



American Indian Health Commission for
Washington State

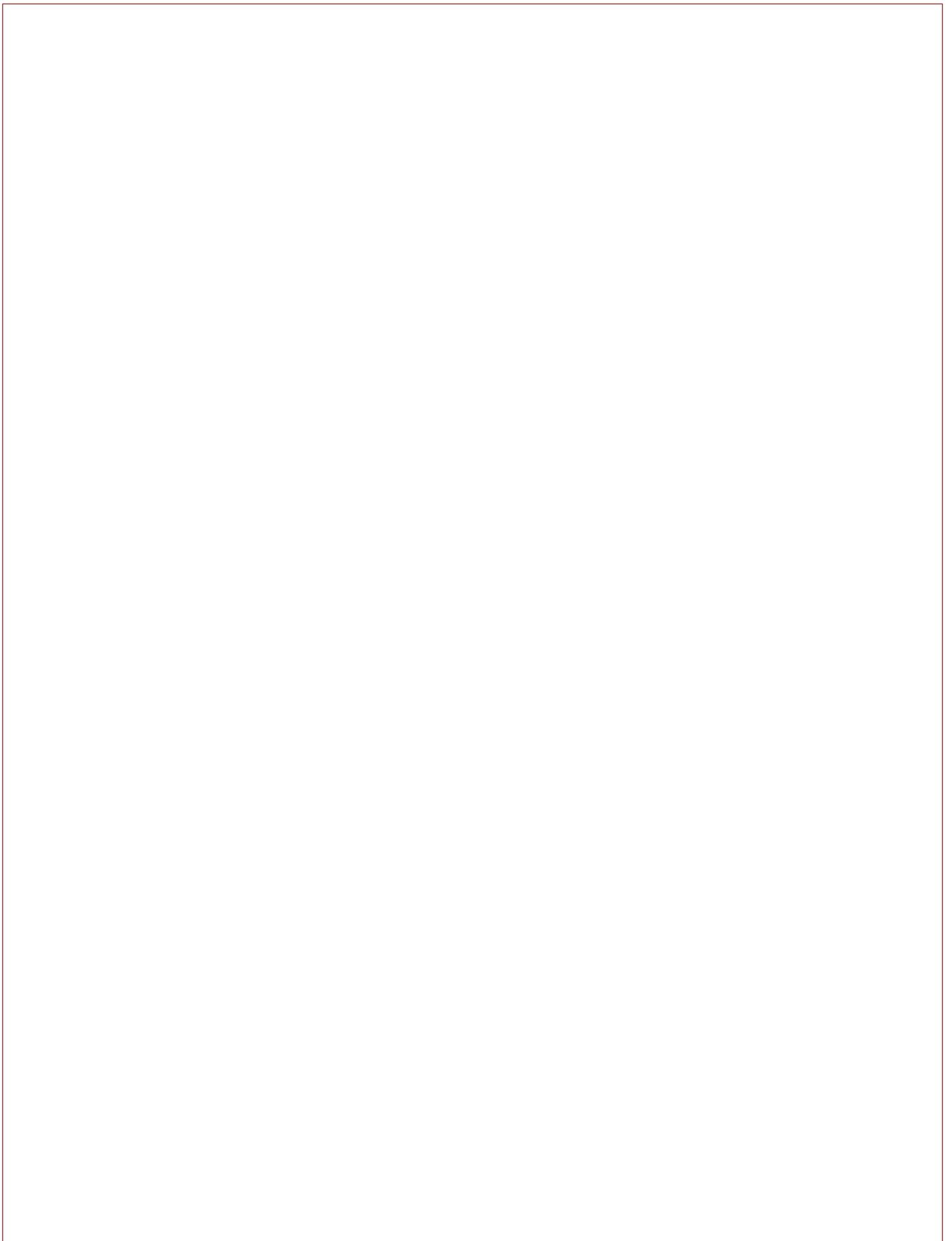


Opportunities for Change:

*Improving the Health of
American Indians/Alaska Natives
in Washington State*

American Indian Health Care Delivery Plan 2010-2013

April 2010





Dear Colleague:

We are pleased to present the new health care delivery plan for American Indians/Alaska Natives in Washington. The American Indian Health Commission for Washington State and the Washington State Department of Health developed this plan collaboratively.

The plan for 2010-2013 is titled *Opportunities for Change: Improving the Health of American Indians/Alaska Natives in Washington State*.

Since 1997 the American Indian Health Care Delivery Plan has been the foundation of the work to address the health disparities of American Indians/Alaska Natives in Washington. Tribes, Urban Indian Health Organizations, the commission, and the state Department of Health use the plan. It provides a policy framework to improve the health of Indian people.

There has been significant progress toward this end, yet much work remains. In this time of extraordinary economic challenge, it is more important than ever to build a strong foundation and partnership. We must continue to address Indian health disparities. There must be a joint commitment to identify the resources needed and implement culturally-appropriate strategies for improvement. The 2010-2013 American Indian Health Care Delivery Plan is the road map to guide this work in the next four years. We will update you on the progress.

