



NATIONAL COUNCIL of
URBAN INDIAN HEALTH

SOCIAL DETERMINANTS OF HEALTH AFFECTING URBAN AMERICAN INDIAN AND ALASKA NATIVE COMMUNITIES:

KEY FINDINGS & RECOMMENDATIONS

2026

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ACRONYMS

- AI/AN – American Indian and Alaska Native
- AOIC – Alone or in Combination (with one or more other races)
- CAPK – Community Action Partnership of Kern
- CDC – Centers for Disease Control and Prevention
- CDSS – California Department of Social Services
- EBT – Electronic Benefits Transfer
- FMAP – Federal Medical Assistance Percentage
- HDAP – Housing and Disability Advocacy Program
- HMIS – Homeless Management Information System
- IHCA – Indian Health Care Improvement Act
- IHS – Indian Health Service
- LGBTQIA2S – Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and Two-Spirit
- MAT – Medication-Assisted Treatment
- MCO – Managed Care Organizations
- MSA – Metropolitan Statistical Area
- NCUIH – National Council of Urban Indian Health
- NRCNAA – National Resource Center on Native American Aging
- SAPTA – Substance Abuse Prevention, Treatment and Aftercare
- SDOH – Social Determinants of Health
- SPIP – Suicide Prevention, Intervention, and Postvention
- SUD – Substance Use Disorder
- UIO – Urban Indian Organization
- WIC – Women, Infants, and Children

EXECUTIVE SUMMARY

Social Determinants of Health (SDOH) refer to the conditions in which people are born, grow, and live (Centers for Disease Control and Prevention, 2024), and these factors can contribute to disparities in health outcomes and care. Key factors related to SDOH which affect American Indian and Alaska Native (AI/AN) communities include housing insecurity, transportation barriers to care, food insecurity, and Indigenous language and identity challenges. Findings from an environmental scan of public data sources and a survey of California Urban Indian Organizations (UIOs) highlighted the disparities that AI/AN communities experience across each of these four key factors, both nationally and in California specifically. Findings across all factors point to the need for sustained, flexible, and culturally responsive investments.

- **Housing Insecurity:** AI/AN communities experience some of the highest rates of homelessness across the United States (National Alliance to End Homelessness, 2020; De Sousa & Henry, 2024), and disparities persist in AI/AN housing affordability, housing quality, and access to culturally competent housing resources (Levy et al., 2017). UIOs play a pivotal role in providing culturally competent care, with all surveyed California UIOs offering housing services and nearly all surveyed California UIOs described a high prevalence of housing insecurity in their communities. The enhancement of sustainable funding mechanisms for culturally competent and relevant providers of housing services, as well as additional transitional housing programs to address gaps in the types of housing facilities available, can reduce the burden of housing insecurity on AI/AN communities.
- **Transportation Barriers to Care:** AI/AN communities often experience longer geographic distances and travel times to health care, as well as poorer access to and quality of transportation, compared to their counterparts (Warne et al., 2025; Zeledon et al., 2020). Services such as patient transportation and telehealth offered by California UIOs have helped respondents to find success in improving access to care for the communities they serve, but funding and billing for these services presents challenges for many UIOs. By increasing the availability of sustainable funding mechanisms for patient transportation services and telehealth infrastructure, transportation barriers to care can be mitigated for AI/AN communities.
- **Food Insecurity:** AI/AN households are more than twice as likely to experience food insecurity compared to overall households across the United States (Office of Minority Health, 2026), and AI/AN communities experience disproportionate challenges with low access to grocery stores, high food costs, disconnection from traditional food systems, and limited food sovereignty (United States Government Accountability Office, 2024; Jernigan et al., 2017; Jernigan et al., 2021). UIOs play a significant role in reducing food insecurity through culturally relevant food programming, with surveyed California UIOs offering services such as community gardens, food pantries, and nutrition education programs. Improved investment into programs which support

AI/AN food sovereignty and increase access to traditional foods can mitigate food insecurity disparities for AI/AN communities.

- Indigenous Language and Identity Challenges:** AI/AN communities have experienced disconnection from Indigenous languages and traditions due to persistent historical violence and discriminatory policies (Sierra, 2023; Ditzenberger, 2023), but research indicates that access to traditional healing programs which incorporate cultural practices can improve behavioral and cardiovascular health outcomes (Whalen et al., 2022; Schweigman et al., 2011). UIOs help connect AI/AN communities to culturally relevant programs and traditional healing services, with results from the survey of California UIOs highlighting the importance of traditional healing services and the incorporation of Indigenous languages and practices into care. Enhanced investment into traditional healing programs, as well as health care services and materials provided in Indigenous languages, can alleviate these challenges for AI/AN communities.

Figure 1. Summary of Recommendations to Address SDOH

SDOH Challenge	Recommended Priority Areas for Policies, Funding, and Resources to Address SDOH Challenge
<i>Housing Insecurity</i>	Cultural competency of services and staff at housing programs
	Transitional housing programs
<i>Transportation Barriers to Care</i>	Patient transportation services
	Telehealth services and coverage
<i>Food Insecurity</i>	Food programs that supply nutritious traditional foods
	Food production programs that support Indigenous food sovereignty
<i>Indigenous Language and Identity Challenges</i>	Traditional healing programs
	Health care services and materials offered in Indigenous languages

UIOs play a vital role in addressing SDOH and advancing health equity for urban AI/AN communities. Despite demonstrated success at the community level, systemic barriers and funding limitations continue to constrain their impact. Strategic policy action and sustained investment are essential to reduce disparities, strengthen culturally responsive systems, and improve long-term health outcomes for AI/AN populations.

INTRODUCTION

Data from the 2024 American Community Survey 1-Year Estimates indicates that there are approximately 9.1 million people across the United States who identify as AI/AN alone or in combination with one or more other races (AOIC) (U.S. Census Bureau, n.d.). This data also indicates that an estimated 1.3 million AI/AN AOIC people live in California, representing approximately 14.5 percent of the total AI/AN AOIC population (U.S. Census Bureau, n.d.).

Social Determinants of Health (SDOH) refer to the conditions in which people are born, grow, and live (Centers for Disease Control and Prevention, 2024). These include non-medical factors which affect health such as education access and quality, health care and quality, neighborhood and built environment, social and community context, and economic stability (Centers for Disease Control and Prevention, 2024). Many researchers have also identified Indigenous SDOH which uniquely impact the health and well-being of Indigenous communities, such as Indigenous knowledge, language and identity, and sovereignty (Parker et al., 2023).

Of the 575 total federally recognized Tribes across the United States, 109 are located in California, the second-highest number of any state (Bureau of Indian Affairs, 2026). In addition to the Indian Health Service (IHS) and Tribal facilities, Urban Indian Organizations (UIOs) also play a role in the Indian Health System to fulfill the federal government's trust responsibility to provide health care to AI/AN communities. UIOs were created by urban AI/AN people with the support of Tribal leaders in the 1950s in direct response to severe problems with health, education, employment, and housing caused by the federal government's forced relocation policies (National Council of Urban Indian Health, n.d.-b). More than 70 percent of AI/AN people now live in urban areas, compared to eight percent in 1940, a shift driven significantly by federal government coercion during the Relocation Era from 1945 to 1968 (National Council of Urban Indian Health, n.d.-b). Congress formally incorporated UIOs into the Indian Health System in 1976 with the passage of the Indian Health Care Improvement Act (IHCA), recognizing that the federal responsibility for health care services does not end at the borders of an Indian reservation and, as a result of relocation policies, that responsibility follows Indian people to the urban areas where they reside (U.S. Senate Select Committee on Indian Affairs, 1988).

The social and economic conditions documented in this report — housing instability, transportation barriers, food insecurity, and challenges related to Indigenous language and identity — reflect the documented consequences of federal relocation and land policies affecting AI/AN communities, not general population health trends. The programs UIOs provide in response to these conditions fulfill Congress' trust and treaty obligations to a population defined by its political relationship to federally recognized Tribal entities, consistent with the Indian health policy established in 25 U.S.C. § 1602 (U.S. Senate Select Committee on Indian Affairs, 1988). There are 41 UIOs who contract with the IHS across the United States,

ten of which are in California¹, the highest number of any state (National Council of Urban Indian Health, n.d.-a).

The following report presents findings on how key SDOH affect AI/AN communities nationally and in California, as well as recommendations for how to minimize disparities affected by these SDOH. The key factors related to SDOH which are analyzed in this report are housing insecurity, transportation barriers to care, food insecurity, and Indigenous language and identity challenges.

¹ Note: At the time of data collection, there were only nine Title V Urban Indian Organizations (UIOs) in California who could be considered for project participation.

METHODS

The collection and analysis of data on key SDOH affecting AI/AN communities nationally and in California involved two key components: an environmental scan of publicly available data sources, and a survey of UIOs in California. Each factor related to SDOH analyzed in this report includes key findings from both the environmental scan and survey.

Environmental Scan Methods

An environmental scan was conducted to review publicly available data sources for key information on housing insecurity, transportation barriers to care, food insecurity, and Indigenous language and identity challenges affecting AI/AN communities across the United States and in California. Sources included government websites, scientific open-access databases, peer-reviewed articles, and other publications by reputable scholarly and professional organizations.

Nearly 100 sources were reviewed for relevant research, data, policies, and recommendations related to each key SDOH. Findings were compiled and organized by population demographics and key themes and refined to identify the most recent and relevant information.

Survey Methods

From December 2025 to February 2026, NCUIH disseminated a survey on SDOH to UIOs in California. This survey was developed using a combination of open-ended and closed-ended questions to collect quantitative and qualitative insights from UIOs on housing insecurity, transportation barriers to care, food insecurity, and Indigenous language and identity challenges within their communities. Responses were collected through Qualtrics. Only UIOs in California were eligible to complete the survey, with only one response allowed per UIO. Each UIO respondent was offered a \$750 incentive as appreciation for their contributions to the survey. UIOs were encouraged to have their Executive Director/Chief Executive Officer, or a staff member familiar with their UIO's programs and patient/client population, complete the survey. When completing the survey, respondents were prompted to focus specifically on the urban AI/AN community served by their UIO.

