

A woman with glasses and a floral dress is holding a large, white feathered headdress with a colorful circular emblem. She is smiling and looking towards the camera. The background is a warm, wooden interior with other people visible in the distance.

# Our health in our hands

The path to Tribally managed health care in Alaska: 1950s to today

In Alaska, Tribal management of health care recognizes the importance of local decision making for the unique health needs of the Tribal members served.

The Alaska Tribal Health System is a voluntary affiliation of Tribes and Tribal organizations providing health services to Alaska Native and American Indian people. Comprised of the 25 signing organizations of the Alaska Tribal Health Compact, which authorizes Tribal management of services previously provided by the Indian Health Service, each Tribal health organization is autonomous and serves a specific geographical area across the state of Alaska.

Alaska Native Tribal Health Consortium was created in 1997 by Congressional authorization to provide statewide health services and support for all Alaska Tribal health organizations and communities.

This narrative overview of the path to Tribally managed health care in the Alaska Tribal Health System was sponsored by ANTHC through a partnership with the Anchorage Daily News in 2019.



*Alaska Native Service Hospital, Anchorage, Alaska*

## The early days of Alaska Tribal health, 1953–1968

Health care has long been part of Tribal relations across the United States. The federal government began to acknowledge “certain responsibilities” toward Native American people in the late 18th century, according to an Indian Health Service publication released to mark the agency’s 50th anniversary in 2005. Early Tribal health programs began as early as the 1800s, and it was not unusual for cession treaties to list medical care as partial compensation when Tribes were forced to surrender their traditional lands.

### The Indian Health Service in Alaska

In 1955, the Indian Health Service was established as a bureau of the U.S. Public Health Service, which the Bureau of Indian Affairs had previously managed. IHS assumed management of the Anchorage Medical Center of the Alaska Native Service (known as ANS) in downtown Anchorage, which opened under BIA management in 1953.

Growing up, Anchorage resident Vivian Echavarria recalls, going to the doctor at ANS was a day-long affair.

“My mother would take me out of school all day,” she said. “I would go to the front area of the old hospital, and she would take a number, and from there she would wait to get my chart. Then we would go to the ER and she’d drop the chart off, take another number, and we’d wait. I remember sitting long hours in that waiting room. And then if I needed to go get my lab (tests) or get an image done, we’d go to all of these ancillary areas and we’d draw a number, wait, draw a number, wait.”

According to its own reports, IHS facilities across the country were already considered “poor and outmoded.” Primarily located on or around reservations, IHS facilities were small and focused on critical inpatient care. ANS provided routine primary care for the Anchorage Service Unit, which covered a huge area, from the Aleutians to Glennallen and served patients from other parts of the state who required a higher level of care than was available in their regions.

The hospital was as much a social gathering spot as it was a medical facility. “I remember my mother bringing all of us kids in tow to the Native hospital because relatives were being brought in for care,” Echavarria said. They’d bring food and visit with friends and family in the wards.



TB rates decrease dramatically in the 1960s thanks to advances in treatment and new facilities like the Alaska Native Service Hospital.

## A one-size-fits-all approach

Headquartered in Anchorage, the Alaska Area of IHS was divided into seven regional service units that oversaw medical care in different areas of the territory, from village clinics to hospitals.

By the time Alaska became a state in 1959, the federal government was nearly 20 years into the Indian termination policy, a succession of laws that attempted to force the assimilation of Native people. The result was the loss of indigenous languages and traditions across the country, including in Alaska.

While individual IHS officers worked to provide health care, preventive medicine and sanitation in Indian Country, the agency’s structure reflected the indigenous policies of the day. In 2005, IHS described its administration at the time as “paternalistic and highly centralized, with local service units reporting to Area Offices, which reported to Washington,” with “little input” from Tribal leaders.

Echavarria, who today serves as vice president of professional and support services for Alaska Native Tribal Health Consortium, says that blanket approach didn’t work, especially in Alaska. National priorities didn’t always translate to every region. And the top-down approach lingered long after boarding schools and relocation initiatives had been abandoned. During her years working in the federally managed health care system, Echavarria remembers IHS pushing nationwide programs to prevent hantavirus — a disease that has never been reported in an Alaska patient.