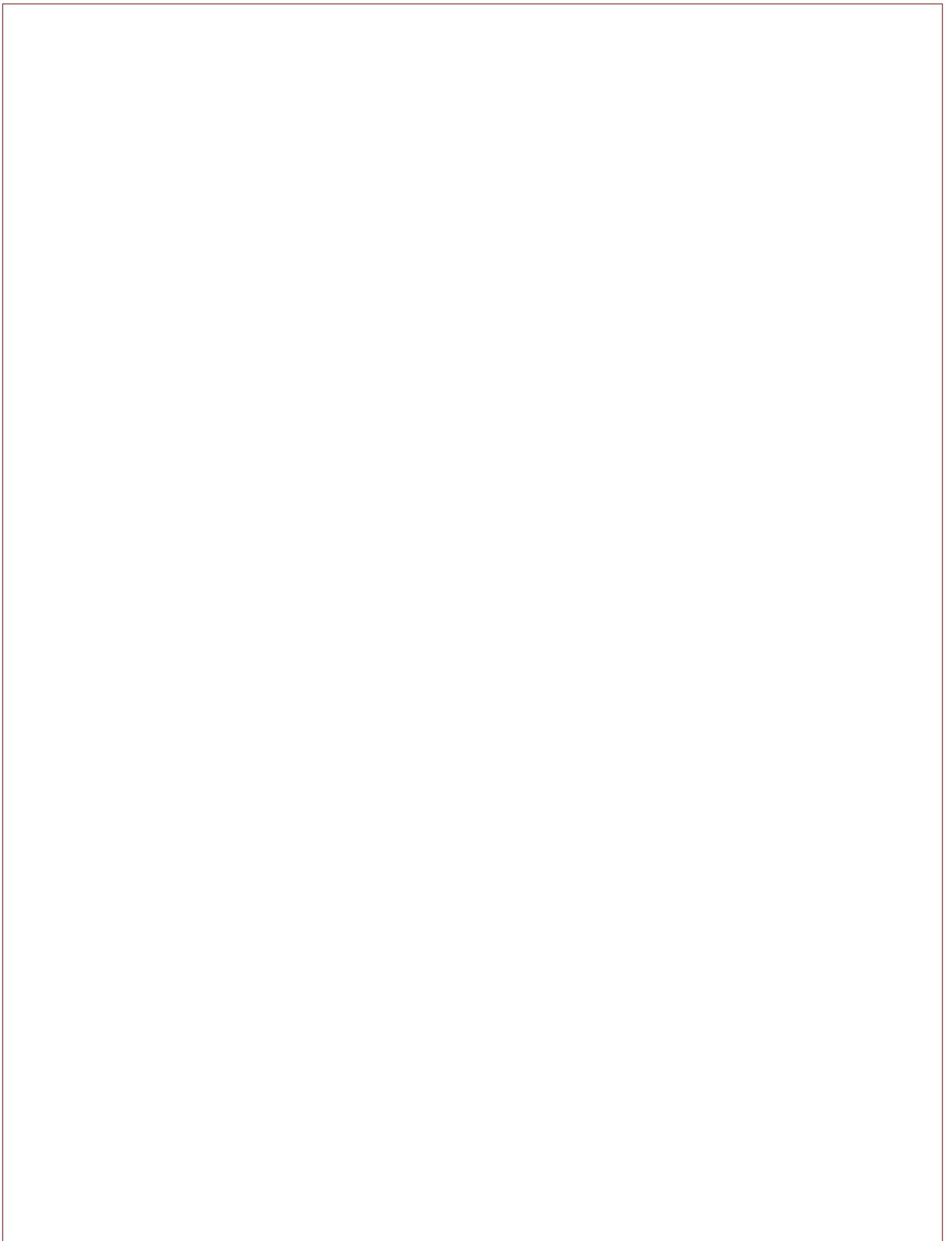
Our goals are ambitious and challenging to reach; however, we believe much can be accomplished by effectively combining our resources and expertise. This plan is a blueprint to build the bridge to better health outcomes for American Indian/Alaska Native residents in Washington. We hope the plan is useful in your commitment to eliminate health disparities.

Sincerely,

Marilyn Scott, Chairwoman
American Indian Health Commission

Mary C. Selecky, Secretary
Washington State Department of Health

Enclosure



Acknowledgements

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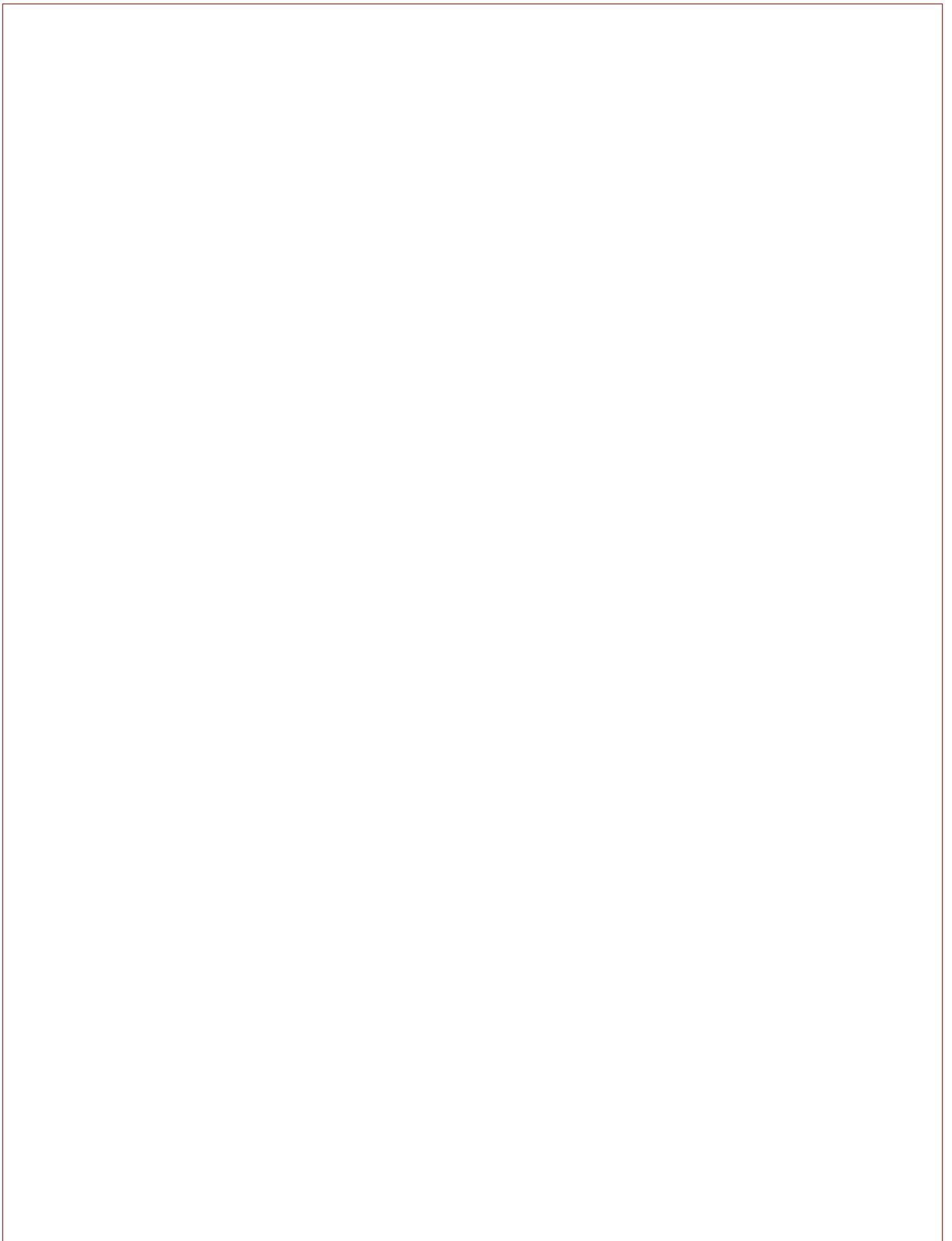
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Lummi Tribe	Makah Tribe	Muckleshoot Tribe
N.A.T.I.V.E. Project	Nooksack Tribe	Port Gamble S’Klallam Tribe
Puyallup Tribe	Quinault Nation	Quileute Tribe
Samish Nation	Sauk-Suiattle Indian Tribe	Seattle Indian Health Board
Shoalwater Bay Tribe	Skokomish Tribe	Snoqualmie Nation
Spokane Tribe	Squaxin Island Tribe	Stillaguamish Tribe
Suquamish Tribe	Swinomish Tribe	Tulalip Tribe
Upper Skagit Tribe		





American Indian Health Care Delivery Plan 2010-2013

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A: Acronyms Reference

Opportunities for Change:

“For more than fourteen years, Congress has failed to reauthorize the Indian Health Care Improvement Act and comprehensively modernize Native American health care services. This is unfair and unacceptable.

