN people live in poverty, almost double the national poverty rate. AIAN people also have significantly higher rates of unemployment, lower rates of home ownership, and are less likely to have a bachelor’s degree. AIAN people report being in poor or fair health at nearly twice the rate of American adults overall (20.6% versus 12.1%).<sup>10</sup>
- AIAN people had infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19 and have higher rates of mortality at younger ages than non-Hispanic Whites.<sup>11</sup>
- Research into the characteristics of different reservations — such as access to running water and English proficiency — suggests a correlation with disparities in COVID-19 rates.<sup>12</sup>



<sup>8</sup> <https://www.commonwealthfund.org/publications/2020/sep/learning-pandemic-responses-across-indian-country>

<sup>9</sup> COVID-19 Vaccination among American Indian and Alaska Native People | KFF

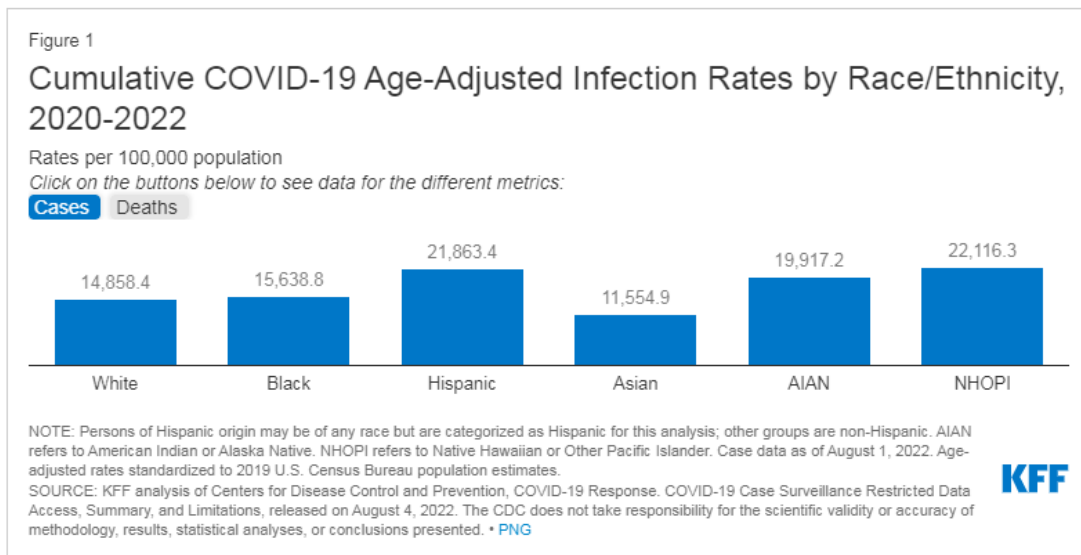
<sup>10</sup> <https://www.macpac.gov/wp-content/uploads/2021/02/Medicoids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf>

<sup>11</sup> [Coronavirus | Indian Health Service \(IHS\)](#)

<sup>12</sup> [Identifying Differences in COVID-19 Rates on American Indian Reservations - JPHMP Direct](#)

An analysis of data published in August 2022 (updating a February 2022 analysis to reflect data through mid-2022) found:<sup>13</sup>

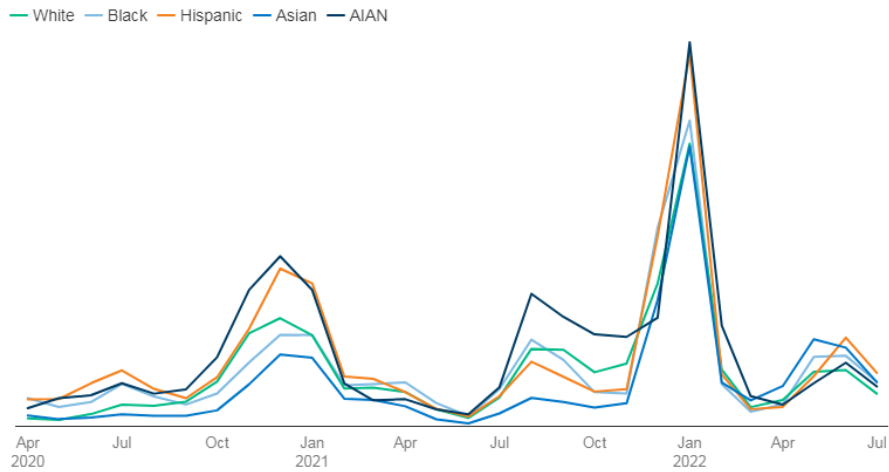
- Higher rates of infection among people of color likely reflect increased exposure risk due to working, living, and transportation situations, including being more likely to work in jobs that could not be done remotely, to live in larger households, and to rely on public transportation.
- While disparities in cases and deaths narrowed and widened during different periods over time, the underlying structural inequities in health and health care and social and economic factors that placed people of color at increased risk at the outset of the pandemic remain.
- Black, Hispanic, and AIAN people may remain at increased risk as the pandemic continues to evolve and for future health threats, such as the Monkeypox virus, for which early data show similar disparities emerging.
- Potential disparities in access to COVID-19 treatments will be important to monitor going forward.



