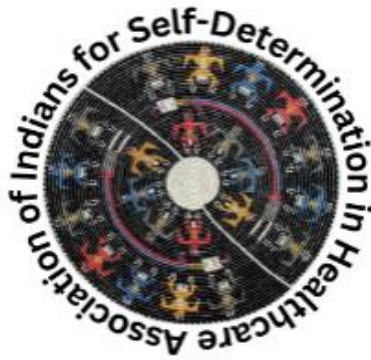




ASSOCIATION OF INDIANS FOR SELF-DETERMINATION IN HEALTHCARE

638 ASSOCIATION

25th Navajo Nation Tribal Council

Fall Session Report

REPORTING ORGANIZATIONS

Fort Defiance Indian Hospital Board, Inc.

Winslow Indian Health Care Center, Inc.

Tuba City Regional Health Care Corporation

Sage Memorial Hospital – Navajo Health Foundation

Utah Navajo Health System, Inc.

Executive Summary

The 638 healthcare system represents Tribal self-determination in action. Through Title I self-determination contracts and Title V self-governance compacts authorized under the Indian Self-Determination and Education Assistance Act, Tribes and Tribal organizations assume responsibility for planning, operating, and improving healthcare programs that would otherwise be provided by the Indian Health Service. These authorities strengthen local decision-making, accountability, and the delivery of culturally responsive care shaped by the needs and priorities of Diné communities. Expanding services across the 638 healthcare system is essential to building a more comprehensive and connected continuum of care on the Navajo Nation. Adding primary, specialty, surgical, behavioral health, elder care, diagnostic, transportation, and other needed services allows more Diné relatives to receive care closer to home and near their families and support systems. Local service expansion also reduces the financial, physical, and emotional burden of long-distance travel, limits delays in diagnosis and treatment, improves follow-up and continuity of care, and decreases avoidable transfers to distant facilities. Continued investment in 638 organizations strengthens access, improves health outcomes, and helps create a sustainable healthcare system that keeps more care, and more relatives, within their own communities.

Organization	Title I or Title V	Healthcare organization type
Fort Defiance Indian Hospital Board, Inc.	Title I	Tribally chartered 501(c)(3) nonprofit multifacility healthcare and public health organization
Winslow Indian Health Care Center, Inc.	Title V	Integrated rural healthcare and hospital based that supports clinical care (inpatient/outpatient), nursing, community health programs, and essential administrative and operational functions including facilities management, finance, HR, and Quality
Tuba City Regional Health Care Corporation	Title V	Tribal, non-profit, healthcare organization operating a 73-bed licensed hospital, multisite outpatient clinics, community health and support services.
Sage Memorial Hospital – Navajo Health Foundation	Title I	Critical Access Hospital with Rural Health Clinic, outpatient, community health, and support services.
Utah Navajo Health System, Inc.	Title V	Critical Access Hospital and FQHC outpatient clinics, community health and support services

I. Achievements

This section highlights the collective progress and measurable accomplishments of the 638 healthcare organizations. The activities and projects presented below reflect shared efforts in which all 638 healthcare organizations are actively involved, contributing their expertise, resources, and organizational perspectives. Together, these achievements demonstrate how Tribal self-determination strengthens local decision-making, expands access to quality and

culturally responsive care, builds workforce and system capacity, and brings essential services closer to Diné relatives.

- **Joint 638 highlight: NUKA conference collaboration.** The NUKA conference was held August 25–27, 2026, in Flagstaff, Arizona, with participation from the 638 organizations. Approximately 80 staff attended from different organizations, creating a shared learning space to educate teams on processes that improve coordination of care, strengthen communication, support smoother transitions, and promote more connected care for Diné relatives across facilities.
- **Navajo Area Health Service Master Plan:** The 638 health organizations actively participated in the development of the Navajo Area Health Service Master Plan, led by Forvis Mazars and Bodwé planning team in partnership with Navajo Area IHS. Tribal health organizations shared critical data and local perspectives regarding population needs, patient utilization and referrals, existing services, workforce and staffing, facilities, specialty care, and future healthcare priorities. This collaborative planning effort is establishing a comprehensive vision for healthcare delivery across the Navajo Nation through 2040 and will help identify future service, facility, workforce, staff housing, and community healthcare needs.

II. At-a-Glance Impact by Organization

The matrix below provides a clear, side-by-side summary of each 638 organization’s communities served and current services. This information allows readers to compare organizational reach, understand how services strengthen local healthcare systems, and identify shared and regional gaps where targeted support can improve access, coordination, and care closer to home for Diné relatives.