Contact information was compiled for the Executive Director/Chief Executive Officer of each of the nine² UIOs in California. Each UIO received an individual direct outreach email to promote the survey opportunity. Multiple rounds of follow-up emails were sent to target UIOs as needed to encourage participation.

² Note: At the time of data collection, there were only nine Title V Urban Indian Organizations (UIOs) in California who could be considered for project participation.

Promotions of the survey opportunity were also released in the NCUIH Newsletter, on the “[Funding Opportunities](#)” page of the NCUIH website, and during NCUIH calls with UIOs.

Seven of the nine³ target California UIOs submitted responses to the survey. One UIO submitted two responses from two different employees, so only one response was included for analysis. One UIO did not submit a complete response in their initial submission, so only their partial response was incorporated into the analysis. Survey response data were analyzed using Qualtrics and Microsoft Excel. Descriptive statistics were generated to analyze data from closed-ended questions. Thematic analysis was completed to analyze data from open-ended questions.

³ Note: At the time of data collection, there were only nine Title V Urban Indian Organizations (UIOs) in California who could be considered for project participation.

HOUSING INSECURITY

Housing is a key SDOH, as shelter and access to necessities and utilities through safe, stable, and affordable living conditions can affect health and well-being (Healthy People 2030, n.d.-b). Housing insecurity refers to the conditions of unstable, unsafe, or unaffordable housing for individuals, whether they are experiencing homelessness or not (Healthy People 2030, n.d.-b). The following section describes the state of housing insecurity and how this challenge affects AI/AN communities, both across the United States and specifically in California. Findings from both the environmental scan of public data sources and the survey of California UIOs are displayed below and were used to inform the key recommendations to address housing insecurity.

Environmental Scan Findings

Historical trauma, structural inequities, and discrimination contribute to significant disparities in housing insecurity which affect AI/AN communities. The California Interagency Council on Homelessness (2025) notes that homelessness within Tribal communities is linked to generations of land dispossession, forced relocation programs, assimilation policies, violence, and chronic underfunding. Structural racism and discrimination continue to contribute to economic inequities and barriers to housing stability today (Kushel et al., 2023). Additionally, AI/AN individuals can experience mistrust of housing and social service systems due to perceived lack of cultural responsiveness and discrimination within housing service settings which further exacerbate adverse housing outcomes (Levy et al., 2017).

Housing insecurity and homelessness disproportionately affect AI/AN communities across the United States and in California. Although AI/AN people comprise only approximately 1.3 percent of the total United States population, they represent a disproportionately larger share of the homeless population nationally (Soto et al., 2020). According to the 2024 Annual Homelessness Assessment Report, approximately 2.7 percent of all people experiencing homelessness in 2024 across the United States were AI/AN or Indigenous people, with nearly half of this population experiencing unsheltered homelessness (De Sousa & Henry, 2024). National data demonstrates that AI/AN communities experience some of the highest rates of homelessness in the country, with homelessness rates substantially higher than those of their White counterparts (National Alliance to End Homelessness, 2020). In 2024, AI/AN people also had the lowest sheltered rates among all racial and ethnic groups (De Sousa & Henry, 2024). While California has the largest AI/AN population in the United States, with approximately 14 percent of all AI/AN people residing in the state, California also experiences one of the highest rates of homelessness nationally and contains approximately half of the nation's unsheltered homeless population (Soto et al., 2020; Sundeen, 2024). In 2024, California had the highest percentage of unsheltered homelessness among all states, with 66 percent of the homeless population estimated to be unsheltered (De Sousa & Henry, 2024). California has also experienced substantial increases in homelessness over time, including increases in chronic homelessness,

homelessness among veterans, and homelessness among unaccompanied youth (Senate Housing Committee, 2024).

AI/AN communities also experience broader disparities related to housing affordability and housing quality. Nationally, AI/AN households experience lower rates of homeownership, reduced access to home financing, higher loan denial rates, and higher rates of overcrowding compared to the general population (Levy et al., 2017). Housing quality concerns such as incomplete plumbing or kitchen facilities are also more common among AI/AN households (Levy et al., 2017). In California, many Tribal communities report overcrowded housing conditions, unsheltered homelessness, and Tribal members living in vehicles (California Interagency Council on Homelessness, 2025). For urban AI/AN communities in particular, distinct barriers exist related to housing insecurity and homelessness. The urban AI/AN population grew from forced relocation programs and continues to grow due to factors such as employment opportunities, educational opportunities, housing conditions, cost of living, and relocation for medical care (California Interagency Council on Homelessness, 2025; Levy et al., 2017). However, urban AI/AN individuals can encounter challenges including limited affordable housing, limited social support systems, employment barriers, and unfamiliarity with urban housing systems (Levy et al., 2017). Data from multiple metropolitan areas suggests that AI/AN people are disproportionately represented among individuals experiencing homelessness in urban communities (Levy et al., 2017).

Housing instability is closely interconnected with health and behavioral health outcomes. Research involving AI/AN adults experiencing homelessness or unstable housing in California demonstrates strong connections between homelessness, intergenerational trauma, and substance use disorder (Soto et al., 2020). Research on statewide homelessness indicates high rates of chronic health conditions, disability, and unmet health care needs among people experiencing homelessness in California (Kushel et al., 2023). In California specifically, data indicates that unstable housing and lack of sober living opportunities are key barriers to Medication-Assisted Treatment (MAT) participation and adherence among AI/AN communities affected by the opioid epidemic (Zeledon et al., 2020).

Survey Findings

Seven UIOs in California shared their insights on housing insecurity in the survey disseminated by NCUIH from December 2025 to February 2026. Key findings on housing insecurity from this survey include:

- When asked to describe the prevalence of housing insecurity in the community they serve, 85.7 percent of UIO respondents said high prevalence and 14.3 percent said moderate prevalence (see **Figure 2**).
- One-hundred percent of UIO respondents offer services related to housing (see **Figure 3**). Specifically, 100 percent of UIO respondents offer housing-related services including referral to

local public social services, referral to homeless shelters, referral to transitional housing facilities, and referral to shelters for individuals affected by domestic violence (see **Figure 3**).

- Approximately 85.7 percent of UIO respondents have found success in addressing housing insecurity for the community they serve (see **Figure 5**).
- Examples of partnerships and/or resources which have been the most successful in helping UIO respondents to effectively address housing insecurity in the communities they serve include the California Department of Social Services, California Department of Public Health, Managed Care Organizations (MCOs) funded by the state’s Enhanced Care Management program, and city/county task forces and databases related to homelessness (see **Figure 6**).
- The most common housing challenges affecting the population served by UIO respondents include limited space at local temporary housing facilities (100 percent), lack of culturally competent housing programs/staff (85.7 percent), and lack of affordable housing (85.7 percent) (see **Figure 7**).
- The most common challenges experienced by UIO respondents to address housing needs for the communities they serve include lack of available local housing resources to refer to (100 percent), lack of affordable spaces available to use for UIO housing services (85.7 percent), and challenges with funding/billing for housing services (57.1 percent) (see **Figure 8**).
- Examples of things that would help UIO respondents to better address housing issues in the communities they serve include affordable housing, reduced housing restrictions and stigmas, co-located housing (such as residential models with private living units and shared common spaces), improved rent control policies and enforcement, prohibition of corporate ownership of private housing, funding and training for the workforce, reimbursement options for housing support services, and improved data (see **Figure 10**).
- Approximately 85.7 percent of UIO respondents collect information on the housing status of patients/clients during intake (see **Figure 11**). Examples of things these respondents have learned from the collection of this housing status data include an improved understanding of the prevalence and levels of housing insecurity, the demographics of housing insecurity in their communities and how it impacts AI/AN communities specifically, how the cost of housing contributes to disproportionate homelessness in certain areas, and how homelessness can persist for long periods due to difficulties with service navigation (see **Figure 12**).
- The subpopulations/groups that UIO respondents serve who experience the most disproportionate challenges with housing include elders (71.4 percent) and youth (57.1 percent) (see **Figure 13**).

Figure 2. Survey Responses to “How would you describe the prevalence of housing insecurity in the community your UIO serves?”

Response Option [Single-Select]	n (% of N)
High prevalence	6 (85.7%)

Moderate prevalence	1 (14.3%)
Low prevalence	0 (0%)
No prevalence	0 (0%)
Total Responses (N):	7

Figure 3. Survey Responses to “Does your UIO offer any of the following services related to housing? Please select all that apply.”

Response Option [Multi-Select]	n (% of N)
We do not offer any services related to housing [<i>Exclusive response</i>]	0 (0%)
Direct housing support (through UIO-owned temporary or permanent housing)	1 (14.3%)
Case management by UIO social worker	5 (71.4%)
Referral to local public social services	7 (100%)
Referral to homeless shelters	7 (100%)
Referral to transitional housing facilities	7 (100%)
Referral to shelters for individuals affected by domestic violence	7 (100%)
Other (Please describe)	3 (42.9%)
Total Responses (N):	7

Figure 4. Survey Responses from Respondents who Selected *Other (Please describe)* for “Does your UIO offer any of the following services related to housing? Please select all that apply.”

Free-Text Response
Enhanced Case Management through Cal-AIM, CA specific
Financial support for utility stipends, deposits, etc. for housing related needs.
We also distribute emergency rental assistance funds on behalf of our municipal government.
Total Responses: 3

Figure 5. Survey Responses to “Has your UIO found success in addressing housing insecurity for the community you serve?”

Response Option [Single-Select]	n (% of N)
Yes	6 (85.7%)
No	1 (14.3%)
Total Responses (N):	7

Figure 6. Survey Responses to “What partnerships and/or resources have been most successful in helping your UIO to effectively address housing insecurity for the community you serve, if any?”