“I’m not trying to knock down Indian Health,” Echavarria said. “It’s just that Indian Health is a government entity that has its governance from people in Maryland.” Under that arrangement, she said, “you are banking (on) the decisions from people that may not have a clue as to what the real health care concerns are of the (local) people.”

## Planting the seeds of self-governance

At the time IHS was established, the leading cause of death among Alaska Native people was tuberculosis. Introduced by European immigrants in the 1700s, TB had grown to epidemic proportions in the villages. In some places, as many as 75 percent of Alaska Native children tested positive for the disease, according to a 2017 State of Alaska Epidemiology Bulletin. In the 1960s, that number began to decline, thanks to advances in treatment and new hospital facilities like ANS, which was built primarily to address TB.

There was another reason for the disease’s decline: a new trial program that designated “community health aides” who were trained to provide medical care in villages where there was no permanent clinic or full-time physician. These new health care professionals were Alaska Native people serving their home communities in most cases.

“It was in response to the TB effort that IHS created the community health aides,” said Paul Sherry, a longtime Alaska health care administrator who helped form the Tribal health consortium in the



The CHAP authorization in 1968 was the first step toward putting health care management in the hands of Alaska Native people.

1990s. “They needed on-site providers in the communities to do medications management.”

“It was in response to the TB effort that IHS created the community health aides,” said Paul Sherry, a longtime Alaska health care administrator who helped form the Tribal health consortium in the 1990s. “They needed on-site providers in the communities to do medications management.”

Officially authorized by Congress in 1968 — the same year President Lyndon Johnson proposed ending termination policies — the Community Health Aide Program was the first step toward putting Alaska Native health care in the hands of Alaska Native people. Soon, in addition to dispensing tuberculosis medication, community health aides were responding to emergencies and providing care for expectant mothers.

“That was the first time, essentially, that (IHS) moved outside of the model of hiring Western medical practitioners who traveled around and treated people,” Sherry said. “The idea was that we’ll use local Native people to help get the job

done, and of course those people quickly became relied on to do other things.”

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The Community Health Aide Program changed the way health care was delivered to Alaska Native villages — and it would prove to be the first small step toward putting Tribal health care under Tribal management.



The Alaska Native Service Hospital was as much a social gathering place as it was a medical facility.

### Late 1700s

TB epidemic is brought on by European immigrants and explorers

### 1800s

Early Tribal health programs began

### Mid-1940s - Mid-1960s

Indian Termination Policy. Tribal communities were forced to assimilate into mainstream U.S. society, leading to disastrous loss of language and cultural traditions.

### 1953

BIA opened Anchorage Medical Center of the Alaska Native Service, known as ANS, in downtown Anchorage.

### 1959

Alaska becomes the 49th state in the U.S.

### 1968

Community Health Aide (CHAP) Program is established in Alaska which was one of the first steps to put Alaska Native Health Care in that hands of Alaska Native people. That same year President Lyndon Johnson proposed ending the termination policies IHS authorized the creation of the Alaska Native Health Board to provide the Alaska Area Native Health Service with input into its programs and priorities

### 1971

Alaska Native Claims Settlement Act (ANCSA) was approved by Congress. This created 13 new regional for-profit Alaska Native Corporations

### 1975

Indian Self-Determination and Education Assistance Act (ISDEAA). This act authorized government agencies like Secretary of the Interior and Secretary of Health, Education, and Welfare to contract with tribes

### 1976

Indian Health Care Improvement Act which afforded Tribal health organizations the ability to bill Medicare and Medicaid for eligible patients

**Alaska Tribal Health  
history at a glance**



## The road to self-governance, 1968–1980s

On a summer day in 1975, a Washington, D.C. attorney, Jacob Pompan, flew to the village of Tanana, then boarded a boat and traveled 12 miles upriver to a fish camp. Fish strips hung in the smokehouse. Flies and mosquitoes buzzed around the outhouses. Pompan stepped off the boat in a three-piece suit and wing tip shoes. “I don’t know where he thought he was going, but he dressed for D.C., and he came to Indian Country,” recalled Sherry.

At the time, Sherry was part of a group of Tanana Chiefs Conference (TCC) health board members and staff gathered at the fish camp to learn from Pompan about the Indian Self-Determination and Education Assistance Act, a law poised to open up a whole new universe of possibilities for Alaska Native Tribes.