638 organization	Communities Served	Current Services
Fort Defiance Indian Hospital Board, Inc.	Crystal, Houck, Cornfields, Fort Defiance, Ganado, Greasewood, Kindalichee, Wide Ruins, Klagetoh, Lupton, Nahat’a Dziil, Oaksprings, Red Lake, Sawmill, St. Michaels, Steamboat	Adolescent Care Unit, adult and pediatric inpatient services including ICU, OBGYN including labor and delivery, ancillary services, community health, wellness, school-based health, and Traditional Cultural Services
Winslow Indian Health Care Center, Inc.	Leupp, Tolani Lake, Birdsprings, Teesto, Dilkon, Indian Wells, Whitecone, Jeddito	Primary Care & Family Practice, Physical Therapy, Dental, Optometry, Laboratory, Radiology, Pharmacy, 24/7 Emergency Room, Urgent Care, Acute Care, General Surgery, Respiratory Therapy, Podiatry and Wound Care, Behavioral Health and Substance Abuse, Nutrition Services, Diabetes Education, Maternal-Child Health, Neurology, Traditional Healing and hospital support services
Tuba City Regional Health Care Corporation	Tuba City, Tonalea, Coppermine, Kaibeto, LeChee, Gap, Coalmine, Cameron, Hopi Village of Moenkopi, and San Juan Southern Paiute	Hospital inpatient and outpatient services, including emergency medicine and trauma care, surgery (Ortho, OB/GYN, General, ENT), laboratory, radiology (X-ray, CT, ultrasound, MRI, mammography), pharmacy, rehabilitation therapy, durable medical equipment, mental health, community health programs, public health,

		traditional health services, specialty services (Infusion, Hematology, Oncology), dental care, eye care, and ENT/Audiology. Mobile medical and dental services and adolescent school-based clinics.
Sage Memorial Hospital – Navajo Health Foundation • Greasewood Clinic	Steamboat, Greasewood Springs, Cornfields, Ganado, Kin dah lichee, Klagetoh, Nazlini, Wide Ruins	Hospital, emergency, rural health clinic, outpatient, surgical, community health, laboratory, imaging, pharmacy, home health, DME, Traditional Healing, and support services.
Utah Navajo Health System, Inc.	Montezuma Creek, Blanding, Monument Valley, Navajo Mountain, Shiprock	Inpatient and outpatient services, including emergency, surgery, laboratory, radiology, pharmacy, durable medical equipment, behavioral health, community health, public health, traditional health services, EMS services, specialty services, veterinary services, transportation, and home-based programs.

III. Visits and System Activity

This matrix summarizes the reach and activity of each 638 healthcare organization by showing the number of unique Diné relatives served, total visits or encounters, recently added services, and upcoming new services. Together, these measures illustrate community demand, organizational capacity, and how continued service expansion improves access. Reviewing the information side by side also helps identify growth, remaining gaps, and opportunities to strengthen local care, reduce travel burdens, and keep more relatives closer to home.

Visits by Organization – FY2026				
638 organization	Unique relatives served	Total visits / encounters	New services in FY2026	Upcoming New Services in FY2027
Fort Defiance Indian Hospital Board, Inc.	45,486	347,924	Adult Infectious Disease, CT Calcium Coronary studies	Cardiology
Winslow Indian Health Care Center, Inc.	18,052	219,607	Respiratory Therapy, radiology modernization initiative, community and staff wellness initiatives, continued participation in HRSA 340B Pharmacy Program, Central Sterile, Audiology, Integrated Clinical Care Coordination and services (a/k/a PCMH)	Dilkon Medical Center: Veteran's Services, expansion of Cardiology, expansion of Maternal-Child health, expansion of Podiatry Dilkon Medical Center/Winslow Indian Health Care Campus: Expansion of Telehealth Services
Tuba City Regional Health Care Corporation	34,680	373,982	Traditional medicine, Street Medicine Program, and expanded clinic hours,	Long-term care and new clinic expansion at Echo Cliffs Health Center.

			including weekends, at several outpatient sites.	
Sage Memorial Hospital – Navajo Health Foundation	10,500	109,000	Surgical Services, NEMT, podiatry, wound clinic, and prenatal/postnatal care.	Elder day care, outpatient dialysis, and interfacility transport.
Utah Navajo Health System, Inc.	15,820	115,000	Home health, grocery, expanding traditional services, and new clinic expansions.	Home health, grocery, expanding traditional services, and new clinic expansions.