<sup>13</sup> [COVID-19 Cases and Deaths by Race/Ethnicity: Current Data and Changes Over Time | KFF](#)

Figure 2

### COVID-19 Monthly Age-Adjusted Cases in the United States per 100,000 by Race/Ethnicity, April 2020 to July 2022

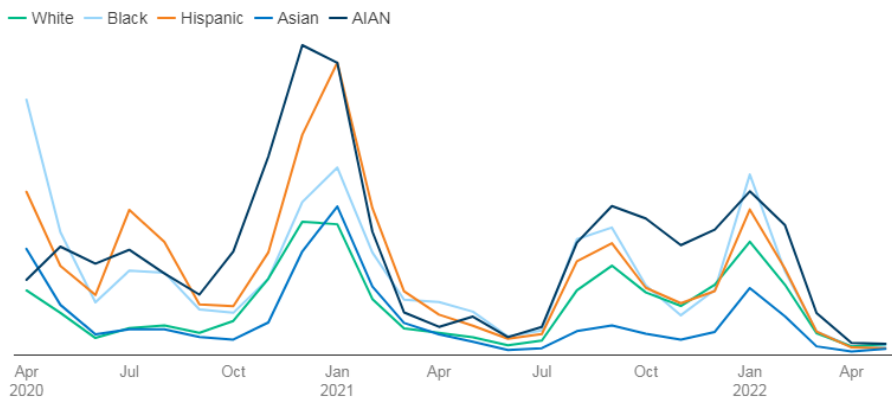


NOTE: Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. AIAN refers to American Indian/Alaska Native. Age-adjusted rates standardized to 2019 U.S. Census Bureau population estimates.  
SOURCE: KFF analysis of Centers for Disease Control and Prevention, COVID-19 Response. COVID-19 Case Surveillance Restricted Data Access, Summary, and Limitations, released on August 4, 2022. The CDC does not take responsibility for the scientific validity or accuracy of methodology, results, statistical analyses, or conclusions presented. • PNG



Figure 3

### COVID-19 Monthly Age-Adjusted Deaths in the United States per 100,000 by Race/Ethnicity, April 2020 to May 2022



NOTE: Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. AIAN refers to American Indian/Alaska Native. Data for Native Hawaiian and Other Pacific Islander people not shown due to insufficient number of deaths for several months during the analysis period. Age-adjusted rates standardized to 2019 U.S. population estimate. Death data as of August 3, 2022 but only shown through May 2022 because data during recent periods are often incomplete because of the lag in time between when the death occurred and when the death certificate is completed, submitted to NCHS and processed for reporting purposes. This delay can range from 1 week to 8 weeks or more, depending on the jurisdiction and cause of death.  
SOURCE: National Center for Health Statistics, Provisional COVID-19 Deaths by Race and Hispanic Origin, and Age. Date accessed August 4, 2022. Available from <https://data.cdc.gov/d/ks3g-spdg>. • PNG



## AIAN Population Vaccination

Analysis of available COVID-19 vaccination data among AIAN people from federal and state sources as of April 5, 2021, found:<sup>14</sup>

- Higher rate of vaccination compared to other racial/ethnic groups. Federal data show that 32% of AIAN people had received at least one dose of a COVID-19 vaccine, compared to 19% of White people, 16% of Asian people, 12% of Black people and 9% of Hispanic people. State data similarly finds higher vaccination rates among AIAN people compared to other groups.
- The high vaccination rate among AIAN people largely reflected Tribal leadership in implementing vaccine prioritization and distribution strategies that met the preferences and needs of their communities.
- The high rates may also, in part, reflect the greater supply of vaccine doses delivered to the IHS relative to the number of people served compared to state vaccination programs.
- Tribes supported and built upon existing trusted community resources and providers to distribute vaccines.

## What Worked Well; Lessons Learned

The pandemic has affected different AIAN communities in different parts of the country in different ways. Lessons that emerged from providers' creative responses can be used to strengthen AIAN health care services for the long term.