Today’s Native Americans are disproportionately suffering from debilitating illnesses, like diabetes, heart disease and stroke. The infant mortality rate is 150 percent higher for Native American infants than white infants, and the suicide rate for Native Americans is two and a half times the national rate. With these alarming statistics, improvements to Native American health care could not come at a more urgent time.”

- Then Senator Barack Obama
January 18, 2008; U.S. Senate Floor

I. Executive Summary

The American Indian Health Care Delivery Plan (herein after referred to as “the plan”) is a collaborative effort between Washington State Department of Health, the American Indian Health Commission for Washington State (AIHC), and Washington State Tribes. Since 1997 the plan and its subsequent updates has served as a framework for Tribes, Urban Indian Health Organizations (UIHO), the commission, and Washington State (herein after referred to as “the state”) to address a shared goal of improving the health status of American Indian/Alaska Native people (AI/AN). Over the past 12 years much has been accomplished, yet more work remains. While the overall health of AI/ANs slowly improves over time; the significant gap in health outcomes between AI/AN and other populations has not significantly changed.

Today, the state, Tribes, and Urban Indian Health Organizations face extraordinary challenges in proactively addressing health issues as they grapple with the impacts of a national recession unlike any seen in many years. While these challenges are daunting, they also present unique opportunities to redefine the approaches used to address Indian health disparities and to improve collaboration across multiple systems, governments, organizations, infrastructures, and policies. Leadership and partnerships are more important than ever, not only to survive the current crisis, but to continue moving forward with the complex work in addressing health disparities and wisely leveraging limited resources available to do so.

Over the next four years, Tribes, the American Indian Health Commission, Department of Health, the Governor’s Office, the Washington State Health Care Authority (HCA), and Washington Department of Social and Health Services (DSHS) will work to address tribally-identified priority health issues in collaboration with other state agencies and stakeholders that share similar goals. At the same time, a more targeted effort will be launched to determine the true extent of health disparities for the overall state AI/AN population in the 21st century. Through a more systematic assessment of the current health status of AI/AN and the environments and systems in which Tribal health programs function today, we can begin developing a stronger, strategic framework for addressing future priority areas. The ultimate goal of these efforts is to close the gap between good health outcomes and increased mortality for Washington’s AI/AN population and develop more comprehensive services in Tribal communities.

In *Section I, Health Disparities and Service Delivery*, a more detailed look at the plan and its history is provided in order to emphasize its importance in on-going tribal-state work on Indian health issues. The plan, mandated by the Washington Legislature in 1995, is an important blueprint for addressing the poor health status of American Indian and Alaskan Natives in a collaborative and strategic manner.

The plan is developed through a unique, Tribally-driven process. Every other year, American Indian Health Commission hosts a Tribal Leaders Health Summit to shape strategies for addressing identified priority health issues on which the commission will work over a two- to four-year period of time. Tribal leaders and commission delegates define those priority areas prior to the summit, and AIHC creates workgroups around each topic, workgroups that include Tribal leaders, Tribal health providers, Tribal health policy experts, AIHC delegates, state leaders and state health experts. Workgroups develop draft position papers on the priority issues identified with recommended strategies on how to resolve the issues collaboratively. The papers are presented and discussed at the summits, revised and approved by the AIHC delegates. These papers serve as the framework for subsequent plans.

AIHC is more thoroughly discussed in Section I for its uniqueness as a state-Tribal model for health collaboration. AIHC's mission is to improve the health of AI/AN people through tribal-state collaboration on health policies and programs that will help decrease disparities. The commission continues to serve as an effective forum for achieving unity and guiding the collective needs of Tribal governments and urban Indian health programs in providing high-quality, comprehensive health care to AI/ANs in Washington.

Section I also describes the existing Indian health care delivery system. The federal government's obligation to provide health care services to AI/AN, explicit in some treaties, has been set forth in a series of federal laws, executive orders and court decisions. The landmark Snyder Act of 1921, was the first time Congress enacted legislation permanently authorizing appropriations for American Indian health care. In present day, the Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638) – authorizing the federal Indian Health Service (IHS) to turn over full administrative responsibility for IHS programs, through contracts, to tribes upon their request - and the Indian Health Care Improvement Act of 1976 (P.L. 94-437) – authorizing a series of health programs based on a “community health model” approach and directing increased appropriations for such programs – and their subsequent amendments, now guide the delivery of health services to Indian people. Tribes can operate health programs through Title I of P.L. 93-638 and contract with IHS,

or under Title III, and enter compacts with the federal government to assume full responsibility for health programs. Indian health programs provide primary, environmental, community, and contract health services through programs either operated by the federal government through the IHS, by local tribal government, or by urban Indian health organizations. The system is complex yet important to understand in the context of Indian health status today.

Section I also describes in greater detail the Urban Indian Program and its delivery system. Many AI/AN live in urban areas and are not eligible for health services in the same way in which reservation-based AI/AN are. Urban Indian Programs warrant attention as these services are severely underfunded and the needs are as great as those for reservation-based Indian people.

Indian health disparities are also explored in Section I. Although American Indians comprise only about two percent of Washington's population, their significant health care needs and unique legal status warrant public attention. American Indian and Alaskan Natives in Washington experience disproportionately high mortality and morbidity compared to the general population. Data from 2003-2007 indicate that AI/ANs have the highest mortality rates for all causes than any other population in the state,¹ with specific causes including but not limited to suicide, injury, chronic liver disease, Chronic Obstructive Pulmonary Disease, and heart disease.

While progress has been made in improving the health of AI/AN over the last 30 years, the gap in health outcomes remains. A targeted commitment and effort is needed in order to ensure this gap is eliminated. The state and Tribes will work together to implement effective public health programs, disease prevention and treatment strategies, and pursue adequate levels of resources, both financial and professional. The ongoing government-to-government relationship continues to raise the issue of improving the status of American Indian and Alaskan Natives as a mutual priority.

Section II, Opportunities for Change describes three initiatives that provide the potential for further reducing AI/AN health disparities and developing policies that improve the ability of Tribes to provide needed services in their communities. With the economic challenges we face also come opportunity to rethink our approaches to overall improved health, and in particular, Indian health. During this time, there are opportunities for clearly formulating a shared vision and mission and to implement strategies that look beyond the crisis of today.