It was the kind of training that’s held in a conference center or hotel, but as Sherry tells it,

TCC Health Director Claude Demientieff Jr. wanted to show people that the road to self-determination didn’t have to follow the beaten path. Alaska Native people could forge their own way, guided by their own values.

It was as much a learning experience for the attendees as it was for Pompan — who continued to work with Tribal health leaders but presumably packed differently for his next trip to Alaska.

If a big city attorney on the banks of the Yukon seems like an odd visual, it might also be the most vivid example of the monumental shift that was then taking place across Alaska’s Tribal health care system. For the first time, Alaska Native people were in control of their health priorities — not as wards of the federal government, but as its partners.

### The early days of health self-determination in Alaska

In 1968, the Indian Health Service Alaska Area was led by Gerald Ivey from McGrath, who felt strongly that Alaska Native people needed more of a voice in their health care. During Ivey’s tenure, IHS authorized the creation of the Alaska Native Health Board to provide the Alaska Area Native Health Service with input into its programs and priorities.

Around the same time, a movement was afoot to begin improving health care at the regional level. In the Bering Strait and Yukon Delta regions: Norton Sound Health Corporation and Yukon-Kuskokwim Health Corporation were established with funding through the federal Office of Economic Opportunity. Each corporation was governed by a board elected by local Tribal councils.

“The health system can be as good as it can be, but if the people don’t become a partner to the health system, then you don’t see improvement.”

Another program, Healthright, funded by the OEC, was an Alaska Federation of Natives initiative to fund health services development in the rest of the state. In some regions, this money was used to expand existing organizations such as TCC, the Maniilaq Association, and Chugachmiut. In others, separate nonprofits were established, leading to the development of Southeast Alaska Regional Health Consortium and the Bristol Bay Area Health Corp.

Self-determination and self-governance emerged early as priorities. Leaders felt it was essential for Alaska Native communities to take an active role in managing health care problems and solutions, rather than being treated as passive recipients of federal services.

“The health system can be as good as it can be, but if the people don’t become a partner to the health system, then you don’t see improvement,” Sherry said.



President Richard Nixon signed the Alaska Native Claims Settlement Act in December 1971 creating 13 for-profit regional Alaska Native Corporations as a solution to long-standing land claims issues in Alaska.

### Federal legislation brings sweeping change

In December 1971, Congress approved the Alaska Native Claims Settlement Act (ANCSA). The 13 new ANCSA regional corporations created a second tier of for-profit Tribal resources, while preserving the nonprofit network of Tribal organizations and associations.

As the dust from ANCSA settled, IHS began contracting Alaska initiatives to regional nonprofits, beginning at the front lines with Community Health Aides. The Community Health Aide Program was unique to Alaska and made more sense under Tribal management, Sherry said, making it the perfect place for Tribes to begin dipping their toes into health care.

#### 1980

Bristol Bay Areal Health Corp. made history when it assumed exclusive responsibility for its service area, including Dillingham’s Kakanak Hospital, becoming the first Tribal group in the U.S. to manage an IHS hospital

#### Mid-1980s

Several more of the Tribal health organizations were ready to assume responsibility for management of the IHS service unit hospitals

#### 1992

Congress amended ISDEAA to authorize a Tribal Self-Governance Demonstration Project within the IHS giving federally recognized Tribes the option of entering into self-governance compacts to gain more autonomy in the management and delivery of their health care programs

#### 1994

IHS approved Alaska Native Health Board’s proposed “All-Alaska Compact” in 1994 as part of its first round of Tribal health care compacts, and the Alaska Tribal Health Caucus was organized later that year

#### 1995–1997

The Caucus refined its vision: an inter-Tribal health consortium that would elevate care for all Alaska Native people

#### 1997

IHS finished construction on the \$170 million ANMC hospital in Anchorage  
Senator Ted Stevens introduced language in the appropriations act that allowed IHS to enter into a compact to manage statewide services with a then-nonexistent statewide inter-tribal health consortium

In December, leaders from the state’s Tribal health organizations convened in Anchorage to organize what would become known as the Alaska Native Tribal Health Consortium.