In a 2021 Kaiser Family Foundation (KFF) analysis of AIAN population vaccination rates, the data available showed a high COVID-19 vaccination rate among AIAN people, largely reflecting the role of Tribes in designing and implementing vaccine distribution strategies that met the needs and preferences of the communities they serve. The success Tribes have achieved in vaccinating their communities provide lessons learned that may help inform broader vaccination efforts going forward. The KFF study found:<sup>15</sup>

- Experiences suggest the autonomy provided to Tribes to design and implement vaccine distribution efforts among their communities has contributed to success in vaccinating the population. The high rates may also, in part, reflect the greater supply of vaccine doses delivered to the IHS relative to the population served compared to state vaccination programs.
- IHS, Tribal health programs, and Urban Indian Organizations had autonomy and flexibility to implement priority and distribution strategies that meet the needs and preferences of their communities. The IHS developed a COVID-19 Vaccine Task Force to advance plans for prioritization strategies, vaccine administration, distribution, data management, safety and monitoring, and communications. IHS first prioritized health care workers and residents of long-term care facilities. Initial doses allocated to IHS were estimated to be sufficient for 100% of its health care workforce and residents of long-term care facilities. Many chose to prioritize elders and some, like the Standing Rock Sioux Tribe, prioritized speakers of native languages, to protect against further losses of culture and traditions that the pandemic has threatened. Several

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<sup>14</sup> [COVID-19 Vaccination among American Indian and Alaska Native People | KFF](#)

<sup>15</sup> [COVID-19 Vaccination among American Indian and Alaska Native People | KFF \(https://www.kff.org/racial-equity-and-health-policy/issue-brief/covid-19-vaccination-american-indian-alaska-native-people/#\)](https://www.kff.org/racial-equity-and-health-policy/issue-brief/covid-19-vaccination-american-indian-alaska-native-people/#)

Tribes, including Chickasaw Nation, Cherokee Nation, and Lummi Nation, had so much success in vaccinating their priority groups that they have expanded distribution to include non-Native members of the public.

- Tribes built up and supported existing trusted community resources and providers to distribute vaccines. Tribes are using the networks and resources in the community and drawing upon years of experience to reach tribal members with various access barriers. For example:
  - The Navajo Nation vaccinated between 4,000 and 5,000 homebound citizens by collaborating with public health workers to reach those residents in rural communities.
  - In Alaska, tribal health organizations relied on longstanding strategies developed to reach geographically isolated communities, including partnering with local pilots to transport pharmacists and vials of vaccines to such areas.
  - Many Tribes had established vaccine sign-up systems to match the resources and preferences of their populations. For example, some Tribes set up call centers to answer inquiries, book appointments, and reach out to people.
- Tribes launched tailored outreach and communication plans that shared culturally relevant messages through trusted individuals in the community. A national survey of AIAN people conducted in late 2020 found that the majority were willing to receive the COVID-19 vaccine and the key motivation for getting a vaccine was a sense of responsibility to protect their community and preserve cultural ways. Some Tribes have used fluent language speakers to address concerns about the vaccine in the community. For example:
  - The Cherokee Nation prioritized Cherokee language speakers to create optimism and show that the vaccine was safe.
  - The Navajo Nation employed fluent doctors and health care professionals to serve as trusted sources of information on the vaccine.

In a 2020 study, research suggested the importance of having access to relevant public health information in Indigenous languages when sharing information about COVID-19 and ways to help minimize the spread. Data suggested having this type of tailored information helps reduce the infection rate in some tribal communities.<sup>16</sup>

In the case of Hawaii's experience concerning availability of accurate data, Kim Ku'ulei Birnie, Communications and Engagement Lead for Project Vision, worked alongside the Native Hawaiian and Pacific Islander Response Team to improve the collection and reporting of accurate data. When substantial data was collected, it showed Native and Pacific Islanders were significantly impacted by COVID-19, which was contrary to early information.

An article by the Commonwealth Fund, an organization focused on promoting a high-performing equitable health care system, looked at the efforts to contain and mitigate the virus by the three Indian Health Care Providers (IHCPs or I/T/Us) – providers in IHS medical facilities, Tribal health facilities, and

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<sup>16</sup> [How COVID-19 is impacting indigenous peoples in the U.S. | PBS NewsHour](#)



Urban Indian Organizations. Examples provided offered lessons for the rest of the country and pointed to policies that could strengthen AIAN communities for the long run:<sup>17</sup>