Free-Text Response
California CDC and CDSS HDAD* and IHS SIP**/SAPTA grants and Cal Works
California Department of Social Services & Managed Care Plans
City of [<i>redacted for confidentiality</i>] Homeless Task Force

Housing Support Services- Homeless Navigation
Our partnership with a local affordable housing developer has increased the number of affordable apartment units available to our community. We also work with one of our municipal governments to distribute emergency rental assistance funding, including back rent, future rent, and move-in assistance to prevent community members from becoming unhoused.
Our state program for Enhanced Care Management funds care coordination efforts through regional Medicaid managed care organizations (MCOs). The MCOs work with community benefit and other organizations to provide coordinated assistance to community members.
[Redacted for confidentiality] County HMIS (Homeless Management Information System)
Total Responses: 7

* “HDAD” described by respondent may be referring to Housing and Disability Advocacy Program (HDAP).

** “SIP” described by respondent may be referring to Suicide Prevention, Intervention, and Postvention (SPIP).

Figure 7. Survey Responses to “Do any of the following challenges with housing commonly affect the population served by your UIO? Please select all that apply.”

Response Option [Multi-Select]	n (% of N)
We are not aware of any common housing challenges affecting the population we serve <i>[Exclusive response]</i>	0 (0%)
Lack of local temporary housing facilities	5 (71.4%)
Limited space at local temporary housing facilities	7 (100%)
Restrictive stay limits at local temporary housing facilities	4 (57.1%)
Lack of transportation to local temporary housing facilities	4 (57.1%)
Difficulty connecting to social service programs related to housing	4 (57.1%)
Lack of culturally competent housing programs/staff	6 (85.7%)
Lack of affordable housing	6 (85.7%)
Exclusionary requirements for accessing housing	1 (14.3%)
Overcrowding in permanent housing	5 (71.4%)
Fear of racism, discrimination, and/or violence at local temporary housing facilities	3 (42.9%)
Unsafe conditions at available housing	3 (42.9%)
Long wait times to receive housing support	4 (57.1%)
Other (Please describe)	0 (0%)
Total Responses (N):	7

Figure 8. Survey Responses to “Does your UIO experience any of the following challenges to addressing housing needs for the community you serve? Please select all that apply.”

Response Option [Multi-Select]	n (% of N)
We do not experience any challenges in addressing housing needs in the community we serve <i>[Exclusive response]</i>	0 (0%)
Insufficient capacity of UIO staff	3 (42.9%)
Shortage of available workforce	3 (42.9%)

Challenges with funding/billing for housing services	4 (57.1%)
Lack of available local housing resources to refer to	7 (100%)
Lack of affordable spaces available to use for UIO housing services	6 (85.7%)
Lack of sufficient infrastructure to use for UIO housing services	3 (42.9%)
Other (Please describe)	1 (14.3%)
Total Responses (N):	7

Figure 9. Survey Responses from Respondents who Selected *Other (Please describe)* for “Does your UIO experience any of the following challenges to addressing housing needs for the community you serve? Please select all that apply.”

Free-Text Response
We could benefit from additional funding streams to support housing access for our community members. There are limited resources in our community that are insufficient to meet the great demand for affordable housing.
Total Responses: 1

Figure 10. Survey Responses to “Is there anything that would help your UIO to better address housing issues in the community you serve?”

Free-Text Response
Affordable housing and less restrictions like credit check requirements and Justice Involved background checks. Too much stigma associated with housing this population.
Co-located housing, case management and healthcare
enforced rent control measures prohibited corporate ownership of private housing
Funding for staffing and resources
Not at this time
Trained available workforce, affordable housing spaces and reimbursement for supportive services.
We need better data to understand the specific housing challenges facing urban AIAN community members in our region.
Total Responses: 7

Figure 11. Survey Responses to “Does your UIO collect information about the housing status of patients/clients during intake?”

Response Option [Single-Select]	n (% of N)
Yes	6 (85.7%)
No	1 (14.3%)
Total Responses (N):	7

Figure 12. Survey Responses to “If yes, what have you learned from housing data collected regarding the communities you serve and their housing challenges? [Only displayed to respondents who selected Yes for “Does your UIO collect information about the housing status of patients/clients during intake?”

Free-Text Response
Clients often have struggle to guide themselves through the housing navigation process, and become hopeless and end up homeless for long periods of time.
Cost of housing is a big factor in the homeless population contributing to the large volume of cases in the south bay area.
Housing Insecure is defined differently in Native community
Levels of housing insecurity and associated demographics
The prevalence of homelessness and housing insecurity.
Unchanged over time
Total Responses: 6

Figure 13. Survey Responses to “Are there any specific subpopulations/groups that your UIO serves who experience disproportionate challenges with housing? Please select all that apply.”

Response Option [Multi-Select]	n (% of N)
We are not aware of any specific subpopulations/groups in the community we serve who experience disproportionate housing challenges [<i>Exclusive response</i>]	1 (14.3%)
Youth	4 (57.1%)
Elders	5 (71.4%)
People in the LGBTQIA2S+ community	3 (42.9%)
Individuals impacted by domestic violence	3 (42.9%)
Formerly incarcerated people	3 (42.9%)
Veterans	3 (42.9%)
Pregnant people	1 (14.3%)
People with disabilities	3 (42.9%)
People with mental health conditions	3 (42.9%)
People with Substance Use Disorders (SUDs)	3 (42.9%)
Other (Please describe)	1 (14.3%)
Total Responses (N):	7

Figure 14. Survey Responses from Respondents who Selected *Other (Please describe)* for “Are there any specific subpopulations/groups that your UIO serves who experience disproportionate challenges with housing? Please select all that apply.”

Free-Text Response
"Families - many spaces are too small or do not accept families where both parents are present. Low income - this is a very expensive area with no suburb housing"
Total Responses: 1

Recommendations

The following two areas are recommended to prioritize policies, funding, and resources to address AI/AN housing insecurity:

- 1. Cultural competency of services and staff at housing programs***
- 2. Transitional housing infrastructure***

Findings from the environmental scan and survey of California UIOs demonstrate that the AI/AN population experiences disparities in access to, and quality of, housing services. The impacts of forced relocation, ongoing structural racism, and discriminatory housing policies have contributed to disproportionate burdens of housing insecurity on the AI/AN population (California Interagency Council on Homelessness, 2025; Kushel et al., 2023). Research indicates that access to housing services can be limited and often difficult to navigate, particularly with housing programs that may lack cultural sensitivity and cultural competence when serving AI/AN people (Levy et al., 2017; Kushel et al., 2023). For example, an assessment by the U.S. Department of Housing and Urban Development highlighted how one of the most frequently expressed needs from housing providers serving AI/AN people in Metropolitan Statistical Areas (MSAs) was the need for housing that reflects AI/AN cultural values and practices (Levy et al., 2017). Given that nearly all surveyed California UIOs described a lack of culturally competent housing programs and staff as a common challenge affecting the communities they serve, improving the cultural competency of housing services is crucial in order to improve access and utilization of housing services by the AI/AN population. Additionally, one of the most common challenges in addressing housing insecurity for UIO respondents included challenges with funding or billing for their housing services, and reimbursement options for housing support services were identified as a factor which would help support UIO respondents to better address housing insecurity. Given that all surveyed UIOs offer at least one service related to housing and nearly all UIO respondents felt that they have found success in addressing housing security for the community they serve, UIOs play a pivotal role in providing culturally competent services and reducing the burden of housing insecurity on AI/AN communities. Improving investment into existing culturally relevant housing providers such as UIOs, Tribal organizations, and other AI/AN-serving organizations through sustainable funding mechanisms should be prioritized to reduce AI/AN housing insecurity.

Research also indicates that there are gaps in the types of housing programs and services available, particularly for transitional housing programs besides shelters (Zeledon et al., 2020; Soto et al., 2020; Levy et al., 2017). Specifically, the lack of available sober living programs, transitional housing for those exiting incarceration, and transitional housing for those exiting substance use recovery programs have all been identified as gaps in housing services for AI/AN communities (Zeledon et al., 2020; Levy et al., 2017). All surveyed California UIOs offer referrals to transitional housing facilities, but all UIO respondents also identified a lack of available local housing services to refer to as one of the most common challenges they

face in addressing housing insecurity. Additionally, approximately 43 percent of UIO respondents identified formerly incarcerated people and people with SUDs as groups experiencing disproportionate challenges with housing insecurity. Improved investment into transitional housing infrastructure can help to alleviate the burden of housing insecurity on other housing programs and expand housing access for AI/AN communities.

In order to improve investment into culturally relevant housing services and transitional housing infrastructure, sufficient federal appropriations for stakeholders like UIOs are needed. Federal investment in UIOs depends on adequate appropriations for the Urban Indian Health line item in the IHS budget, which has historically represented only approximately one percent of the total IHS appropriation and has not kept pace with medical inflation or growing patient need (National Council of Urban Indian Health, 2026). Additionally, the structural gap in federal Medicaid reimbursement for services provided at UIOs further constrains UIO capacity to fund housing support services (National Council of Urban Indian Health, 2023). Unlike services provided at IHS and Tribal facilities, which are reimbursed at 100 percent Federal Medical Assistance Percentage (FMAP), services provided at UIOs are reimbursed at a lower matched rate, leaving states to cover a portion of costs that the federal government bears for other components of the Indian health system (National Council of Urban Indian Health, 2023). Closing this gap through permanent 100 percent FMAP for UIOs would directly expand UIO capacity to sustain and expand housing-related services for AI/AN communities (National Council of Urban Indian Health, 2023).

TRANSPORTATION BARRIERS TO CARE

Transportation is a key SDOH which affects how people access jobs, education, food, social networks, and health care (Atherton et al., 2021). The following section describes the state of transportation barriers to care (including care from health care facilities, behavioral health services, and social services) and how these affect AI/AN communities, both across the United States and specifically in California. Findings from both the environmental scan of public data sources and the survey of California UIOs are displayed below and were used to inform the key recommendations to address transportation barriers to care.