¹ Washington State Vital Statistics 2006. Annual Report. Center for Health Statistics, Olympia, WA. January 2009

First, a State-Tribal-Urban Indian Health Collaborative has been re-instituted at a state/tribal leader policy level for addressing appropriate systems change and policy decisions that need to be made to change health outcomes for Indian people. This group — comprised of tribal governments, health staff, and state leaders across multiple systems and departments — will be strategically aligning statewide Indian health disparities work with Governor Gregoire’s 5-Point Health Care Initiative. This will allow the group to leverage existing resources, maximize the limited funds currently available, and create the infrastructure necessary to further reduce Indian health disparities in the future.

Second, several agencies, organizations, and institutions have expressed a renewed interest in coming together to develop a more complete set of American Indian health status data. Accurate data is necessary to support community health assessments and policy development to improve service delivery and health status of Indian people. Without painting a more thorough picture of Indian health in Washington today, the ability to plan or improve services, monitor quality, and analyze costs is severely impaired. Tribal governments must be intricately involved in such efforts to assure the use of the data is culturally-appropriate, acceptable, and meaningful in improving the health of their people. By reinstating efforts that began in 1997 between the American Indian Health Commission and Washington State Department of Health through an American Indian Data Committee, an updated framework can be developed for addressing priority health issues for AI/AN.

Third, sweeping national health reform and the current administration offer a unique opportunity for change in how health care is provided to AI/ANs. As Indian health leadership such as the U.S. Indian Health Services, the National Indian Health Board, and more regionally, the Northwest Portland Area Indian Health Board, strongly advocates for the inclusion of Indian health reform in national reform strategies, the state is also rethinking how it provides quality, affordable, and cost-effective health care to its citizens. The state, Tribes, and the commission will actively partner in these efforts to address the need for AI/AN increased access to existing services, increased Tribal provider reimbursement opportunities so culturally-appropriate services can be provided in Tribal communities, and develop mechanisms for evaluating progress for improved Indian health status.

Section III, 2007-2009 Accomplishments, highlights some of the major achievements made for Indian health in the state since the last plan was published in 2007. Additional partnerships have been developed, key policy issues have been addressed, and there

are an increased number of Tribal representatives serving on relevant state committees and task forces.

Section VI, Goals and Objectives, identifies the priority issue areas targeted to be addressed over the next four years. The goals are those that AIHC, Tribes, Urban Indian Health Organizations (UIHO), and the state will work together on to further the mission of eliminating Indian health disparities. The first component, *Tribal Forum for Improving AI/AN Health*, focuses on strategies to strengthen the collective voice for Tribes and Urban Indian Health Programs to greater influence health policy and assure full access by AI/ANs to health services and programs in the state. This goal also includes efforts to develop and implement stronger strategies for addressing Indian health disparities and the development of more effective communication avenues between Tribes and the state so Tribes are aware of emergent health news, information, and opportunities. While plans in the past have served well in informing individuals, Tribes, and organizations on the poor status of Indian health and identifying policy work being accomplished, further collaborative conversations and efforts across tribes, systems, organizations, and research institutions must be pursued to strategically *address* these disparities. This component outlines how that might begin to be accomplished over the next four years.

The four health priority areas — Maternal-Infant Health, Long-Term Care, Oral Health, and Mental Health services — were identified at the 2008 Tribal Leaders Health Summit and serve as the areas of disparities from which the broader work described above could be shaped. Each priority area includes: (a) Goal statement; (b) Problem statement; (c) Any supporting data; and (d) Strategies (objectives) for addressing the problem. The strategies are recommendations developed in American Indian Health Commission position papers at the Tribal Leaders Health Summit in November 2008 and subsequently approved by commission delegates in 2009. A targeted focus in these four priority Tribal health areas will allow us to not only develop solutions to these specific problems; it will also serve as a way to further define the process by which additional Indian health disparities can be addressed in the future. The strategies identified in this section will be pursued based on resource availability in each area.

The final section, *Tribal Health Programs in Washington State*, provides specific information about existing Tribal and Urban Indian health programs and clinics. It also provides information about the types of service that are provided by each site in order to complete the profile of the Indian health delivery system in our state.

Many opportunities for change exist in the current environment. Over the next four years, Tribes, AIHC, and partners have the opportunity to identify and implement new, more impactful ways of addressing the health of Indian people. The 2010-2013 American Indian Health Care Delivery Plan is a guide for furthering that effort and for achieving healthy outcomes and comprehensive, culturally appropriate health services for American Indians/Alaska Natives in Washington.

II. Health Disparities and Service Delivery

A. American Indian Health Care Delivery Plan

The Washington State Health Services Act of 1993 originally authorized the American Indian Health Care Delivery Plan. In 1995, responsibility for the plan was transferred from the Health Care Authority to the Department of Health, which allocated funds to develop the plan.

The purpose of the plan as stated in RCW 43.70.590 was to:

- ◆ (make) recommendations to providers and facilities' methods for coordinating and joint venturing with the Indian health services for service delivery
- ◆ (find) methods to improve American Indian specific health programming, and;
- ◆ (create) co-funding recommendations and opportunities for the unmet health services programming needs of American Indians

A separate law, RCW 43.70.052 (4) also directed the Department of Health "in consultation and collaboration with the federally recognized tribes, urban or other Indian health service organizations, and the federal area Indian health service, (to) design, develop, and maintain an American Indian-specific health data, statistics information system. The department rules regarding confidentiality shall apply to safeguard the information from inappropriate use or release."

The first plan was published in July 1997, marking the beginning of a significant partnership between Washington's Tribes and Department of Health to identify and address health disparities affecting American Indians and Alaska Natives. An advisory group was created to develop the first plan, comprised of American Indian and non-Indian health care providers and representatives of tribal, state, and local organizations. The three primary plan objectives set forth by this group aptly describe the premise of the plan today:

1. Understand the health status of American Indians in the state
2. Develop strategies to improve their health status
3. Close gaps in the provision of health care services

The plan has been the result of active collaboration between tribes, tribal organizations, and the department. It has also helped to spark additional collaboration with other state agencies and various public and non-profit entities in Washington. While the plan seeks to provide a comprehensive overview of the progress, opportunities and challenges that tribes and the state face in eliminating health disparities affecting Washington's AI/AN population, it by no means is a substitute for the government-to-government relationship that exists between federally recognized Tribes and state government. Through the auspices of the commission, tribes continue to be the driving force in the plan's content and scope.