#### 1999

Jan. 4, a ceremony in the main lobby of ANMC celebrated the completion of the transition to statewide Tribal health services under Alaska Native ownership

#### 2001

Telehealth is implemented in four regional hospitals and 20 village clinics, providing for the first time a regular connection between rural patients and medical specialists. Since its implementation, 370,000 telehealth cases have been reviewed by 4,000 health care providers, and a conservative estimate puts total travel savings somewhere north of \$105 million

#### Present

The path to Tribally managed health care has grown since the early days to provide the best quality care to people and will grow as our leaders prepare for what’s on the horizon.

Then came another turning point: the 1975 passage of the Indian Self-Determination and Education Assistance Act. Previously, government officials had the option to enter into contracts with Tribes, as IHS had done with the Community Health Aides. Under the new law, if a Tribe asked to provide services to its own members, the federal agency was now required to agree to a contract.



*Year after year, Alaska Tribes brought more programs under their management from IHS.*

With the regional health organizations already in place, Alaska Tribes were ready to begin taking responsibility for health care. Year after year, Tribal organizations brought more programs under their management through IHS contracts.

Bureaucracy moves slowly, and IHS was no exception. Tribal organizations sometimes felt as though IHS contracting requirements were unduly burdensome, from highly detailed budgets to rules around who could approve certain hires.

“It used to drive us absolutely crazy, the amount of control that they demanded,” Sherry said.

In fairness, he added, it was critical that the Tribal organizations be set up for success.

“If you don’t have systems in place to support your employees, to house your employees, to manage your funds, all of that, you’re going to fail,” Sherry said. “The Indian Health Service, to their credit, demanded that these organizations prove that they could do that.”

Dr. Dick Mandsager, who took over the Alaska Area director role in 1985, acknowledged the process could be complex and challenging even as IHS recognized the importance of supporting Tribal groups.

“Generally speaking, we all saw that our job was to make this transition happen,” he said.

“The fact that every village is its own Tribe makes Alaska very different from any other region in the IHS.”

### Slow, steady progress

The Self-Determination Act was written with the Lower 48 reservation system in mind. Tribal governments were required to authorize any new contract that served their members, a task that was more challenging in Alaska.

“The fact that every village is its own Tribe makes (Alaska) very different from any other region in the IHS,” Mandsager said. With regional health organizations serving multiple Tribal governments, the process of communicating the details of each contract and securing approval from dozens of Tribes could be time-consuming.



*In 1975, the Indian Self-Determination and Education Assistance Act was passed authorizing government agencies to contract services with Tribes.*

Slowly but surely, progress was made. Tribal organizations worked with the Alaska Legislature to secure capital funding for clinic and hospital buildings. Improved runways and telecommunications, along with water and sanitation, were other top priorities. State grants helped augment existing programs such as emergency medicine and substance abuse treatment. In 1976, the Indian Health Care Improvement Act was passed which afforded Tribal health organizations the ability to bill Medicare and Medicaid for eligible patients.

In 1980, Bristol Bay Area Health Corp. made history when it assumed exclusive responsibility for its service area, including Dillingham’s Kakanak Hospital, becoming the first Tribal group in the U.S. to manage an IHS hospital. By the mid-1980s, several more of the regional Tribal health organizations were ready to assume responsibility for management of their IHS service unit hospitals.



## Alaska’s Tribal health consortium takes shape, 1990–1999

The historic effort to unite 229 Tribes under a single health consortium was complex, but not unprecedented – it had already been managed on a smaller scale in Alaska, one region at a time. For the average Alaskan, 1997 was the year that brought the most visible change to Tribal health care. That’s when the Indian Health Service finished construction on the \$170 million Alaska Native Medical Center in midtown Anchorage.

### The Alaska Tribal Health Compact

Since the 1970s, Alaska’s Tribes had been contracting with the federal government to manage an increasing number of health care programs overseen by IHS. In 1992, those opportunities expanded with new legislation that gave Tribes the ability to enter into long-term compacts with IHS and manage a wider range of programs. Four Tribal health organizations — Tanana Chiefs Conference, SouthEast Alaska Regional Health Consortium, Southcentral Foundation, and Yukon-Kuskokwim Health Corp. — received grants to help them prepare for the new self-governance designation, and soon it was proposed that the regional organizations collaborate on a single statewide compact to include all Alaska Tribes.