Environmental Scan Findings

Historical policies related to forced relocation and current socioeconomic forces affect where AI/AN communities live (California Interagency Council on Homelessness, 2025), and these factors likely also contribute to how transportation access may differ for AI/AN people. **Figure 15** presents findings from the 2024 American Community Survey on modes of transportation used by workers 16 years and over to commute to work, highlighting the differences in transportation use between the general population and the AI/AN population nationally and in California (U.S. Census Bureau, n.d.). At both the national level and state level for California, AI/AN alone or in combination with other races (AOIC) workers had lower rates of driving a vehicle alone, as well as higher rates of carpooling in a vehicle and higher rates of walking (U.S. Census Bureau, n.d.). Additionally, according to findings from the 2007 California Health Interview Survey, when asked about their usual mode of transportation to get to the doctor’s office, 28.2 percent of respondents said they use a personal vehicle as a driver or passenger, 48.4 percent said public transportation, 6.1 percent said paratransit/transportation provided by the Department of Health and Human Services, 12.7 percent said walk or ride bike, and 4.6 percent said taxicab or other (UCLA Center for Health Policy Research, 2024).

Figure 15. Transportation to Commute to Work* (U.S. Census Bureau, n.d.-a)

Mode of Transportation	All Workers 16 Years and Over in the United States	AI/AN AOIC Workers 16 Years and Over in the United States	All Workers 16 Years and Over in California	AI/AN AOIC Workers 16 Years and Over in California
Driving a vehicle alone	69.2%	66.7%	67.3%	67.1%
Carpooling in a vehicle	9.2%	12.8%	10.2%	12.3%
Public transportation	3.7%	3.7%	3.3%	3.6%
Walking	2.4%	3.0%	2.5%	2.9%

*Findings presented above are from the 2024 American Community Survey, where “AI/AN AOIC” refers to surveyed respondents who identify as American Indian and Alaska Native (AI/AN) alone or in combination with other races (AOIC) (U.S. Census Bureau, n.d.-a).

In 2017, an estimated 5.8 million people across the United States delayed medical care each year due to transportation barriers such as lack of access to a private vehicle, costly or inconvenient transportation, or poor road infrastructure, compared to only 4.8 million in 1997 (Labban et al., 2023; Wolfe et al., 2020). Transportation barriers to care can contribute to delayed care, poor medication adherence, and increased reliance on costly acute-care settings like emergency departments (Labban et al., 2023; Wolfe et al., 2020). Patients with disabilities and/or comorbidities, lower socioeconomic status, and those from racial/ethnic minorities experience the most disproportionate burdens of disease (such as higher rates of many acute illnesses and chronic diseases compared to the general population) while also facing greater transportation barriers to care, as well as often longer travel times to access medical care (Labban et al., 2023; Wolfe et al., 2020). Due to longstanding discriminatory housing policies, populations from racial/ethnic minorities are more likely to live in neighborhoods which are farther from high-quality health care services and have insufficient public transportation (Labban et al., 2023). Adults without vehicle access in neighborhoods with poor transportation are also significantly more likely to forgo necessary health care compared to their counterparts (Smith et al., 2023). For those living in urban areas, even with potentially shorter distances to health care facilities compared to their rural counterparts, insufficient public transportation can impede health care access due to poorly maintained infrastructure, accessibility challenges for those with limited mobility, and poor reliability and affordability of transit (Wolfe et al., 2020).

Transportation barriers disproportionately affect AI/AN communities. In 2022, non-Hispanic AI/AN adults were 3.6 times more likely than their White counterparts to lack reliable transportation for daily living (Ng et al., 2024). Long geographic distances to health care are significant barriers for AI/AN communities, particularly for those seeking specialist health care services (Warne et al., 2025). For example, while AI/AN communities are disproportionately impacted by diseases like diabetes which may require neuro-ophthalmology services, AI/AN patients report the longest travel times of any racial/ethnic group to access neuro-ophthalmology specialty care (Warne et al., 2025). According to a survey of Native elders by The National Resource Center on Native American Aging, when asked about the reasons they could not access medical care in the past 12 months, 7.8 percent expressed that lack of transportation was a barrier and 7.2 percent cited distance to care as a barrier (National Resource Center on Native American Aging [NRCNAA], 2024). Additionally, approximately 36 percent of respondents expressed that they would use patient transportation services if they were available, and 6 percent expressed lack of transportation as the reason they could not access necessary dental care (NRCNAA, 2024). Transportation options can be particularly limited for AI/AN communities living in rural areas, including inaccessible remote communities who are far from health care facilities and have overburdened Tribal transportation infrastructure that cannot meet the logistical demands of the AI/AN patient populations it serves (Warne et al., 2025). Lack of transportation to health care also contributes to relocation for many AI/AN individuals who move to urban areas for necessary medical care for themselves or their family members, and inaccessible or unaffordable transportation to return to rural areas after receiving health care can be limited (Levy et al., 2017).

The AI/AN population in California is also affected by many transportation barriers to care. Based on a previous review of UIO websites and social media in 2024, 40 percent of UIOs in California indicated that they offer transportation services for their patients (National Council of Urban Indian Health, 2025). According to a 2020 needs assessment of AI/AN communities in California affected by the opioid epidemic, limited availability of transportation was a significant barrier to substance use treatment, with many respondents reporting long geographic distances to treatment centers that made it difficult to access and adhere to treatment consistently (Zeledon et al., 2020). Additionally, a study with AI/AN adults 18 years or older experiencing homelessness in California found that 42 percent of participants described transportation as a barrier to accessing care, with geographical distance to care, lack of transportation to services (particularly for culturally-sensitive services), and inability to pay for public transportation identified as challenges (Soto et al., 2020). Findings from the California Tribal Nations Transportation Planning Needs Assessment Study (2023) also indicate transportation challenges for Tribal communities in California, with underfunded infrastructure for maintenance of public roads, limited and costly mass transit options, and rural isolation presenting challenges which can inhibit access to health care (Reddy et al., 2023).

Survey Findings

Seven UIOs in California shared their insights on transportation barriers to care in the survey disseminated by NCUIH from December 2025 to February 2026. Key findings on transportation barriers to care from this survey include:

- When asked to describe the prevalence of transportation barriers to care in the community they serve, 57.1 percent of UIO respondents said moderate prevalence, 28.6 percent said high prevalence, and 14.3 percent said low prevalence (see **Figure 16**).
- Approximately 100 percent of UIO respondents offered at least one service which may address transportation barriers to care. The most common services offered by UIO respondents to address transportation barriers to care included transportation for patients/clients to care (85.7 percent) and telehealth services (85.7 percent) (see **Figure 17**).
- Approximately 85.7 percent of UIO respondents felt that they had found success in addressing transportation barriers to care for the communities they serve (see **Figure 19**).
- Examples of partnerships and/or resources which have been successful in helping UIO respondents to effectively address transportation barriers to care for the communities they serve include rideshare-fulfilled non-emergency medical transportation services such as Uber Health, funding from public agencies/grants, community partners, in-house transportation services, and accessible public transportation (see **Figure 20**).

- The most common transportation barriers to care which affect the populations served by UIO respondents include costly public transportation (42.9 percent) and unreliable public transportation (42.9 percent) (see **Figure 21**).
- The most common challenges UIO respondents experience in addressing transportation barriers to care for the communities they serve include shortage of available transportation workforce (71.4 percent), insufficient capacity of UIO staff (57.1 percent), and challenges with funding/billing for transportation services (57.1 percent) (see **Figure 22**).
- The things that UIO respondents felt would help them to better address transportation barriers to care include funding for transportation vehicles and staffing, as well as reimbursement for transportation services (see **Figure 24**).
- Approximately 71.4 percent of UIO respondents collect information from patients/clients during intake about transportation barriers to care (see **Figure 25**). Of these UIO respondents, examples of things they have learned from collection of this data include the demographics of the affected population, the complex commutes that some patients experience in order to access care, and difficulties with access to transportation (see **Figure 26**).
- The specific populations/groups that UIO respondents identified as experiencing disproportionate transportation barriers to care include elders (71.4 percent), people in the LGBTQIA2S+ community (57.1 percent), and people with disabilities (57.1 percent) (see **Figure 27**).

Figure 16. Survey Responses to “How would you describe the prevalence of transportation barriers to care in the community your UIO serves?”

Response Option [Single-Select]	n (% of N)
High prevalence	2 (28.6%)
Moderate prevalence	4 (57.1%)
Low prevalence	1 (14.3%)
No prevalence	0 (0%)
Total Responses (N):	7

Figure 17. Survey Responses to “Does your UIO offer any of the following services which may address transportation barriers to care? Please select all that apply.”

Response Option [Multi-Select]	n (% of N)
We do not offer any services which address transportation barriers to care [<i>Exclusive response</i>]	0 (0%)
Transportation for patients/clients to care	6 (85.7%)
Funding/reimbursement to patients/clients for transportation to care	0 (0%)
Home health services	1 (14.3%)
Mobile health services	2 (28.6%)

Telehealth services	6 (85.7%)
Other (Please describe)	2 (28.6%)
Total Responses (N):	7

Figure 18. Survey Responses from Respondents who Selected *Other (Please describe)* for “Does your UIO offer any of the following services which may address transportation barriers to care? Please select all that apply.”

Free-Text Response	
We cover the cost for Uber Health services for to patients in need.	
Substance Use Disorder Services	
Total Responses: 2	

Figure 19. Survey Responses to “Has your UIO found success in addressing transportation barriers to care for the community you serve?”

Response Option [Single-Select]	n (% of N)
Yes	6 (85.7%)
No	1 (14.3%)
Total Responses (N):	7

Figure 20. Survey Responses to “What partnerships and/or resources have been most successful in helping your UIO to effectively address transportation barriers to care for the community you serve, if any?”

Free-Text Response	
Community partners	
Having in-house transportation services has enhanced timeliness to respond to request.	
IHS Grantee able to access government vehicles for this service delivery benefit.	
Medicaid non-emergency transportation	
Accessible public transportation	
Uber Health for patients establishing care	
Uber Health services	
We received funding through the California Department of Healthcare Services to acquire two vans for transporting patients/community members to Behavioral Health and Community Wellness services. This has allowed us to increase community member participation in prevention and early intervention and culturally based programming.	
Total Responses: 7	

Figure 21. Survey Responses to “Do any of the following transportation barriers to care commonly affect the population served by your UIO? Please select all that apply.”