- Community-wide testing “blitzes.”
- Mobile health services to improvised shelters for quarantining.
- Outreach to meet people’s basic needs.
- Aggressive testing, contact tracing, and enforcing quarantines — leveraging a strong collective spirit and past experiences with infectious disease outbreaks to encourage participation.
- Evening and weekend curfews.
- Large events testing – the tribe quickly quarantined the handful who tested positive, creating shelters for those who couldn’t do so in their homes (Northern Cheyenne, MT). “We’re a very tight-knit community.” “We’re used to relying on each other for survival.”
- Tribes offering gift cards as incentives for vaccination participation.
- Indian health boards in charge of notifying members of results – “we have a responsibility to our patients to maintain continuity of care and to do contact tracing...no one in the AIAN population is going to take a call from the federal government.” [FEMA ultimately agreed; Seattle’s King County.]
- Offered COVID-19 tests in a tent outside its main Indian Health facility, the health center offered tests at a day center for people experiencing homelessness.
- Issued a Tribal state of emergency and passed new laws for tribal citizens who had tested positive for COVID-19 or were awaiting test results to quarantine or risk a fine. Leaders used an anonymous tip line so people could report those who violate quarantine orders.
- Established new or depending on existing partners (for example, FEMA, CDC, and HHS helped tribes secure personal protective equipment, procure test kits and supplies, and prepare response plans).
- Established Tribal IHS teams (including nurses, a critical care physician, and a respiratory therapist) with experience to work in COVID-19 hot zones.

In Navajo Nation, New Mexico, response efforts included:<sup>18</sup>

- Health care providers at the Gallup Indian Medical Center – the largest IHS hospital on the border of the Navajo Reservation – partnered with another local hospital, Rehoboth McKinley Christian Health Services, and the state health department to convert four Gallup hotels into temporary “respiratory shelters.” Community Outreach and Patient Empowerment (COPE), a local nonprofit, used these shelters to quarantine people who didn’t have another place to safely shelter on their own, including those who were exposed to COVID-19 and awaiting test results or those recovering from the virus. The COPE shelters housed over 700 individuals over the course of the pandemic.

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<sup>17</sup> <https://www.commonwealthfund.org/publications/2020/sep/learning-pandemic-responses-across-indian-country>

<sup>18</sup> <https://www.copeprogram.org/covid-response>

- Physicians and nurses from the University of California San Francisco medical school offered treatment to COVID-19 patients in the shelters.
- COPE staff and volunteers:
  - Delivered meals, medications, and other supplies to the respiratory shelter residents, while providing on-call support to community-led respiratory shelters at Gallup’s four hotels, offering translation services and coordination with medical providers.
  - Developed accurate, culturally informed, clear, and consistent information on contact tracing, COVID prevention, and response for contact tracers.
  - Provided direct aid relief by delivering food, water, and essential goods, such as livestock feed to quarantined communities.
  - Donated 40+ tons of emergency supplies and donations to hotspot areas in partnership with World Central Kitchen, With Love from Strangers, Angel Flight, and local chapters.
  - Provided COVID-19 stations (consisting of hand sanitizer stations, gloves, facial masks, and six COVID-19 related educational posters) to small community stores.
  - Collaborated – under the guidance of the Navajo Nation Health Command Operations Center – with IHS staff, Johns Hopkins Center for American Indian Health, and Fourth Sky Media to create videos encouraging practices to prevent COVID-19 at schools.
- Storytelling in their native (Diné) language is one effective way that they’ve been able to reach their community members and educate them about COVID-19.
- AIAN community responses in the wake of the COVID-19 pandemic can offer takeaways and lessons for all. For example:<sup>19</sup>
  - ***To have the most impact, federal, state, and tribal pandemic responses should be aligned.*** While tribes operate as sovereign nations, and some are geographically isolated enough to seal their borders. Public health policies that are not aligned across tribes and their home states can sow confusion and work at cross purposes. For example, while North Dakota — which in early September had the nation’s highest rates of COVID-19 infection — has no official masking policy, North Dakota’s Turtle Mountain Band of Chippewa has a masking mandate on its reservation. Many members of the tribe must travel to work or shop off the reservation.
  - ***Funding for the IHS enhancement to reflect actual need.*** The IHS received \$2.4 billion in additional funds to support COVID-19 responses, including the deployment of critical care response teams, creation of alternate care sites, and transition to telehealth platforms. Moving forward, IHS funding should be increased to improve the health of a population that is disproportionately ill and vulnerable to infectious disease. “Funding levels for the IHS are not based on actuarial analysis but just on historical spending,” says Donald Warne, M.D., M.P.H., professor of family and community medicine at the University of North Dakota. “Medicare has cost reports from hospitals to assist in determining funding levels, for example. The IHS does not have an equivalent process.”