IHS approved the Alaska Native Health Board’s proposed “All-Alaska Compact” in 1994 as part of its

first round of Tribal health care compacts, and the Alaska Tribal Health Caucus was organized later that year. During two years of meetings from 1995 to 1997, the Caucus refined its vision: an inter-Tribal health consortium that would elevate care for all Alaska Native people.

### A new hospital, a new health care hub

Around the same time, IHS was undertaking its most ambitious capital improvement project in the state: construction of a brand-new, state-of-the-art hospital at Tudor Centre to replace the aging Alaska Native Service hospital downtown.

“During that planning process, it became very clear to me that the standards IHS were using were very old standards that were very hospital-based and weren’t really keeping up with new standards,” Mandsager said.

In particular, the old hospital wasn't well equipped for outpatient care. IHS approached Southcentral Foundation, the nonprofit organization serving Alaska Native people from the Cook Inlet region, about contracting to manage small health centers around Anchorage. That proposal evolved into a central ambulatory care clinic, built alongside the new hospital and operated by Southcentral Foundation.

This new medical campus was only the second biggest change coming to Tribal health care in Alaska. By the time the hospital building was complete, Tribal leaders were ready to proceed with plans to contract for its operations.

### A senator steps in

It was the most complex and ambitious step yet for Alaska's self-governance movement. Because the hospital would serve the entire state, all of Alaska's 229 federally recognized Tribes would have to sign authorizing resolutions. This undertaking would require outreach and negotiation that seemed, if not impossible, at least monumental.

In 1997, Senator Ted Stevens introduced language in the appropriations act that allowed IHS to enter into a compact to manage statewide services with a then-nonexistent statewide inter-Tribal health consortium. Known as Section 325, Stevens' language outlined the structure of the new consortium — and allowed the agreement to be made without authorization from individual Tribal governments.

This development met with a mixed response from Tribal leaders.

"There was an incredible amount of anger," Mandsager said. It wasn't that the law itself was bad — in his opinion, Stevens "got it about 95 percent right" — but leaders felt blindsided by the specifics. On one hand, Section 325 advanced the goal of full Tribal management of health care. It also flouted the requirement that Tribes authorize the contract — a fundamental principle of self-governance.

### Building from the ground up

Leaders from the state's Tribal health organizations convened in Anchorage in December 1997 to organize what would become known as the Alaska Native Tribal Health Consortium. The following month, Paul Sherry was asked to serve as the new consortium's interim president and CEO.

Sherry was presented with a monumental task: to organize, from scratch, an entity that would impact the life and health of every Alaska Native person. With

start-up loans from Norton Sound Health Corp. and Yukon-Kuskokwim Health Corp., the new ANTHC leadership opened a bank account, rented some office space, and got to work.

In the spring of 1998, ANTHC worked with IHS to establish an initial self-determination contract with a three-stage transition plan for management of statewide offices in IHS' Alaska Area, with the final phase scheduled for January 1999.

One of the trickier pieces to negotiate was the new hospital, because IHS had a co-management agreement in place with Southcentral Foundation.

"Trying to lay out that first agreement got really into the weeds of hospital management," Mandsager said.



On Jan. 4, 1999, ANMC celebrated the completion of the transition to statewide Tribal Health Services under Alaska Native Ownership

ANTHC and Southcentral Foundation agreed to the establishment of a joint operating board, a formula for dividing federal funding, and a system by which each organization would purchase services from the other. ANTHC took responsibility for inpatient services, while Southcentral Foundation oversaw outpatient services. The hospital building itself remained federally owned.

Then there was the framework of a new, complex organization, all of which had to be built from the ground up. It was important that the new consortium be able to secure revenue from sources other than IHS. Systems were established to bill Medicare, Medicaid, and private insurance, as well as to seek state, federal, and private grants. When possible, Sherry said, ANTHC would adopt best practices from the regional health care organizations, which served the dual purpose of saving work while building trust among the consortium's partners.

On Jan. 4, 1999, a ceremony in the main lobby of ANMC celebrated the completion of the transition to statewide Tribal health services under Alaska Native ownership.