Response Option [Multi-Select]	n (% of N)
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We are not aware of any transportation barriers to care which commonly affect the population we serve <i>[Exclusive response]</i>	2 (28.6%)
Costly public transportation	3 (42.9%)
Insufficient public transportation options	2 (28.6%)
Concerns of safety on public transportation	1 (14.3%)
Unreliable public transportation	3 (42.9%)
Lack of available rideshare options	2 (28.6%)
Lack of safe, walkable pathways	1 (14.3%)
Other (Please describe)	0 (0%)
Total Responses (N):	7

Figure 22. Survey Responses to “Does your UIO experience any of the following challenges in addressing transportation barriers to care for the community you serve? Please select all that apply.”

Response Option [Multi-Select]	n (% of N)
We do not experience any challenges in addressing transportation barriers to care in the community we serve <i>[Exclusive response]</i>	1 (14.3%)
Insufficient capacity of UIO staff	4 (57.1%)
Shortage of available transportation workforce	5 (71.4%)
Lack of affordable transportation resources	3 (42.9%)
Challenges with funding/billing for transportation services	4 (57.1%)
Other (Please describe)	1 (14.3%)
Total Responses (N):	7

Figure 23. Survey Responses from Respondents who Selected *Other (Please describe)* for “Does your UIO experience any of the following challenges in addressing transportation barriers to care for the community you serve? Please select all that apply.”

Free-Text Response
High turnover in this position level.
Total Responses: 1

Figure 24. Survey Responses to “Is there anything that would help your UIO to better address transportation barriers to care in the community you serve?”

Free-Text Response
Better pay and benefits and funding for Administrative & Operational supervision and cost.
Funding for transportation
Funds for dedicated transportation driver
Funds to support the acquisition of additional fleet vehicles would allow us to expand transportation. We are also exploring ways to subsidize public transit for our elders, who have especially expressed difficulty affording transit options in our region.

none to report at this time
Reimbursement for the provision of transportation services. Higher wages for these entry level positions.
Transportation coordination specific staffing
Total Responses: 7

Figure 25. Survey Responses to “Does your UIO collect information from patients/clients during intake about transportation barriers to care?”

Response Option [Single-Select]	n (% of N)
Yes	5 (71.4%)
No	2 (28.6%)
Total Responses (N):	7

Figure 26. Survey Responses to “If yes, what have you learned from data collected regarding the communities you serve and their transportation challenges?” [Only displayed to respondents who selected Yes for “Does your UIO collect information from patients/clients during intake about transportation barriers to care?”]

Free-Text Response
No change from past years
multiple bus routes and stops, in congruent bus schedules and partial day transportation coordination
associated demographics of those encountering challenges
Access transportation is a huge need.
A high prevalence of elders losing their driving privileges due to health related issues and affordability of fuel for high Healthcare utilizers
Total Responses: 5

Figure 27. Survey Responses to “Are there any specific populations/groups that your UIO serves who experience disproportionate transportation barriers to care?”

Response Option [Multi-Select]	n (% of N)
We are not aware of any specific subpopulations/groups in the community we serve who experience disproportionate transportation challenges <i>[Exclusive response]</i>	1 (14.3%)
Youth	2 (28.6%)
Elders	5 (71.4%)
People in the LGBTQIA2S+ community	4 (57.1%)
Individuals impacted by domestic violence	2 (28.6%)
Formerly incarcerated people	3 (42.9%)
Veterans	3 (42.9%)
Pregnant people	2 (28.6%)
People with disabilities	4 (57.1%)
People with mental health conditions	3 (42.9%)

People with Substance Use Disorders (SUDs)	3 (42.9%)
Other (Please describe)	0 (0%)
Total Responses (N):	7

Recommendations

The following two areas are recommended to prioritize policies, funding, and resources to address AI/AN transportation barriers to care:

- 1. Patient transportation services***
- 2. Telehealth services and coverage***

Findings from the environmental scan and survey suggest that sustainable funding opportunities for patient transportation services need to be increased and expanded in order to reduce transportation barriers to care. Research indicates that there is a demand for patient transportation services among AI/AN communities, and that insufficient logistical and financial support for Tribal facilities and other health care organizations serving AI/AN communities makes it difficult to meet this demand (NRCNAA, 2024; Warne et al., 2025; Wolfe et al., 2020). Additionally, California UIOs surveyed expressed that transportation workforce shortages, insufficient staff capacities, and challenges with funding/billing for transportation services were their greatest challenges to addressing transportation barriers. Surveyed UIOs also highlighted how Uber Health services, funding from public agencies/grants, and in-house transportation services have helped their organizations to effectively address transportation barriers for the communities they serve. By enabling organizations to provide or reimburse patient transportation through sustainable funding mechanisms, transportation barriers to care can be minimized, leading to improved access and adherence to treatment and ultimately better health outcomes for patients. Permanent 100 percent FMAP for Medicaid services provided at UIOs would also strengthen UIO capacity to fund patient transportation programs on a sustainable basis, as the current reimbursement gap limits the financial resources UIOs have available to invest in transportation infrastructure and staffing (National Council of Urban Indian Health, 2023).

Findings also suggest that the expansion of telehealth services and coverage can help to reduce the burdens of transportation barriers to care. While telehealth cannot replace all necessary medical care, use of telehealth services increased during the COVID-19 pandemic and helped to improve access for those experiencing transportation barriers to care, particularly for mental health and primary care services (Atherton et al., 2021; Smith et al., 2023). Further investment into the expansion of broadband infrastructure for both patients and providers can help to alleviate these barriers, particularly for those from racial/ethnic minorities or low-income communities who experience disproportionate barriers to transportation and telehealth access (Atherton et al., 2021; Labban et al., 2023). Additionally, approximately 85.7 percent of surveyed UIOs offer telehealth services to help address transportation barriers to care for the communities

they serve. By expanding telehealth infrastructure for both providers and patients, transportation barriers to care and disparities in health care access can be minimized.

FOOD INSECURITY

Access to nutritious foods is a key SDOH that affects health and well-being, as hunger and poor diet can lead to adverse health outcomes (Healthy People 2030, n.d.-a). Food insecurity refers to limited or uncertain access to adequate foods, which can manifest through reduced quality of diet, disrupted eating patterns, and reduced overall food intake (Healthy People 2030, n.d.-a). The following section describes the state of food insecurity and how these affect AI/AN communities, both across the United States and specifically in California. Findings from both the environmental scan of public data sources and the survey of California UIOs are displayed below and were used to inform the key recommendations to address food insecurity.

Environmental Scan Findings

Food insecurity disproportionately burdens AI/AN communities across the United States. Many studies have linked food insecurity among AI/AN communities to the long-term impacts of colonization, forced relocation, disrupted traditional food systems, and loss of food sovereignty (First Nations Development Institute, 2024; Intertribal Agriculture Council & Food Research and Action Center, 2022). Research indicates that discriminatory federal policies, forced assimilation, environmental disruption, and replacement of traditional foods with commodity foods have all contributed to persistent disparities in nutrition, chronic disease, and access to culturally relevant foods for AI/AN communities (Intertribal Agriculture Council & Food Research and Action Center, 2022).

Nationally, AI/AN households experience substantially higher rates of food insecurity compared to the general population of the United States (United States Government Accountability Office, 2024). Data indicates that in 2022, approximately 28 percent of AI/AN households experienced food insecurity, compared to 13 percent of all households in the United States (United States Government Accountability Office, 2024). Research indicates that AI/AN households are also more than twice as likely to experience food insecurity and very low food security compared to overall households across the United States (Office of Minority Health, 2026). AI/AN households with children also experience disproportionately high rates of food insecurity compared to their counterparts (Office of Minority Health, 2026). Despite California producing a large share of the nation's fruits and vegetables, food insecurity remains widespread across the state, particularly among low-income populations (Public Health Institute, 2023). For example, 55.7 percent of AI/AN adults in California with incomes below 200 percent of the federal poverty level reported experiencing food insecurity in 2024 (California Health Interview Survey, AskCHIS, 2023–2024c). Additionally, 56.5 percent of AI/AN individuals with incomes below 200 percent of the federal poverty level reported using food assistance programs in California (California Health Interview Survey, AskCHIS, 2023–2024b).

Urban AI/AN communities face additional barriers related to food insecurity. Research suggests urban AI/AN individuals may experience higher rates of food insecurity than rural or reservation-based AI/AN communities due to limited access to culturally relevant foods, geographic dispersion, social isolation, and

exclusion from Tribal food programs (Dong et al., 2023; Nikolaus et al., 2022). Studies have found significantly higher rates of food insecurity among urban AI/AN households compared to rural households, including one study reporting food insecurity rates of 80 percent among urban AI/AN households compared to 45 percent among rural AI/AN households (Tomayko et al., 2017). Urban AI/AN communities may also face disconnection from traditional food systems and reduced access to community and familial support networks that support food sharing and food security, as many of these systems and resources are tied to Tribal settings (Jernigan et al., 2017).

Poverty, limited transportation, geographic isolation, lack of nearby grocery stores, and high food costs have all been identified as major contributors to food insecurity in AI/AN communities (United States Government Accountability Office, 2024). Access to healthy and culturally relevant foods is further limited by barriers to traditional food practices, restrictions on foraging and procurement, and reduced and restricted access to hunting, fishing, and farming resources (Intertribal Agriculture Council and Food Research and Action Center, 2022). AI/AN communities also experience disproportionate rates of nutrition-related chronic disease, including diabetes, cardiovascular disease, and obesity, which are closely linked to changes in diet and food access resulting from colonization and disrupted traditional foodways (California Indian Culture and Sovereignty Center, 2023).