IV. Accreditation, Certification, and Survey Readiness

Continuous survey readiness is essential because safe, high-quality care depends on consistent compliance with clinical, operational, infection prevention, environment-of-care, and regulatory standards every day, not only when a survey is scheduled. Accreditation means an independent accrediting organization has evaluated a healthcare organization and determined that it meets established standards for quality, patient safety, leadership, accountability, and performance. Maintaining accreditation, certification, and Patient-Centered Medical Home (PCMH) recognition supports public trust, promotes continuous improvement, strengthens coordinated primary care, and helps ensure that systems are in place to reduce risk and provide dependable care to Diné relatives. The matrix below summarizes each organization’s accreditation, certification, or survey status.

Each organization is surveyed or accredited by the Joint Commission, the Centers for Medicare & Medicaid Services (CMS), or the Accreditation Association for Ambulatory Health Care (AAAHC). These surveys are generally conducted unannounced and are important, extensive reviews of patient safety, quality of care, regulatory compliance, leadership accountability, clinical operations, and the environment of care.

Hospital / organization	Accreditation, certification, or survey	Date / period	Status
Fort Defiance Indian Hospital Board, Inc.	Centers for Medicare & Medicaid Services	June 5, 2025	In compliance with Medicare Conditions of Participation
Winslow Indian Health Care Center, Inc.	Joint Commission (JC): Hospital and PCMH certification Association of Diabetes Care & Education Specialist (ADCES): Certified Diabetes Care and Education Specialist (CDCES) C.O.L.A.: Laboratory	05/2026 01/2025 07/2026	Accredited (“Deemed Status”) 5 year Certification renewal 2 year Accreditation Renewal
Tuba City Regional Health Care Corporation	Joint Commission Accreditation for Hospital, Home Health (DME), and Patient Centered Medical Home (PCMH) certification.	Joint Commission Accreditation for Hospital, PCMH, DME, issued July	Accreditations, Designations, and Certifications are all current.

	Joint Commission Accreditation for Laboratory. American College of Surgeons (ACS) Trauma Level 3 Designation, Arizona Perinatal Trust, Perinatal Care Center Level 2 Certification Baby Friendly Designation American College of Radiology (ACR) certified MRI, Mammography and CT.	12, 2025 valid for 36 months Joint Commission Accreditation for Lab, issued June 26, 025 valid for 36 months. ACS Trauma Level III Designation, valid to 12/10/2027 Baby Friendly Designation, valid to Aug. 29, 2027. Perinatal Care Center Level II, current for 3 years 2029. ACR Accreditation for Mammography, April 15, 2024 – July 18, 2026 ACR Accreditation for CT, June 30, 2026– June 30, 2029. ACR Accreditation for MRI, June 22, 2026 – August 16, 2029.	Opening of the New Echo Cliffs Health Center location was communicated to Joint Commission, we expect an unannounced Joint Commission Survey in the next 6 months.
Sage Memorial Hospital – Navajo Health Foundation	Joint Commission: Critical Access Hospital; Rural Health Clinic, Laboratory, Home Health – DME, and PCMH certified	Initial Surveys July 2, 2026	Accredited <i>Opening of new services will result in an unannounced survey.</i>
Utah Navajo Health System, Inc.	Joint Commission: Hospital, Ambulatory, DME, PCMH and Laboratory		Has been accredited for over 20 years.

V. Workforce Strategy and Human Capital

Workforce capacity remains a shared priority across the 638 organizations. The matrix below provides an important side-by-side view of workforce size, Navajo employment, vacancy rate, and staffing conditions, helping readers identify shared trends, organizational strengths, and areas requiring targeted support. Provider and nursing vacancy rates are especially important because unfilled physician, advanced practice provider, nursing, and other clinical positions can reduce appointment availability, limit service capacity, increase wait times and referrals, and create greater reliance on agency or temporary staffing. Limited workforce housing further affects

recruitment and retention for both clinical and nonclinical staff. Tracking these measures over time supports informed workforce planning and helps protect access, continuity, quality, and care closer to home for Diné relatives.