A group of ANTHC and Southcentral Foundation employees celebrate the kickoff of Mental Health Awareness Month by dressing in regalia and walking, drumming and singing their way across the Alaska Tribal Health Campus in May 2017.

## Our Health in Our Hands: Tribal health care in the 21<sup>st</sup> century

After achieving self-governance, Alaska's new Tribal health consortium set its sights on reimagining a health care system built for Alaska Native people, by Alaska Native people.

"We knew if we had that authority, we could move in a more agile way," said Roald Helgesen, a Tribal health care leader from Sitka who was named CEO of ANTHC in 2011.

From the beginning, ANTHC's leaders prioritized a proactive approach to health and health care, in ways designed specifically for Alaska Native people and the communities where they live.

### Groundbreaking telehealth

Early in its existence, ANTHC joined the Alaska Federal Health Care Partnership to collaborate with other complex health systems operating in the state, including the Veterans Administration, the Department of Defense, and the Coast Guard, as well as IHS, now a partner rather than a parent organization. That partnership made possible the development of what was then the world's largest telemedicine system.

Tribal health organizations asked for connections in more communities.

"A lot of our village clinics didn't have computers," said Chief Information Officer Stewart Ferguson, who

continues to lead ANTHC's telemedicine program today. "We didn't have connectivity. It was very, very nascent. But clearly people saw the value."

Buoyed by this initial success, the Alaska Federal Health Care Partnership sought and received Congressional funding to build a telehealth system that would be used throughout the Tribal health care network and at remote locations like Coast Guard stations and vessels. ANTHC eventually took on management of the collaborative, inter-agency project.

When the telemedicine program went live in 2001, dial-up internet was the best that could be hoped for in many rural communities. Live videoconferencing simply wasn't an option. So Ferguson and his team pioneered an asynchronous approach called "store

and forward.” Images and information were digitally packaged and sent like an email to providers who could then remotely review and prescribe treatment for each case.

**Take, for example, someone who lives in Helgesen’s family hometown of Hydaburg. To travel to Anchorage for a checkup with a cardiologist, that person used to have to get up at 4 a.m., drive across Prince of Wales Island, take a ferry to Ketchikan, fly to Sitka and then Juneau, and finally land in Anchorage late in the evening, not accounting for the weather delays that are an expected part of travel in rural Alaska.**

“The adoption was quite fast,” Ferguson said. “By 2003, we had the equipment out to 248 sites.”

As connectivity improved, the system expanded to include real-time videoconferencing along with store and forward. Initially used primarily for otology and cardiology, today the telemedicine system is used across multiple specialties. Double-blind studies have established its accuracy and efficacy. Now that more villages are getting broadband, Ferguson said he expects telehealth to reach even further into both clinics and homes, with expanded options for behavioral health, palliative care, post-discharge support for NICU babies and their families, and even trauma care.

“There’s a whole world here,” he said.

### ‘Care closer to home’

Since 2001, 370,000 telehealth cases have been reviewed by 4,000 health care providers, and Ferguson said a conservative estimate puts total travel savings somewhere north of \$105 million.

What’s important to remember, Helgesen said, is that each number represents a real patient who benefited from being treated close to home.

Take, for example, someone who lives in Helgesen’s family hometown of Hydaburg. To travel to Anchorage for a checkup with a cardiologist, that person used to have to get up at 4 a.m., drive across Prince of Wales Island, take a ferry to Ketchikan, fly to Sitka and then Juneau, and finally land in Anchorage late in the evening, not accounting for the weather delays that are an expected part of travel in rural Alaska.

Now, that same patient can go to the village clinic for their initial tests. That information goes into the electronic health record that is now used across much of Alaska’s Tribal health care system.