B. The American Indian Health Commission for Washington State

American Indian Health Commission was created in 1994 by federally recognized tribes, Urban Indian health organizations, and other Indian organizations to provide a forum for addressing Tribal-state health issues. The commission's mission is to improve the health of AI/AN people through tribal-state collaboration on health policies and programs that will help decrease disparities. The commission works on behalf of the 29 federally-recognized Tribes and 2 Urban Indian Health Organizations in the state. Delegates are officially appointed by Tribal Councils to represent each individual Tribe, and Urban Indian Health Organization representatives serve as members-at-large. This model has been presented in state, regional, and national settings as a framework, or tool, for others in their work in forming strong tribal-state partnerships on health care issues. The commission continues to serve as an effective forum for achieving unity and guiding the collective needs of Tribal governments and urban Indian health programs in providing high-quality, comprehensive health care to AI/ANs in Washington. The ultimate goal in promoting increased Tribal-state collaboration is to improve the health status of American Indians and Alaska Natives by influencing state and Tribal health policy and resource allocation. Key activities include:

- Identifying health policy issues and advocating strategies to address Tribal concerns
- Coordinating policy analysis
- Soliciting and collecting information from the state for Tribal review and response
- Disseminating information to Tribal health programs and leaders
- Promoting the government-to-government relationship between Tribes and state health agencies

Please see Section V. A. for further details about the commission.

C. The Indian Health Service Delivery System

Federal governmental responsibility for providing health services to American Indians dates back more than 200 years to the assumption of responsibility for Indian education and ‘civilization.’ Legal responsibility for American Indian health traces back to many of the treaties enacted between 1776 and 1858 and their inclusion of medical care as partial compensation for the ceding of land and other resources. About 30 treaties specified access to a physician or medical facility, while an equal number merely contained general clauses promising assistance to the poor and infirm. Every treaty signed by tribes in Washington included a reference to medical attendance to be defrayed by the United States. In most cases, little was done to meet these obligations.² Treaties negotiated by the United States, which exchanged 400 million acres of Indian lands, created a trust obligation for the provision of health care services to AI/ANs. This solemn responsibility has been affirmed in numerous treaties, statutes, U.S. Supreme Court decisions, and Executive Orders.

Legal basis for American Indian Health Care

Over the past 85+ years, the federal government’s obligation to provide health care services to American Indians and Alaska Natives, explicit in some treaties, has been explicitly set forth in a series of federal laws, executive orders and court decisions. Among the most important:

- ◆ Snyder Act of 1921 – Congress, for the first time, enacted legislation permanently authorizing appropriations for American Indian health care. The act authorized the Bureau of Indian Affairs to expend federal funds and employ physicians “for the relief of distress and conservation of health.”
- ◆ Johnson O’Malley Act of 1934 – affirmed the federal government’s financial responsibility for Indian health services, authorizing the Secretary of the Interior to contact with state and local governments and private organizations to provide educational, medical, and other assistance to American Indians who no longer lived on the reservation.
- ◆ Transfer Act of 1954 – health services for AI/AN was transferred from the Interior Department to a newly created Division of Indian health (re-titled the Indian Health Service [IHS] in 1955) under the U.S. Public Health Service in the Department of Health, Education and Welfare. Primary motivation for the transfer was to improve

² American Indian Policy Review Commission; Report on Indian Health: Task Force Six-Indian Health. Washington DC: US Government Printing Office. 1976

quality of medical services to American Indians through supervision by an agency with more administrative expertise and funding in health care.

- ◆ Indian Health Facilities Act of 1957 – authorized IHS to contribute to the construction costs of community hospitals in cases where such facilities could provide better access and care than would the direct construction of Indian facilities.
- ◆ Indian Sanitation Facilities and Services Act of 1959 – expanded the scope of IHS programs by authorizing the agency to provide sanitation facilities including water supplies, drainage and waste disposal for American Indian homes, communities and lands.
- ◆ Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638) – authorized the IHS to turn over full administrative responsibility for IHS programs, through contracts, to Tribes upon their request.
- ◆ Indian Health Care Improvement Act of 1976 (P.L. 94-437, IHCA) – authorized a series of health programs based on “community health model” approach and directed increased appropriations for such programs; included first specific legislative acknowledgement of the special federal responsibility for American Indian health services, established urban Indian health programs, and removed prohibition of Medicaid and Medicare reimbursements to IHS and Tribally-operated facilities.
- ◆ Indian Health Care Improvement Act Amendments of 1992 (P.L. 102-573) – extended Tribal self-governance to the IHS; self-governance allows tribes to assume responsibility for resource management and service delivery, providing greater flexibility to design and develop programs that better meet the needs of its members, with no abrogation of the federal government’s trust responsibility.

The Federal Indian Health Service (IHS)

The foundation of the Indian Health Service is to uphold the federal government’s obligation to promote healthy AI/AN people, communities and cultures and to honor and protect the inherent sovereign rights of Tribes. Its mission is “to raise the physical, mental, social and spiritual health of AI/ANs to the highest level” and its goal is to “assure that comprehensive, culturally acceptable personal and public health services are available and accessible to AI/AN people.”³ The Indian Health Service delivery system was designed to be an integrated, community-based system that emphasizes prevention and public health, delivers and purchases health care services and provides the infrastructure for health improvements by building health facilities and sanitation

³ Indian Health Services, Indian Health Services Introduction, http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/IHSintro.asp

systems, as well as guaranteeing long-term improvement through training, recruitment and retention of health personnel. Inadequate resources, however, create barriers for the Indian health system to fully achieve its mission.

The following is excerpted from an article, *“Health Disparities Challenge Public Health Among Native Americans”* by Jim Roberts and Dr. Joshua Jones, published in the 2004 Fall/Winter edition of the Northwest Public Health Journal that more fully describes the Indian health delivery system as it exists today⁴:

“The AI/AN health care delivery system consists of approximately 594 health care facilities across the country, including 49 hospitals, 545 ambulatory facilities (231 health centers, five school-based health centers, 133 health stations, and 176 Alaska Native village clinics). These health care facilities can be grouped into three categories: those operated directly by IHS, those operated by the tribes through a Tribal Health Authority (THA) by contract or compact with IHS, and those providing services to urban AI/ANs (individuals not residing on or near an Indian reservation).

Along with ambulatory primary care services, facilities may offer inpatient care, medical specialties, traditional healing practices, dental care, mental health care, eye care, and substance abuse treatment programs. Many tribes are also served by community health (e.g., childhood immunizations, home visits) and environmental health (e.g., sanitation, injury prevention) programs, which may be administered by IHS or Tribes. Specialty services and types of medical care that are not available at a given facility are often purchased from providers in the private sector through a contract health service (CHS) program. The IHS and THAs apply stringent eligibility criteria to determine which patients qualify for CHS funding. The severely limited pool of CHS dollars also means that most CHS programs limit reimbursement to those diagnostic or therapeutic services that are needed to prevent the immediate death or serious impairment of the health of the patient. Among other problems, this results in reduced access to screening services and contributes to increased cancer mortality; for example, access to breast cancer screening is a particular problem for Native women, with only 52 percent in 2000 reporting a mammogram in the past two years.