Survey Findings

Six UIOs in California shared their insights on food insecurity in the survey disseminated by NCUIH from December 2025 to February 2026. Key findings on food insecurity from this survey include:

- When asked to describe the prevalence of food insecurity in the community they serve, 66.7 percent of UIO respondents said high prevalence, 16.7 percent said moderate prevalence, and 16.7 percent said low prevalence (see **Figure 28**).
- One-hundred percent of UIO respondents offered at least one service which may address food insecurity (see **Figure 29**). The most common services offered by UIO respondents to address food insecurity included community gardens (66.7 percent), food pantries (66.7 percent), and nutrition education programs (66.7 percent) (see **Figure 29**).
- Approximately 83.3 percent of UIO respondents felt that they had found success in addressing food insecurity in the community they serve (see **Figure 31**).
- Examples of partnerships and/or resources which have been successful in helping UIO respondents to effectively address food insecurity in the communities they serve include food banks, food pantries, and educational classes/workshops on healthy eating (see **Figure 32**).
- The most common challenges with food insecurity which affect the populations served by UIO respondents include food deserts with limited local access to healthy and affordable food options (100 percent), food swamps with higher local abundance of unhealthy fast food options

than healthy food options (50 percent), and lack of sufficient infrastructure at local food programs (50 percent) (see **Figure 33**).

- The most common challenges UIO respondents experience in addressing food insecurity for the communities they serve include challenges with funding/billing for food programming (83.3 percent), insufficient capacity of UIO staff (66.7 percent), and lack of affordable resources to provide food programming (66.7 percent) (see **Figure 35**).
- The things that UIO respondents felt would help them to better address food insecurity in the communities they serve include greater and less restrictive funding and coverage/reimbursement options for food insecurity programs (see **Figure 36**).
- Approximately 66.7 percent of UIO respondents collect information from patients/clients during intake about challenges with food insecurity (see **Figure 37**). Of these UIO respondents, examples of things they have learned from collection of this data include trends over time, living conditions contributing to food insecurity, and challenges related to insurance coverage and financial hardship (see **Figure 38**).
- The specific populations/groups that UIO respondents identified as experiencing disproportionate challenges with food insecurity include elders (100 percent), people with disabilities (66.7 percent), and people with mental health conditions (66.7 percent) (see **Figure 39**).

Figure 28. Survey Responses to “How would you describe the prevalence of food insecurity in the community your UIO serves?”

Response Option [Single-Select]	n (% of N)
High prevalence	4 (66.7%)
Moderate prevalence	1 (16.7%)
Low prevalence	1 (16.7%)
No prevalence	0 (0%)
Total Responses (N):	6

Figure 29. Survey Responses to “Does your UIO offer any of the following services to address food insecurity? Please select all that apply.”

Response Option [Multi-Select]	n (% of N)
We do not offer any services related to food insecurity [<i>Exclusive response</i>]	0 (0%)
Traditional food programs	3 (50%)
Community gardens	4 (66.7%)
Produce prescription programs	2 (33.3%)
Food pantries	4 (66.7%)
Nutrition education programs	4 (66.7%)
Referral to local food insecurity services	3 (50%)
Other (Please describe)	1 (16.7%)
Total Responses (N):	6

Figure 30. Survey Responses from Respondents who Selected *Other (Please describe)* for “Does your UIO offer any of the following services to address food insecurity? Please select all that apply.”

Free-Text Response	
WIC EBT services and free produce giveaways.	
Total Responses: 1	

Figure 31. Survey Responses to “Has your UIO found success in addressing food insecurity in the community you serve?”

Response Option [Single-Select]	n (% of N)
Yes	5 (83.3%)
No	1 (16.7%)
Total Responses (N): 6	

Figure 32. Survey Responses to “What partnerships and/or resources have been most successful in helping your UIO to effectively address food insecurity in the community you serve, if any?”

Free-Text Response	
CAPK*, food banks, internal food to mood program.	
Food pantry and acting as assigned pick up site.	
Healthy food tied to improved health	
Local food pantry	
The California Food Bank	
We maintain successful partnerships with regional food banks and other non-profit organizations focused on addressing food insecurity in our community, which allow us to directly distribute food to our community members through on-site food pantries and regular food deliveries. We have also partnered with local food/cooking non-profit organizations to provide classes and workshops about healthy affordable eating, which have been very well-received by our community members.	
Total Responses: 6	

* “CAPK” described by respondent may be referring to Community Action Partnership of Kern.

Figure 33. Survey Responses to “Do any of the following challenges with food insecurity commonly affect the population served by your UIO? Please select all that apply.”

Response Option [Multi-Select]	n (% of N)
We are not aware of any challenges with food insecurity which commonly affect the population we serve [<i>Exclusive response</i>]	0 (0%)
Limited local access to healthy, affordable food options (also known as a “food desert”)	6 (100%)
Higher local abundance of unhealthy fast food options than healthy food options (also known as a “food swamp”)	3 (50%)
Lack of local food pantries	2 (33.3%)
Lack of sufficient infrastructure at local food programs	3 (50%)
Other (Please describe)	2 (33.3%)
Total Responses (N): 6	

Figure 34. Survey Responses from Respondents who Selected *Other (Please describe)* for “Do any of the following challenges with food insecurity commonly affect the population served by your UIO? Please select all that apply.”

Free-Text Response
Access to culturally specific food options
Affordable healthy food compared to cheaper less quality food.
Total Responses: 2

Figure 35. Survey Responses to “Does your UIO experience any of the following challenges to addressing food insecurity for the community you serve? Please select all that apply.”

Response Option [Multi-Select]	n (% of N)
We do not experience any challenges in addressing food insecurity in the community we serve [Exclusive response]	0 (0%)
Insufficient capacity of UIO staff	4 (66.7%)
Lack of affordable resources to provide food programming	4 (66.7%)
Challenges with funding/billing for food programming	5 (83.3%)
Other (Please describe)	0 (0%)
Total Responses (N):	6

Figure 36. Survey Responses to “Is there anything that would help your UIO to better address food insecurity in the community you serve?”

Free-Text Response
Access to more food options for patients in need.
Facility and Capital project funding to enhance and construct food pantry that meets state requirements.
Funding
Medi-Cal coverage for food benefits
Reimbursement for addressing food insecurity.
We would like to be able to offer our community members food at every single community activity we offer. However, many funders prohibit grant expenditures on food, limiting our ability to provide this critical and culturally relevant service.
Total Responses: 6

Figure 37. Survey Responses to “Does your UIO collect information from patients/clients during intake about challenges with food insecurity?”

Response Option [Single-Select]	n (% of N)
Yes	4 (66.7%)
No	2 (33.3%)
Total Responses (N):	6

Figure 38. Survey Responses to “If yes, what have you learned from data collected regarding the communities you serve and their food insecurity challenges?” [Only displayed to respondents who selected Yes for “Does your UIO collect information from patients/clients during intake about challenges with food insecurity?”]

Free-Text Response
No changes from previous years
Poverty and living conditions and failed equipment such as refrigeration and storage.
The level of food insecurity, insurance coverage, and financial hardships.
the percentage of folks that utilize multiple programs to piece together appropriate food resources for their family.

Total Responses: 4

Figure 39. Survey Responses to “Are there any specific populations/groups that your UIO serves who experience disproportionate challenges with food insecurity?”

Response Option [Multi-Select]	n (% of N)
We are not aware of any specific subpopulations/groups in the community we serve who experience disproportionate housing challenges <i>[Exclusive response]</i>	0 (0%)
Youth	3 (50%)
Elders	6 (100%)
People in the LGBTQIA2S+ community	2 (33.3%)
Individuals impacted by domestic violence	3 (50%)
Formerly incarcerated people	2 (33.3%)
Veterans	2 (33.3%)
Pregnant people	2 (33.3%)
People with disabilities	4 (66.7%)
People with mental health conditions	4 (66.7%)
People with Substance Use Disorders (SUDs)	3 (50%)
Other (Please describe)	0 (0%)
Total Responses (N):	6

Recommendations

The following two areas are recommended to prioritize policies, funding, and resources to address AI/AN food insecurity:

- 1. Food programs that supply nutritious traditional foods**
- 2. Food production programs that support Indigenous food sovereignty**

Findings from the environmental scan and survey of California UIOs highlighted the need for improved investment into programs that improve access to nutritious foods, particularly for programs that promote traditional foods. The AI/AN population experiences disproportionate burdens of food insecurity compared to the overall national population, with specific barriers to food security including long distances to grocery stores and inflated costs of healthy foods (Intertribal Agriculture Council and Food Research and Action Center, 2022; Office of Minority Health, 2026; United States Government Accountability Office, 2024). Access to traditional foods can improve connection to culture and health outcomes, but funding mechanisms for programs to increase traditional food access can be restrictive in funding use (such as grants which often do not allow food as allowable costs) or limited in sustainability (Dong et al., 2023; National Council of Urban Indian Health, 2024). Surveyed California UIOs highlighted challenges related to insufficient infrastructure at local food programs and funding/billing difficulties with food programming, with respondents expressing that increased and less restrictive funding for food programs would help them to better address food insecurity in the communities they serve. Food banks and food distribution programs, food delivery

services, and produce prescription programs can increase access to healthy foods, including traditional foods (Vanegas et al., 2024; Public Health Institute, 2023; Intertribal Agriculture Council and Food Research and Action Center, 2022). Funding opportunities for UIOs for produce prescription programs have been particularly limited, with no UIOs receiving funding from the IHS Produce Prescription Pilot Program (Indian Health Service, n.d.). Services and partnerships to address food insecurity which were highlighted by surveyed California UIOs included food pantries and food banks, with 83.3 percent of respondents expressing that they felt they had found success in addressing food insecurity in the communities they serve. Improved investment into these food programs through sustainable and flexible funding mechanisms can reduce food insecurity for AI/AN communities and ultimately improve nutrition outcomes.