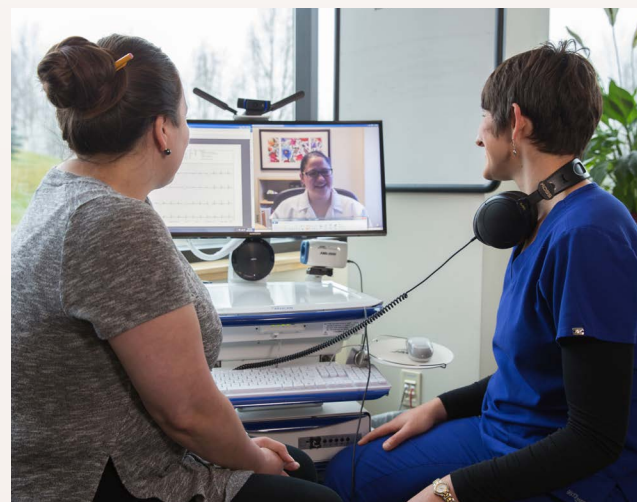
“You walk up to your clinic two days later and you sit down in front of the telemedicine unit and you see your

cardiologist that you’ve known for the last 15 years on the other side,” Helgesen said. That follow-up didn’t generate two 16-hour days of travel. “When we talk about care closer to home, that’s what it means.”

### Innovation and reinvention in Tribal health

Telehealth is just one of the areas in which Tribal health care has innovated and grown over the past two decades to meet the health needs of Alaska Native people across the state.

Health infrastructure was an early focus for ANTHC. A partnership with the Denali Commission helped build more than 100 new community health centers and other facilities in the early 2000s. Water and sanitation improvements have been an ongoing effort, with new innovation necessitated by coastal erosion that complicates plumbing projects in some



Telehealth systems bring care closer to home by connecting patients living in rural Alaska to their providers based in more populated areas.

**“You walk up to your clinic two days later and you sit down in front of the telemedicine unit and you see your cardiologist that you’ve known for the last 15 years on the other side,” Helgesen said. That follow-up didn’t generate two 16-hour days of travel. When we talk about care closer to home, that’s what it means.”**

communities. And the “care closer to home” philosophy behind the original Tribal health care innovation — the Community Health Aide Program — inspired the creation of similar programs for behavioral health and dental care.

### Innovating for the whole person

While Alaska’s Tribal health care system addresses today’s health matters, it’s actively trying to prepare for what may be on the horizon. ANTHC’s Clinical and Research Services program studies issues, trends, and questions that impact the health of Alaska Native people. Recently, Helgesen said, the Consortium has been looking closely at adverse childhood experiences. Alaska Native people are more likely to experience the social factors that are increasingly linked to negative health outcomes in adulthood. More and more, research indicates that community and culture can have a meaningful impact on physical and behavioral health.

“Promoting Alaska Native traditions such as Native language, storytelling, songs and dances, traditional foods and plants are the best medicine for treating our people in a holistic manner,” said Tina Woods, senior director of community health services for ANTHC. “In a system managed by Alaska Native people for Alaska Native people, we take a culturally responsive

approach to promoting wellness in a way that was not imaginable prior to self-governance.”

Today’s Alaska Native Health Campus has very little in common with the old, now-demolished Alaska Native Service Hospital. One thing has stayed the same, today’s Alaska Native Medical Center was designed with culture and community in mind.