Workforce Capacity by 638 Organization – FY2026

638 organization	Total employees	% Navajo workforce	Vacancy rate	Workforce note
Sage Memorial Hospital – Navajo Health Foundation	475 employees	89% Navajo	24%	Need staff housing, clinical and non-clinical.
Fort Defiance Indian Hospital Board, Inc.	1178 employees	71.5% Navajo	19.6%	Need for staff housing
Winslow Indian Health Care Center, Inc.	653 employees	85% Navajo	20%	Workforce contributing to community employment, local community capacity and connections, and culturally informed care and responsive services
Tuba City Regional Health Care Corporation	1126 employees	75.3% Navajo, Hopi, San Juan Southern Paiute	Nursing 24.57% Providers 18.95% Staff (Non-Nursing and Providers) 11.45%	Need for staff housing. Increase healthcare degree programs through High school and local Tribal colleges.
Utah Navajo Health System, Inc.	700 employees	80% Navajo	3%	Additional staff housing would be very beneficial

VI. Top Service Priorities

The following services are considered priority areas because they address some of the most pressing needs across the Navajo Nation. Expanding behavioral health and substance use services, elder care, long-term services, specialty care, surgical services, and labor and delivery strengthens access, reduces delays in treatment, limits long-distance travel, supports families, and helps more Diné relatives receive safe, timely care closer to home.

Top service needed	Current status	Barrier / gap
Behavioral health and substance use services	Demand continues to exceed available local service capacity in many communities.	Limited providers, treatment space, referral options, transportation, and after-hours coverage.
Elder care and long-term services	Local elder care, skilled nursing, and respite options remain limited across the Navajo Nation.	Facility needs, staffing shortages, reimbursement limits, and limited long-term care infrastructure.

Specialty care, surgical, and labor and delivery services	Specialty, surgical, and labor and delivery access varies by region and remains difficult for many relatives.	Limited specialists, OB staffing, equipment, facility capacity, referral funding, and transportation support.
New/replacement hospital construction	Aging hospitals and infrastructure are costly to maintain, inefficient, and not designed for current workflows, accreditation standards, patient volumes, or service growth.	Outdated facility design limits patient privacy, operational efficiency, and the ability to safely accommodate modern care delivery. Aging building systems also require increasingly costly maintenance and replacement.
Workforce recruitment and retention	Recruitment and retention remain priorities because the availability of a ready, qualified workforce directly determines which services can be provided and sustained.	Limited workforce housing restricts the ability to recruit and retain clinical and non-clinical staff, contributing to vacancies and limiting service capacity.

VII. Shared Challenges

This section identifies the shared barriers that limit the ability of 638 healthcare organizations to provide consistent, timely, and high-quality care. These challenges are important because healthcare access depends on having sufficient staff, housing, facilities, funding, and operational capacity in place to meet community needs. When these barriers persist, they can reduce available services, delay appointments and treatment, increase transfers and travel burdens, disrupt continuity of care, place added pressure on employees, and raise operating costs. Addressing them is essential to protecting patient safety, sustaining critical services, and ensuring Diné relatives can receive dependable care closer to home.

- **Clinical staffing shortages and agency reliance.** Across the 638 organizations, clinical staffing remains one of the most significant shared challenges. Persistent vacancies in nursing, provider, allied health, and other direct-care roles require organizations to rely on agency staffing to maintain access, coverage, and safe service delivery.
- **Housing for clinical and non-clinical staff.** Limited workforce housing affects recruitment and retention for both clinical and non-clinical positions. Without accessible housing near service areas, organizations face longer recruitment timelines, increased turnover risk, and greater difficulty building a stable local workforce.
- **Aging Healthcare Facilities**
Several 638 healthcare facilities are aging, including Tuba City Regional Health Care Corporation's hospital, which is more than 50 years old. These facilities no longer reflect modern healthcare design standards and limit the ability to provide the level of care, privacy, safety, and operational efficiency that Diné relatives, families, and staff deserve. Patient rooms are outdated, with as many as four Diné relatives sharing one room and bathroom, resulting in limited privacy and comfort. Aging layouts also hinder efficient staff

workflows and were not designed for the populations, service volumes, and complexity of care they now support.

As demand for healthcare services continues to grow, meaningful expansion is constrained by the physical limitations of existing sites and building footprints. Aging infrastructure and inefficient building systems also require escalating maintenance expenditures. Significant resources must be directed toward sustaining operations, diverting funding that could otherwise be invested in direct patient care, workforce support, modernized facilities, and expanded healthcare services.

- **Aging Staff Quarters**

Housing shortages remain a significant barrier to recruiting and retaining healthcare professionals in Diné communities, ultimately limiting access to quality healthcare services. Although the Indian Health Service includes staff quarters in some new hospital and clinic construction projects, investment in staff housing independent of facility construction has been limited. Expanding housing opportunities for healthcare workers would strengthen recruitment and retention, reduce vacancy rates, and help ensure consistent access to care in underserved communities. Staff housing should be recognized as essential healthcare infrastructure and a critical component of sustaining a stable workforce.