In addition to improved funding mechanisms for food programs that connect people to nutritious foods like traditional foods, expanded investment into programs that support long-term food sovereignty can also help to address food insecurity for AI/AN communities. Indigenous food sovereignty refers to the rights of AI/AN communities to control their own food systems and access healthy and culturally appropriate foods (Jernigan et al., 2021). Forced relocation, disrupted land management, discriminatory policies surrounding agricultural production and hunting/fishing practices, and many other historical and current sociopolitical forces have contributed to disrupted food sovereignty and disconnection from traditional foods for AI/AN communities (Intertribal Agriculture Council and Food Research and Action Center, 2022; California Indian Culture and Sovereignty Center, 2023; Nikolaus et al., 2022). By upholding AI/AN food sovereignty and supporting AI/AN communities with the resources to produce, distribute, and regulate their own foods, access to healthy traditional foods can increase and dependence on highly processed foods and fast foods can decrease, leading to better outcomes for food insecurity and nutrition overall (Jernigan et al., 2021; Intertribal Agriculture Council and Food Research and Action Center, 2022; Tomayko et al., 2017). Programs like community gardens, individual home gardens, and traditional farming can empower AI/AN communities to produce their own traditional foods and reduce barriers to food security (Vanegas et al., 2024; Nikolaus et al., 2022; Jernigan et al., 2021). Two-thirds of surveyed California UIOs offer community gardens and half of respondents offer traditional food programs, with access to culturally specific foods and funding for food programming highlighted as challenges to addressing food insecurity. Expanded investment into programs like these which promote AI/AN food sovereignty and increase access to traditional foods can reduce AI/AN food insecurity and ultimately improve nutrition outcomes.

INDIGENOUS LANGUAGE AND IDENTITY CHALLENGES

In addition to general SDOH, many researchers have identified specific Indigenous SDOH due to the unique conditions that impact the health and well-being of Indigenous communities, including Indigenous language and identity (Parker et al., 2023). Indigenous language and identity refers to the use and revitalization of Indigenous languages, as well as the reclamation of traditional knowledge and practices to support collective identity and cultural connection (Parker et al., 2023). The following section describes how Indigenous language and identity challenges affect AI/AN communities, both across the United States and specifically in California. Findings from both the environmental scan of public data sources and the survey of California UIOs are displayed below and were used to inform the key recommendations to address Indigenous language and identity challenges.

Environmental Scan Findings

The continued historical impacts of colonization, genocide, forced assimilation, and relocation have inhibited the use of Indigenous languages for many AI/AN communities (Whalen et al., 2022). Many traditional practices, customs, and ceremonies were criminalized under laws that ignored Tribal sovereignty, and targeted policies on assimilation and indoctrination removed AI/AN people from their Tribes and families which disrupted their connection to culture and often punished them for engaging in traditional practices or languages (National Library of Medicine, n.d.; Sierra, 2023; Ditzenberger, 2023.). The Federal Relocation program led to the movement of many AI/AN communities from rural Tribal areas to urban metropolitan areas, with large urban AI/AN communities of relocated families across California today from non-California Tribal reservations or lands (Schweigman et al., 2011). According to the 2014 California Health Interview Survey, only 10.1 percent of self-reported AI/AN California respondents reported heritage from a California-based Tribe (California Health Interview Survey, AskCHIS, 2023-2024a).

Discrimination and mistreatment due to Indigenous language and identity poses challenges for AI/AN communities. Research indicates that AI/AN communities report higher rates of discrimination across all institutions (including health care, housing, and the justice system) compared to their White counterparts (Findling et al., 2020; Findling et al., 2019). According to data from the 2023-2024 California Health Interview Survey, approximately 14.4 percent of AI/AN respondents reported having experienced a hate incident in the past year, with 43.4 percent of those who had experienced a hate incident in the past year expressing that the reason was due to their race or skin color (California Health Interview Survey, AskCHIS, 2023-2024d). Challenges with Indigenous language and identity also affect AI/AN youth in particular. The 2020 Indigenous Futures Survey found 60 percent of surveyed AI/AN youth felt they were treated with less courtesy or respect than others during their day-to-day lives, and 80 percent of respondents felt that the average American does not care about the experiences of AI/AN people (Center for Native American Youth, 2021). The Trevor Project's 2023 U.S. National Survey on the Mental Health of LGBTQ Young People found that nearly half of

Indigenous LGBTQ youth surveyed reported experiencing discrimination in the past year due to their race or ethnicity, with those who reported experiencing race-based discrimination in the past year having 1.5 times greater odds of having attempted suicide in the past year compared to their counterparts (DeChants et al., 2023). Focus groups of AI/AN youth by the Center for Native American Youth found that 51 percent of AI/AN youth on reservations felt that their culture was respected outside of their family, compared to only 33 percent in cities and 28 percent in small towns (Stewart & Brady-Runsabove, 2024). Survey data also indicated that 62 percent of AI/AN youth were familiar with their Tribal language on reservations, compared to only 35 percent of those in small towns and cities (Stewart & Brady-Runsabove, 2024).

The health care system can also exacerbate challenges for AI/AN patients, as discrimination and mistreatment due to Indigenous language and identity can deter AI/AN communities from seeking and receiving adequate health care (Pham et al., 2022; Stewart & Gonzalez, 2023). Specifically, historical trauma, racial discrimination, and distrust in the health care system can lead to delayed use or underutilization of health care services among AI/AN communities, particularly for mental health services (Pham et al., 2022; Stewart & Gonzalez, 2023). One study of health care professionals found that many providers held negative implicit attitudes and stereotypes toward AI/AN patients, with higher reported implicit prejudice by providers who had not received any cultural competency training than those who did (Zestcott et al., 2021). A 2017 survey found that 23 percent of AI/AN adults reported experiencing discrimination in clinical encounters, with 15 percent reporting that they avoided seeking health care for themselves or their family members due to expected discrimination (Findling et al., 2019). Surveys of rural adults from 2017-2019 also highlighted significant differences in health care access and quality between rural White and AI/AN adults, with 19 percent of rural AI/AN adults reporting discrimination in health care compared to only 3 percent of White adults, and 14 percent of rural AI/AN adults reported avoiding seeking necessary health care due to fear of unfair treatment (Findling et al., 2020). Fear of discrimination and expectations of care lacking cultural competence have also been expressed by many AI/AN youth as factors deterring them from seeking care from non-Tribal health care facilities, and AI/AN youth who do not live on reservations report lower access to culturally relevant services and providers than those on reservations (Stewart & Brady-Runsabove, 2024). In California, a 2023 needs assessment found that 51.3 percent of Indigenous people surveyed reported a previous negative experience with a health professional who did not understand or respect their culture/language and made them not want to return for further care (Wheeler et al., 2023). Data from the 2021-2024 California Health Interview Survey indicated that approximately 5.4 percent of AI/AN respondents reported experiencing unfair treatment while getting medical care due to their race or ethnicity (California Health Interview Survey, AskCHIS, 2021-2024).

Traditional knowledge shares that Indigenous language, identity, and culture are instrumental to well-being. Recent Western forms of research also uphold the importance of the positive benefits that Indigenous language and identity can have on health outcomes. Language learning and revitalization can have many benefits on behavioral health, cardiovascular health, and socioeconomic outcomes, particularly for

Indigenous language use (Whalen et al., 2022). Specifically, access to traditional knowledge and cultural interventions can improve resiliency, promote confidence and self-esteem, and decrease risks of substance use, depression, and suicide for AI/AN people (Schweigman et al., 2011; Masotti et al., 2023). Indigenous language and identity are particularly important for AI/AN youth and their health and well-being. Findings from focus groups of AI/AN youth demonstrate that AI/AN youth who feel culturally educated are four times more likely to see themselves as capable of making a difference compared to those who do not (Stewart & Brady-Runsabove, 2024). The 2020 Indigenous Futures Survey found that 64.1 percent of AI/AN youth surveyed identified the preservation of Indigenous languages and culture as an extremely urgent priority, and 90 percent of AI/AN youth strongly agreed or agreed that being Native American is an important part of their identity (Center for Native American Youth, 2021).

Survey Findings

Six UIOs in California shared their insights on Indigenous language and identity challenges in the survey disseminated by NCUIH from December 2025 to February 2026. Key findings on Indigenous language and identity challenges from this survey include:

- Approximately 50 percent of UIO respondents integrate Indigenous language and identity into their programs/services (see **Figure 40**).
- Approximately 33.3 percent of UIO respondents offer programs that promote Indigenous language learning and/or Indigenous language revitalization (see **Figure 41**). Of those UIO respondents, examples of these programs include local Tribal courses and traditional Talking Circles (see **Figure 42**).
- Approximately 33.3 percent of UIO respondents have staff who provide services/programs through Indigenous languages (see **Figure 43**).
- Examples of challenges that UIO respondents face in offering services/programs related to Indigenous language and identity include funding, staffing, the large variety of Indigenous languages among the population served, and limitations of available services (see **Figure 44**).
- Approximately 100 percent of UIO respondents screen for language preference of patients/clients during intake (see **Figure 45**). Of these UIO respondents, 83.3 percent offer virtual translator services, 66.7 percent offer translated patient education materials, and 50 percent offer in-person translator services (see **Figure 46**).
- Approximately 16.7 percent of UIO respondents have had patients/clients express concerns regarding their navigation of health care due to their Indigenous language and identity (see **Figure 48**). Of these UIO respondents, examples of concerns included previous negative experiences with disrespectful health professionals, as well as concerns with available translated services and materials (see **Figure 49**).

- Approximately 16.7 percent of UIO respondents have had patients/clients express concerns with sharing/requesting services related to Indigenous language and identity (see **Figure 50**), with concerns specifically expressing interest in more traditional and spiritual healing services (see **Figure 51**).
- Examples of ways that UIO respondents navigate the integration of Indigenous language and identity into their programming while serving populations from various Indigenous/Tribal backgrounds include accepting people from all backgrounds, offering traditional services and translation services, and integrating cultural practices into care (see **Figure 52**).

Figure 40. Survey Responses to “Does your UIO integrate Indigenous language and identity into your programs/services?”

Response Option [Single-Select]	n (% of N)
Yes	3 (50%)
No	3 (50%)
Total Responses (N):	6

Figure 41. Survey Responses to “Does your UIO offer programs that promote Indigenous language learning and/or Indigenous language revitalization?”