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<sup>19</sup> <https://www.commonwealthfund.org/publications/2020/sep/learning-pandemic-responses-across-indian-country>

- ***Given that many AIAN people live in poverty, some are evaluating Medicaid expansion for expanding access to care.*** While the AIAN population generally has access to primary care and preventive health care services at IHS facilities without any financial obligation, they cannot always access specialty care if they lack Medicaid coverage or other insurance due to the limitations of IHS budgets. One member of the Oglala Lakota tribe of Pine Ridge, South Dakota, says a natural experiment has been playing out in the Dakotas since North Dakota expanded eligibility for its Medicaid program while South Dakota did not. This meant Tribal members can use their Medicaid coverage to access a wide range of specialty services in North Dakota. It was noted that there are “still areas where the referral bills are not even getting paid because there's not enough money in that budget.”
- ***Filling workforce gaps among AIAN health care providers will require a multifaceted approach.*** Widespread vacancies in clinical and leadership positions impede efforts to ensure American Indians have access to high-quality care. With evidence suggesting patients may benefit from having clinicians who share their racial/ethnic background, or who are familiar with their culture and traditional healing practices, it will be important to fill positions with Indigenous clinicians. To train more AIAN doctors, the Oklahoma State University Center for Health Sciences partnered with the Cherokee Nation to open the nation’s first medical school on Tribal land. The HEAL initiative with the University of California San Francisco sent doctors and nurses from the U.S. and low- and middle-income countries for fellowships in the Navajo Nation to encourage more people to work there. A third of fellows who came from elsewhere decided to stay. The initiative also offered fellowships for Navajo doctors and other health care professionals to build the local workforce. Ultimately, the goal is to overcome the need to import talent, says Sriram Shamasunder, M.D., one of the initiative’s founders.
  - Using faith leaders and community outreach workers who understand local context and culture is very important.
  - Leveraging those relationships is key. A strong recommendation from trusted individuals greatly influences whether people accept a vaccine.

## What Could Have Worked Better

Initial successes have in some places given way to setbacks as the crisis wears on. For instance, despite the success of Montana’s Northern Cheyenne in testing half of the tribe, the virus spread due to extensive household overcrowding and a growing sense of weariness. Rodriguez-Lonebear, Northern Cheyenne Tribe, shared “We’ve lost nearly 20 tribal members, which is a lot for a small tribe because we are all related somehow and so each loss cuts deep.”<sup>20</sup>

**Boosters Rates – COVID fatigue or Vaccination Apathy or Accessibility?** Data show in 2022 a much smaller share had received booster shots — 44% of fully vaccinated Native Americans ages 12 and up, below the booster rates for whites, Asian Americans, and Native Hawaiians and Pacific Islanders. Nationally, as of March 28, 2022, fewer than half of booster-eligible Native residents had received them.

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<sup>20</sup> <https://www.commonwealthfund.org/publications/2020/sep/learning-pandemic-responses-across-indian-country>

Director of health disparities outreach and prevention education at the University of Arizona’s public health school noted shots were more accessible at the very beginning where there was a mass effort, a community-wide effort. With boosters, the AIAN population must identify where to get booster shots, which were the closest location, and hours of operation. Tribal officials continue to try to figure out how to best educate people on how to protect themselves.<sup>21</sup>

**Data Collection Challenges.** Kim Ku’ulei Birnie (Project Vision) shared that, during the height of the pandemic, there was little-to-no accurate data being collected and reported on Native Hawaiians and Pacific Islanders.<sup>22</sup>

Another problem, which likely masks the true share of AIAN individuals who received the booster shots, involves data inconsistencies. Race data on AIAN people has long been hindered by accuracy issues, including misclassifications of people. With COVID-19 vaccines, the CDC receives data from various systems that generally don’t communicate with one another – state immunization registries, pharmacy chains, and federal vaccine providers, including IHS. Often, race and ethnicity information are also missing from the vaccination records.

## Conclusion/Recommendations

There are many factors to consider when developing an outreach, education, and community involvement strategy – one significant aspect is identification of key community leaders and contributors. Utilizing and empowering community and faith leaders will help build trust to further the effectiveness of education and outreach. Additionally, making sure that materials are culturally and linguistically appropriate can help increase the effectiveness of outreach programs.

*NOTE: The NAIC and the AIAN Committee do not necessarily endorse all measures taken by AIAN governmental bodies to slow the spread of COVID-19. The information contained in this document is intended to foster awareness and communication.*

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<sup>21</sup> <https://khn.org/news/article/native-americans-covid-vaccine-booster-numbers-lag/>

<sup>22</sup> <https://madetosave.org/2021/11/29/planting-our-seeds-lessons-learned-from-indigenous-led-covid-19-vaccination-outreach/>