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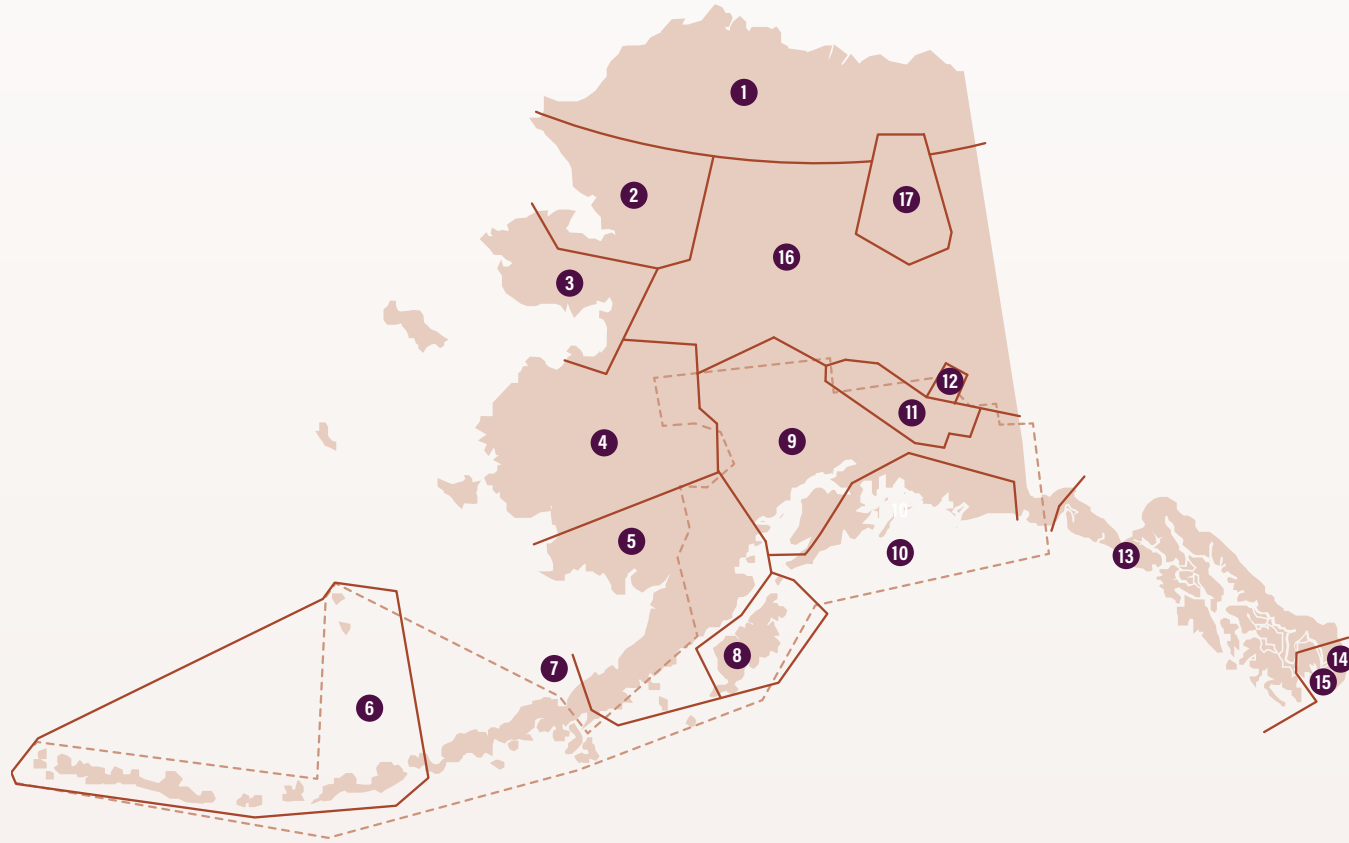
“Come to our gathering spot in the hospital in the evening,” Helgesen said. “You’ll hear drumming and singing and dancing. Our people do that. And it’s really exciting.”



Much like the Alaska Native Service Hospital, Alaska Native Medical Center serves as a gathering place for Alaska Native people from across the state to share culture and community.

## Alaska Tribal Health System

Alaska has 229 federally recognized Tribes across 586,412 square miles, all served by the Alaska Tribal Health System and represented on the Alaska Native Tribal Health Consortium board of directors by regional Alaska Tribal health organization partners.



1. Arctic Slope Native Association
2. Maniilaq Association
3. Norton Sound Health Corporation
4. Yukon-Kuskokwim Health Corporation
5. Bristol Bay Area Health Corporation
6. Aleutian Pribilof Islands Association
7. Eastern Aleutian Tribes
8. Kodiak Area Native Association
9. Southcentral Foundation (dotted line)
10. Chugachmiut
11. Copper River Native Association
12. Mt. Sanford Tribal Consortium
13. SouthEast Alaska Regional Health Consortium
14. Ketchikan Indian Corporation
15. Metlakatla Indian Community
16. Tanana Chiefs Conference
17. Council of Athabascan Tribal Governments

## Glossary

**ANTHC:** Alaska Native Tribal Health Consortium

**IHS:** Indian Health Service

**ANS:** Alaska Native Service Hospital

**CHAP:** Community Health Aide Program

**OEC:** Federal Office of Economic Opportunity

**AFN:** Alaska Federation of Natives

**ANCSA:** Alaska Native Claims Settlement Act

**ANMC:** Alaska Native Medical Center

**Telehealth:** A system used throughout the Tribal health care network and at remote locations across Alaska.





*Prepared by Alaska Native Tribal Health Consortium  
on behalf of the Alaska Tribal Health System*