Several 638 organizations are also contending with aging staff quarters that require upgrades to remain safe, energy-efficient, and attractive to healthcare professionals. Investments in energy-efficient windows, insulation, heating and cooling systems, and other infrastructure improvements would reduce operating costs, improve living conditions, and support long-term workforce retention. Just as hospitals and clinics are necessary to deliver care, adequate and updated staff housing is necessary to recruit and retain the workforce needed to operate them.

Risk if unresolved. If staffing and housing gaps persist, facilities may remain dependent on higher-cost temporary staffing, experience reduced continuity of care, and face pressure on access, quality, patient safety, and financial sustainability.

- **IT Modernization**

Information technology modernization is critical to delivering safe, efficient, and high-quality healthcare. The 638 healthcare organizations increasingly rely on technology for care delivery, electronic health records, telehealth, cybersecurity, data management, communication, and remote monitoring. Without reliable infrastructure, both healthcare delivery and access to services are negatively affected. Limited fiber and broadband availability in rural Diné communities continues to create significant connectivity challenges for telehealth, cloud-based applications, electronic health records, and other essential operations. As technology evolves, 638 organizations also face increasing costs to maintain secure, reliable, and compliant systems.

Risk if unresolved. Adequate investment in broadband connectivity, network infrastructure, cybersecurity, and modern healthcare technologies is essential to equitable healthcare access. Without sufficient funding and infrastructure support from local utility providers, 638 healthcare

organizations must divert limited operational resources to critical IT needs, reducing funds available for direct care. Targeted investments would strengthen healthcare delivery, improve operational efficiency, expand telehealth, enhance cybersecurity, and help 638 organizations meet the demands of an increasingly digital healthcare environment.

- **Third-Party Reimbursement**

Funding provided by the Indian Health Service remains inadequate to meet the growing healthcare needs of Diné relatives. This challenge is compounded when the federal government operates under a continuing resolution, further widening the funding gap. Third-party reimbursements have therefore become a critical source of revenue for 638 healthcare organizations and are reinvested directly in care delivery, workforce, infrastructure, and service expansion.

The Navajo Nation's current Tribal Self-Insurance Clause and exception to the Indian Health Service (IHS) Payor of Last Resort policy create reimbursement barriers for Title I and Title V 638 healthcare organizations. While Navajo Nation Council authorization is required for covered exceptions, tribal enterprises, schools, and affiliates claiming self-insured status lack the necessary Navajo Nation legislative authority. These unresolved issues, compounded by fiscal intermediary payment delays and coverage verification challenges, have disrupted Purchased/Referred Care (PRC) payments, limited provider acceptance, and delayed access to essential healthcare services. The Navajo Nation Council should direct a review of entities claiming self-insured status, verify supporting legislation and authorization, and establish clear procedures for reimbursement and PRC eligibility determinations. Clarifying these requirements and ensuring equitable access to authorized reimbursement opportunities will strengthen healthcare systems, improve financial sustainability, and support timely access to care for the Diné people.

- **Water and Electricity Threats to Hospital facilities**

Hospitals and clinics are dependent on local utility infrastructure for water and electricity. Utility infrastructure is critical for regulatory, safety and infection control requirements that ensure safe, reliable protection of patients, staff and facility. Consequences of non-compliance can lead to patient harm, medical equipment damage, certification citations and/or loss of accreditation.

Risk if unresolved. Without reliable utility infrastructure, access to healthcare is negatively impacted. Water line breaks and delay to recovery create water backflow which risks Legionella, limits inpatient preparation of patient foods, port-a-pottie dependency, threat to handwashing protocols and initiation of human monitored fire watch without a reliable fire protection water sprinkler system. Power line disruption causes generator-based healthcare delivery, endangerment of life-support equipment, and pose immediate patient safety risks within laboratory and radiology services (Xray, CT, MRI). Both absence of water and electricity can lead to delay or cancellation of patient care.

Water and electricity systems are patient safety-critical. Targeted investments to prevent utility failure, decrease recovery times for systems down and identification of individual for hospital on-call support would improve healthcare and help 638 organizations adhere to safe, reliable patient care.