Core funding of most of the health services (including CHS) derives from IHS; however, many programs are also dependent on grant funding, tribal revenue,

⁴ Roberts, Jim and Jones, Joshua. *Health Disparities Challenge Public Health Among Native Americans*. Northwest Public Health Journal: University of Washington School of Public Health & Community Medicine, Winter 2004.

and collections from third-party payers (including state Medicaid programs) to remain financially viable. More than 36 percent of AI/AN families in the United States making less than 200 percent of the federal poverty level had no health insurance, a percentage second only to Latinos.

Along with the community health programs associated with the health care facilities in each community, an increasing number of tribes are taking an active role in public health practice and research in their community. These activities include grant-funded collaborations with academic researchers and federal agencies (such as a population-based Behavioral Risk Factor Surveillance Survey specific to tribal communities) and active collaborations with state and county health departments in such areas as increasing access to childhood immunizations.

In addition, the last decade has seen a move toward increasing epidemiologic capacity within tribally run organizations. In the Northwest, three tribally operated epidemiology centers have been founded with funding from IHS and sustained by grant-funded activities: the Northwest Tribal Epidemiology Center at the Northwest Portland Area Indian Health Board, serving the 43 federally-recognized tribes in Idaho, Oregon, and Washington (www.npaihb.org); the Alaska Native Epidemiology Center at the Alaska Native Health Board (www.anhb.org); and the Urban Indian Health Institute at the Seattle Indian Health Board, which focuses on urban Indians nationally (www.uihi.org). The work of these tribal organizations has made progress in documenting the dramatic health problems that face Native communities in the Northwest. Although the health care system serving the AI/AN population may seem comprehensive, the provision of adequate health care to AI/ANs is hampered by chronic underfunding of IHS by the US Congress.

The lack of adequate funding to both CHS programs and the direct services provided by IHS and tribal facilities means that universal access to care for AI/ANs is far from a reality. It is estimated that the IHS is funded at only 50 percent of its level of need; some programs, such as mental health, are funded at as low as 30 percent. The relationship between chronic underfunding and increasing health disparities has been outlined in two recent reports from the U.S. Commission on Civil Rights. The reports conclude that the state of health care delivery to the AI/AN population is in a state of crisis. It seems likely that as access to care becomes even more limited due to inadequate funding, health status disparities between Native people and the general US population will

continue to widen, and AI/ANs will continue to be denied opportunities for building healthier communities.”

The Portland Area Indian Health Service

The Portland Area Indian Health Service (PAO) provides access to health care for an estimated 150,000 Indian residents of the 43 federally recognized Tribes located in Idaho, Oregon, and Washington. Health delivery services are provided by a mix of health centers, health stations, preventative health programs, and urban programs. Health centers provide a wide range of clinical services and are open 40 hours each week. Health stations provide a limited range of clinical services and usually operate less than 40 hours per week. Preventive programs offer counselor and referral services. The Portland Area Indian Health Service operates six federal health facilities in five Tribal communities and one at Chemawa Indian School. Tribes operate health facilities under the authority of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended), Titles I and V.

Twenty-three Tribes have Title V compacts and there are twenty-four Tribes or Tribal organizations that contract under Title I. Overall, Tribes administer more than 74 percent of the Portland-area budget authority appropriation through Self-Determination contracts or Self-Governance compacts. There are also three urban programs with services ranging from community health to comprehensive primary health care services. Current areas of emphasis are:

- Infant Health
- High Risk Maternal and Child Health
- Tobacco Use Intervention
- Domestic Violence
- Diabetes
- Women's Health Care
- Cancer Screening

Northwest Portland Area Indian Health Board

The Northwest Portland Area Indian Health Board (NPAIHB) works closely with the Portland Area Indian Health Service. Established in 1972, the board is a non-profit tribal advisory organization serving the 43 federally recognized tribes of Oregon, Washington, and Idaho. Each member tribe appoints a delegate via tribal resolution, and meets quarterly to direct and oversee all activities of NPAIHB. The board delegates create and update a strategic plan, which contains four main functional areas: health promotion and disease prevention, legislative and policy analysis, training and technical

assistance, and surveillance and research. The board houses a tribal epidemiology center (Epicenter), several health promotion disease prevention projects, and is active in Indian health policy.

Tribal Health Programs and Clinics in Washington State

There are 29 federally recognized Tribes in the state with 34 clinics, three of which are operated by the Indian Health Services, 31 of which are operated by Tribes. The vast majority of specialty care that cannot be provided within Tribal clinics is purchased from private health care providers in nearby communities. Each Tribe receives a fixed amount of Contract Health Services (CHS) funding, which is based on the number of eligible users, the availability of direct care services, and other historical circumstances. As described under “The Federal Indian Health Service” section in the plan, funding for CHS is not adequate to provide all needed services, and a priority system is used to determine what care is purchased and what is deferred until funding is available or until the medical condition is serious enough for treatment. Federal policy dictates that Indian Health Service is a ‘payor of last resort.’ If an AI/AN requires care outside the Indian health care facility and is eligible for Medicaid, Medicare, has private insurance, or if there is any other payor, all of these must pay before the Indian health program is obligated to use Contract Health Services funds.

Each Tribal health program and each clinic is unique. The three Indian Health Service clinics are staffed and operated by the Indian Health Service with their own health professionals within their health care delivery structure. Tribes who are *contracted* with Indian Health Service have assumed administrative responsibility for existing health programs that were formerly run by IHS. Self-governance, or *compacted*, Tribes enter compacts directly with the federal government and negotiate annual funding agreements that can provide greater flexibility in provision of services that meet unique community needs.

Every Tribe has its own culture, infrastructure, traditions, governance, financing, and health priorities that shape how health care is provided in each community. To understand the Tribal health care ‘system’ in Washington, one must have a broad understanding of the factors that play into the uniqueness of each Tribal community and the holistic approach most Tribes have in addressing health priorities.

While the foundation for the health service delivery system in Tribal communities is the federal Indian health care system described above, adequate funding within this system has never been achieved. Washington State Tribes have become extremely

successful in generating revenue through third-party collections, which has become as much a part of an Indian health clinic's base budget as federally appropriated funds.