Response Option [Single-Select]	n (% of N)
Yes (Please describe these programs)	2 (33.3%)
No	4 (66.7%)
Total Responses (N):	6

Figure 42. Survey Responses from Respondents who Selected Yes (Please describe these programs for “Does your UIO offer programs that promote Indigenous language learning and/or Indigenous language revitalization?”

Free-Text Response	Total Responses: 2
Local Tribes offer courses and we share in our newsletter	
Traditional Talking Circles.	

Figure 43. Survey Responses to “Does your UIO have staff who provide services/programs through Indigenous languages?”

Response Option [Single-Select]	n (% of N)
Yes	2 (33.3%)
No	4 (66.7%)
Total Responses (N):	6

Figure 44. Survey Responses to “What challenges does your UIO face in offering services/programs related to Indigenous language and identity, if any?”

Free-Text Response
Funding and staffing.
Funding for the provision for these types of services.
None at this time
speakers.
There are so many indigenous languages that makes it difficult to meet all needs.
We offer many community-based programs integrating cultural and traditional practices and ways with Western bio-medical treatment for a holistic approach to health and well-being. However, our language services are primarily limited to translation/interpretation; we do serve a significant population of Indigenous Mam-speakers. Some of our programming does encourage participants to learn some words in their Tribal language.
Total Responses: 6

Figure 45. Survey Responses to “Does your UIO screen for language preference of patients/clients during intake?”

Response Option [Single-Select]	n (% of N)
Yes	6 (100%)
No	0 (0%)
Total Responses (N):	6

Figure 46. Survey Responses to “If yes, how does your UIO address language preferences of patients/clients? Please select all that apply.” [Only displayed to respondents who selected *Yes* for “Does your UIO screen for language preference of patients/clients during intake?”]

Response Option [Multi-Select]	n (% of N)
We do not offer any services to address language preferences of patients/clients [<i>Exclusive response</i>]	0 (0%)
In-person translator services	3 (50%)
Virtual translator services	5 (83.3%)
Translated patient education materials	4 (66.7%)
Other (Please describe)	1 (16.7%)
Total Responses (N):	6

Figure 47. Survey Responses for Respondents who Selected *Other (Please describe)* for “If yes, how does your UIO address language preferences of patients/clients? Please select all that apply.”

Free-Text Response
Language Line Services (Contract)
Total Responses: 1

Figure 48. Survey Responses to “Have patients/clients served by your UIO expressed concerns regarding their navigation of healthcare due to their Indigenous language and identity?”

Response Option [Single-Select]	n (% of N)
Yes (Please describe examples of concerns expressed by patients/clients)	1 (16.7%)
No	5 (83.3%)
Total Responses (N):	6

Figure 49. Survey Responses from Respondents who Selected Yes (Please describe examples of concerns expressed by patients/clients) for “Have patients/clients served by your UIO expressed concerns regarding their navigation of healthcare due to their Indigenous language and identity?”

Free-Text Response
In a community needs assessment we conducted [redacted for confidentiality], more than half (51.3%) of respondents reported that they previously had negative experience with a medical or other health professional (or their staff) not understanding or respecting their culture or language made them not want to return for further care.
In-Person, Virtual, Translated Educational Materials
Total Responses: 2

Figure 50. Survey Responses to “Have patients/clients served by your UIO expressed concerns with sharing/requesting services related to Indigenous language and identity, such as traditional healing?”

Response Option [Single-Select]	n (% of N)
Yes (Please describe examples of concerns expressed by patients/clients)	1 (16.7%)
No	5 (83.3%)
Total Responses (N):	6

Figure 51. Survey Responses from Respondents who Selected Yes (Please describe examples of concerns expressed by patients/clients) for “Have patients/clients served by your UIO expressed concerns with sharing/requesting services related to Indigenous language and identity, such as traditional healing?”

Free-Text Response
In [redacted for confidentiality] needs assessment, 77.8% of respondents reported wanting more access to Traditional Health/Healers and Spiritual Healers.
Total Responses: 1

Figure 52. Survey Responses to “How does your UIO navigate the integration of Indigenous language and identity into your programming while serving a population from a variety of Indigenous/Tribal backgrounds?”

Free-Text Response
Members of all Tribal backgrounds are welcome to receive services here. Traditional Health Care Services are also being offered.
None

Our [redacted for confidentiality] data show representation from 169 tribal affiliations in our incredibly diverse, intertribal urban community. Many community members also identify as multi-racial and/or multi-ethnic. Our programs are open to all, regardless of identity, and in our wellness approach we strive to honor some of the underlying cultural commonalities across AI/AN tribal communities. We invite spiritual and traditional practitioners from different backgrounds, offer access to a wide range of ceremonial practices and traditional medicines, giving our participants the option to engage with those meaningful and relevant to them.

Some staff and translation services

We allow for them to share language and cultural practices and allow for family or faith leaders to visit together while engaging in Healthcare services.

We offer traditional services to the AI/AN community.

Total Responses: 6

Recommendations

The following two areas are recommended to prioritize policies, funding, and resources to address AI/AN Indigenous language and identity challenges:

- 1. Traditional healing programs***
- 2. Health care services and materials offered in Indigenous languages***

Findings from the environmental scan and survey of California UIOs highlight the need for increased funding for traditional healing programs that promote Indigenous languages and practices to improve health outcomes for AI/AN communities. Historical relocation and assimilation policies have contributed to disconnection from Indigenous languages and cultural traditions for many AI/AN people (National Library of Medicine, n.d.; Sierra, 2023; Ditzenberger, 2023.), and experiences with culturally incompetent or discriminatory health care providers can inhibit health care access and quality for the AI/AN population (Findling et al., 2019; Findling et al., 2020). Access to traditional programs which incorporate cultural practices and interventions can help reduce challenges with Indigenous identity, improve behavioral health outcomes, cardiovascular health outcomes, and more (Whalen et al., 2022; Schweigman et al., 2011). Health care providers such as those at Tribal facilities and UIOs can play a pivotal role in connecting AI/AN patients to culturally competent care through traditional programs (Soto et al., 2020; National Council of Urban Indian Health, 2024). As of 2025, all UIOs in California offer at least one traditional healing program (National Council of Urban Indian Health, 2025), and integration of cultural practices into care was identified as an example of how surveyed California UIOs address Indigenous language and identity in their programming, with respondents indicating a demand for more traditional and spiritual programming. Surveyed California UIOs also expressed that funding was a common barrier to addressing Indigenous language and identity challenges for their population served, with responses indicating that some patients had experienced difficulties with navigating health care due to their Indigenous language and identity. Improved investment into traditional healing programs and staff trainings on cultural humility at health care facilities can

minimize Indigenous language and identity challenges and increase access to culturally competent health care for the AI/AN population. While California has an approved 1115 waiver for beneficiaries who are able to receive services by or through IHS, Tribal health facilities and UIOs and are eligible to participate in the Drug Medi-Cal Organized Delivery system, expanding access to reimbursement for the billing of traditional practices to all Medicaid beneficiaries who receive services delivered by or through these facilities could relieve the funding gap to provide this much needed service (Centers for Medicare and Medicaid Services, 2024).

In addition to improving funding for traditional healing programs, increasing access to health care services and materials offered in Indigenous languages can help to reduce language and identity challenges for the AI/AN population. Findings from the environmental scan highlighted the many historical and current barriers to accessing Tribal languages for AI/AN people, both on Tribal reservations and in urban areas (Whalen et al., 2022; Sierra, 2023; Stewart & Brady-Runsabove, 2024). While lack of familiarity with Tribal languages affects many AI/AN people, the preservation of Indigenous languages is an emerging priority for many AI/AN communities (Stewart & Brady-Runsabove, 2024; Center for Native American Youth, 2021). Only one-third of surveyed California UIOs offer programs which promote Indigenous language learning and/or revitalization, and only one-third of respondents specifically have staff who provide services or programs through Indigenous languages. While the availability of translated services and materials was identified as a challenge for patients at surveyed California UIOs, offering traditional programs and translation services was expressed as a way that respondents navigate the integration of Indigenous language into their programming. Given the growing evidence of the benefits of Indigenous language use on health outcomes for AI/AN people (Whalen et al., 2022; Schweigman et al., 2011), improved dedication of funding and resources towards the provision of health care services and materials in Indigenous languages should be prioritized.

CONCLUSION

This assessment highlighted the interconnected impacts of SDOH on health outcomes, as well as the need for enhanced investment and support to address challenges related to SDOH which disproportionately affect AI/AN people across the United States and in California. Improved policies, funding, and resources directed towards housing security, transportation to care, food security, and Indigenous language and identity can help to improve AI/AN health outcomes. **Figure 53** highlights the key priority areas which are recommended for addressing each challenge. Improved investment for culturally relevant programming and resources across these key areas, as well as adequate Urban Indian Health line item appropriations and 100 percent FMAP for UIOs with Federal Medicaid reimbursement parity, can address these challenges. Additional research efforts to understand how socioeconomic barriers disproportionately burden AI/AN communities, as well as how cultural factors can improve resiliency across AI/AN health outcomes, may also improve the mitigation of AI/AN health disparities. Such research can further inform the federal government's obligations to urban AI/AN people under the IHCA, grounded in the United States' trust responsibility and the documented consequences of federal relocation policies (U.S. Senate Select Committee on Indian Affairs, 1988).

Figure 53. Summary of Recommendations to Address SDOH

SDOH Challenge	Recommended Priority Areas for Policies, Funding, and Resources to Address SDOH Challenge
<i>Housing Insecurity</i>	Cultural competency of services and staff at housing programs
	Transitional housing programs
<i>Transportation Barriers to Care</i>	Patient transportation services
	Telehealth services and coverage
<i>Food Insecurity</i>	Food programs that supply nutritious traditional foods
	Food production programs that support Indigenous food sovereignty
<i>Indigenous Language and Identity Challenges</i>	Traditional healing programs
	Health care services and materials offered in Indigenous languages

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