VIII. Collective Advocacy and Partnerships

The AISDH chief executive officers meet at least once a month to discuss shared concerns, emerging issues, and best practices across their healthcare organizations. These regular meetings strengthen partnership by creating a trusted forum for collaboration, coordinated problem-solving, shared learning, and unified advocacy. Working together allows the organizations to identify common priorities, align resources and strategies, elevate the collective voice of Tribal healthcare, and develop solutions that improve access, quality, continuity, and culturally responsive care for Diné relatives.

Navajo Nation Partnership

Navajo Nation Emergency Medical Services

The 638 healthcare organizations rely on strong, collaborative relationships with local Navajo Nation Emergency Medical Services providers. These relationships are formalized through memoranda of understanding or agreement that support interfacility transport, 911 response, or both. These partnerships are vital to emergency and trauma care because they promote rapid response, seamless coordination, and continuity of care for Diné relatives. Continued Navajo Nation support for these partnerships is critical to protecting the health and safety of Diné communities.

High School and Higher Education Healthcare Programs

The 638 healthcare organizations have established partnerships and affiliation agreements with universities, colleges, and Tribal colleges. Serving as clinical training sites for physicians, nurses, and allied health professionals provides valuable hands-on experience, strengthens the healthcare workforce pipeline, and creates important opportunities to recruit future healthcare professionals.

Expanding healthcare education and training opportunities within Diné communities is essential to building a sustainable local workforce. High schools, Tribal colleges, and other educational institutions should be supported in developing additional healthcare certification programs, career pathways, and degree programs that prepare local students for healthcare careers. Creating these opportunities close to home can encourage more students to enter healthcare professions, strengthen the local workforce, reduce long-term staffing shortages, and improve access to quality care for future generations.

Because workforce development is a long-term strategy, Navajo Nation leaders are encouraged to support and incentivize local high schools, Tribal colleges, and higher education partners to create

and expand these career pathways. Investing in local talent is one of the most effective ways to build a stable healthcare workforce and sustain services for Diné relatives over time.

Federal / IHS Advocacy

The 638 organizations support renewal of Arizona's Section 1115 waiver and continued protection of Tribal benefits, the AIHP fee-for-service option, and meaningful Tribal consultation. Renewal should avoid changes that disrupt reimbursement, culturally responsive services, or continuity of care. Federal advocacy must also address inadequate Medicare reimbursement for skilled nursing and elder-care services. With very few nursing homes on the Navajo Nation, limited reimbursement makes it difficult to sustain or expand services and often requires elders to travel or receive care far from their families and communities.

State Medicaid and Rural Health Initiatives

The AIHP reform proposal presented during the previous legislative session did not pass; however, it raised continuing concerns about potential changes to Arizona's Medicaid system and the administration of the American Indian Health Program. Any future reform should preserve the AIHP fee-for-service option, protect Tribal sovereignty and meaningful Tribal consultation, avoid additional administrative burdens, and ensure timely and reliable reimbursement for Tribal and Indian healthcare providers. Changes made without sufficient Tribal input or a clear transition plan could disrupt provider payments, care coordination, continuity of services, and access to behavioral health and other essential care for American Indian Medicaid members. The 638 organizations will continue to monitor proposed reforms and advocate for Medicaid policies that strengthen accountability and program integrity without creating new barriers for providers or Diné relatives.

IX. Closing Statement

Title I self-determination contracts and Title V self-governance compacts provide effective pathways for Tribes and Tribal organizations to manage healthcare programs with greater local authority, flexibility, and accountability. While each model provides a different level of administrative responsibility and autonomy, both allow healthcare organizations to design services around community priorities, make decisions closer to the people they serve, and strengthen culturally responsive care. Through continued collaboration, the 638 organizations are sharing best practices, aligning advocacy, coordinating resources, and addressing common workforce, infrastructure, reimbursement, and service-delivery challenges. This collective approach strengthens the Navajo healthcare system, expands access to needed services, reduces unnecessary travel and transfers, and helps more Diné relatives receive high-quality care closer to home across the Navajo Nation.

That same spirit of collaboration and shared responsibility is especially important as flu season begins. Along with strengthening healthcare systems and expanding access, the 638 organizations remain committed to prevention and community protection. Getting a flu vaccine is one of the most effective ways to reduce serious illness, protect elders and relatives with chronic conditions, limit missed work and school, and help keep healthcare services available for those who need

them most. Each organization encourages staff, families, and community members to receive their flu vaccine and help protect the health of our Diné communities.

Sincerely,

A handwritten signature in black ink, appearing to read 'C. Curley', with a stylized, sweeping flourish at the end.

Christopher Curley, President
Association of Indians for Self-Determination in Healthcare