One of the largest sources of third-party reimbursement has been through the state-federal Medicaid program. The stability of this revenue-generating source is absolutely vital. Any reduction in this source of funding now results in basic Tribal health services being cut, rather than improvement initiatives being curtailed or delayed. Tribes and the American Indian Health Commission work with the state Medicaid office (Health and Recovery Services Administration) within the Department of Social and Health Services to identify and implement improvements to the Medicaid system for AI/AN access and Tribal provider reimbursement. Some system and service delivery issues have improved through this process; however, the more substantive challenges Tribes have in accessing Medicaid reimbursements are with the federal Centers for Medicaid and Medicare (CMS). Washington State Tribes turn to the Northwest Portland Area Indian Health Board, the National Indian Health Board (NIHB), and the CMS Tribal Technical Advisory Group (TTAG) as a way to influence changes at the national level.

Detailed profiles of the Indian health programs in the state can be found in Section VI of this plan.

D. Urban Indian Health Programs

The AIHC has identified Urban Indian health as an area that warrants additional attention and heightened awareness. Many AI/AN people live in urban areas in the state, and these AI/AN individuals face significant and often unique challenges in accessing care and remaining healthy. Many of these individuals are members of Washington State Tribes, others are members of Tribes from other states, some are members of federally recognized Tribes, others are not. In order to effectively address health disparities of all AI/AN in Washington, there must be a more concerted effort to link urban Indian health programs to health reform efforts taking place. This will allow for improved coordination in providing a comprehensive health care delivery system for Indian people in Washington. In Section III A, one of the priorities identified for the State-Tribal-Urban Indian Health Collaborative is to begin this work by raising awareness of urban Indian health issues.

The following is from an issue brief developed by Ralph Forquera, executive director, Seattle Indian Health Board⁵. This brief provides a comprehensive summary of urban

⁵ Forquera, Ralph. *Urban Indian Health Issue Brief*. Seattle Indian Health Board, for Kaiser Family Foundation. 2001

Indian history, health issues, and challenges experienced by this population and the Urban Indian Health Organization that serve them.

“Few people realize that the majority of American Indians and Alaska Natives in the United States are now living in American cities, not on reservations. Yet, Federal health care policy toward American Indians and Alaska Natives continues to focus largely on the needs of those living on reservations in rural areas—needs that, despite demonstrable progress since the creation of the Indian Health Service (I.H.S.) in 1955, remain substantial (Kauffman et al., 1997). The purpose of this Issue Brief is to describe the large and growing urban Indian population, their health status, and the major federal health programs (i.e., I.H.S. and Medicare) and federal-state programs (i.e., Medicaid and Child Health Insurance Program) that are available to improve Native Americans’ access to needed health services. In setting forth the circumstances of urban Indians, this Issue Brief does not intend to suggest that the health care needs of Indian people living in rural areas are in any way less compelling.

A Growing Population of Urban Indians

In 1990, over half of the 2 million American Indians and Alaska Natives in the United States lived in urban areas. . . In contrast, an estimated 430,000 Indians lived on 279 federal and state reservations that year, and another 40,000 lived in Alaska Native villages (Snipp, 1996).

Who are Urban Indians?

Urban Indians are members of, or descendants of members of, one of the many Indian tribes or other organized groups of aboriginal inhabitants of the Americas who live in cities. The Indian Health Care Improvement Act defines the term “Urban Indian” to mean any individual who “resides in an urban center” ... and “meets one or more of the four criteria” for qualifying as an “Indian” under the Act.

The migration of Indians from the reservations to American cities occurred throughout the past century and is expected to continue. The proportion of Indians living in what the Census Bureau defines as “urbanized areas” grew from 45 percent in 1970 to 56 percent in 1990 (U.S. Census Bureau, 2001, personal communication). Historically, this migration reflected federal government “relocation” policies in effect during the 1950’s. Over 160,000 American Indians and Alaska Natives were forcibly moved from their reservations into cities to promote assimilation into the dominant U.S. society (Kauffman et al., 2000; Hall,

2001). A failed social experiment, this mandatory “relocation” policy was discontinued 30 years ago.

Migration from reservations to cities continues, even though, as they make this transition, Indians frequently lose access to health care and other benefits granted them when living on reservations.

Contemporary migration reflects the search for employment, education, and housing opportunities in light of the high unemployment rates, limited educational systems, and housing shortages on some reservations.

Urban Indians are a highly diverse population. In any given city, the urban Indian population is likely to include members (or descendants of members) of many different tribes, including tribes recognized by the federal government and tribes that are not. These individuals may or may not have cultural, religious, or historical ties. They tend to be dispersed throughout metropolitan areas rather than residing in “urban Indian neighborhoods.” As a result, urban Indians may share less of a sense of community than Indians living on reservations, which frequently are dominated by one or perhaps a few major tribal groups. It is also common for urban Indians to travel back to their home reservations for periodic visits to family or friends as a way of maintaining their cultural connections.

The Health Status of Urban Indians

The poorer health status of American Indians and Alaska Natives, compared to other Americans, has been well documented (Young, 1996). Much less is known about the health of urban Indians. The few empirical and population-based studies that exist suggest that health indices are similar for Indian people who reside on or near reservations and those in urban areas. One study, published in the Journal of the American Medical Association, analyzed births, deaths, and communicable diseases in 1 metropolitan and 7 rural counties in Washington State between 1981 and 1990 and found that, compared with urban whites, urban Indians had higher rates of low-birth weight infants, higher rates of infant mortality, higher rates of injury-and alcohol-related deaths, and higher rates of tuberculosis and sexually transmitted diseases (Grossman et al., 1994). Another article, published in Cancer, suggests that urban Indians experience health risks later in life related to earlier years of living on the reservation (Burhansstipanov, 2000). . .

Several factors confound the study of Urban Indians and their health status. The principal problem is the lack of a clear, uniform definition of urban Indians that local and state health officials can use in identifying the population. Another factor that complicates monitoring of health indices is the dispersion of urban Indians throughout metropolitan areas. A further difficulty is that residential mobility among urban Indians is extremely high, especially among low-income individuals and families. These factors combine to make identifying the population and collecting accurate health status data difficult.

The Urban Indian Health Program

. . .the urban Indian program was first authorized in 1976, more than 20 years after the establishment of the I.H.S., in Title V of the Indian Health Care Improvement Act (P.L. 94-437). As Kauffman (1999) notes, Title V “represented a significant departure for the Indian Health Service, which had previously not included Indians living outside I.H.S. service areas within the scope of the program.” The Congressional rationale for the program (House Report 94-1026) was in part to address the problems resulting from misguided Federal policies towards American Indians and Alaska Natives: “It is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. Unfortunately, the same policies and programs that failed to provide Indians with an improved lifestyle on the reservation have also failed to provide [them] with the vital skills necessary to succeed in the cities”

The purpose of the Title V program is to make outpatient health services accessible to urban Indians, either directly or by referral. These services are provided through non-profit organizations, controlled by urban Indians that receive funds under contract with the I.H.S. Urban Indian organizations commonly supplement these I.H.S. dollars with revenues from other sources, such as Medicaid and Medicare payments, private insurance reimbursements, and support from localities and private foundations. As of FY 2001, the IHS spent \$29.9 million appropriated under Title V to help fund 34 Indian health contractors in 20 states and two I.H.S. urban service sites in Oklahoma. The majority of these programs provide medical services; the remainder offer only referral services or other services, such as alcohol and substance abuse treatment. These programs serve an estimated 130,000 urban Indians (author’s review of I.H.S. Urban Indian Program Statistics, 1999). . .

Unlike I.H.S. and tribal clinics where services are free to the eligible Indian client, medical and dental services at urban Indian programs are provided on a sliding fee basis. The scope of services at urban Indian programs is restricted to primary care. Referrals for inpatient hospital care, specialty services, diagnostics, etc., are at the client's expense. Efforts are made to mitigate these expenses through negotiations and other arrangements. Of the urban Indian programs that provide medical care, several function as "safety net" clinics for the uninsured, not unlike the federally-funded community health centers with which they have much in common (Rosenbaum, 2000).

Policy Implications

The growing recognition of urban Indians and their health care needs raises important issues for both federal and state policymakers. Among these are: the collection and reporting of data on the health status of urban Indians and their access to health care services; the adequacy of the Title V program for serving the health needs of urban Indians; and the changes needed in the Medicaid program to improve access of eligible urban Indians to covered services.

Conclusion

Dramatic changes have occurred in Indian Country in the past century. Among these has been the quiet migration of Indians from reservations to urban areas, so that today the majority of American Indians and Alaska Natives live in cities. Policymakers at both the federal and state levels must understand that Indian Country now extends beyond the reservation borders and into America's cities.

In leaving their reservations, urban Indians did not always escape the conditions that made life so difficult for many tribal communities, including poverty, racism, inadequate education, alcoholism, drug dependence, teen pregnancy, etc. These conditions are acutely felt in cities as the loss—of cultural identity, family support, and social contact, combined with the pressures of money, jobs, crowding, competition—place urban Indians at great physical and emotional risk for health problems."

E. Health Disparities and American Indian/Alaska Natives in Washington State

“Minorities and low income Americans are more likely to be sick and less likely to get the care they need. These disparities have plagued our health system and our country for too long. Now, it’s time for Democrats and Republicans to come together to pass reforms this year that help reduce disparities and give all Americans the care they need and deserve.”

- US Department of HHS Secretary Kathleen Sebelius

What are Health Disparities?

The Minority Health and Health Disparities Research and Education Act of 2000, describes health disparities as, “differences in the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates.”⁶ There are several factors that contribute to health disparities, such as access to care, health outcomes, health care services delivery, and disease patterns in relation to race, ethnicity, gender, social class, or geography.

The Status of AI/AN Health in Washington State

The AI/AN population in Washington is diverse, geographically dispersed, and economically disadvantaged. AI/ANs are more likely to live in poverty than any other racial or ethnic group in Washington. They also experience disproportionately high mortality and morbidity burden compared to the general population.

The state Department of Health’s Center for Health Statistics recently published “Washington State Vital Statistics 2006”⁷ describing the outcomes of a mortality data assessment over a five-year period from 2002-2006, using 10 leading causes of death. The report findings are disheartening. Even more disheartening is that AI/ANs race is often severely underreported and misclassified, therefore it is anticipated that the true health status of AI/ANs is worse than the data describes:

- ◆ American Indian/Alaska Native males had a lower life expectancy than males in other populations in Washington; American Indian/Alaska Native females also had a

⁶ U.S. Health and Human Services, Office of Minority Health. *What are Health Disparities?* <http://www.omhrc.gov/templates/content.aspx?ID=3559>.

⁷ Washington State Vital Statistics 2006. *Annual Report*. Center for Health Statistics, Washington State Department of Health. January 2009

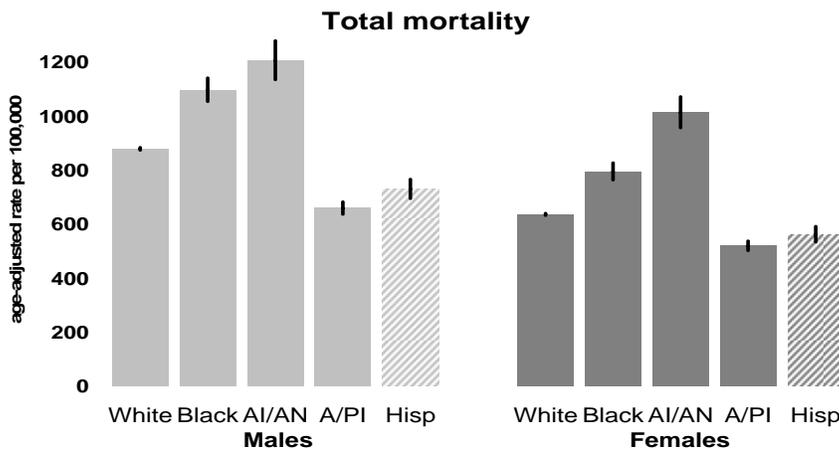
lower life expectancy compared to females in other groups (71 and 75 years of age, for American Indian/ Alaska Native males and females, respectively)

- ◆ American Indian and Alaska Native males’ age-adjusted all cause mortality rate (1187.5 per 100,000) exceeded all other groups and was significantly higher than Whites (897.6), Asians and Pacific Islanders (674.1), and Hispanics (698.5)
- ◆ Health disparities for American Indians/Alaska Natives are increasing. From 1990-2006, there were significant decreases in age-adjusted mortality rates for White, Black, and Asian/Pacific Islander males, while rates for American Indian/Alaska Native males stayed the same. AI/AN females experienced a 1.3 percent increase per year in mortality rates from 1990-2006 while rates for Blacks and Whites decreased.

Specific causes of mortality indicate that AI/AN males had:

- ◆ Significantly higher rates than all other groups for COPD, unintentional injury, and chronic liver disease
- ◆ Together with Blacks, significantly higher rates than all other groups for heart disease
- ◆ Significantly higher rate than all other males, except for Whites, for suicide

Table 1. Average Age-Adjusted Mortality Rates, 2002-2006 in WA State



Specific causes of mortality for AI/AN females indicate that:

- ◆ AI/AN females had significantly higher rates than all other females for COPD, unintentional injuries, and chronic liver disease

- ◆ American Indians and Alaska Natives had significantly higher rates than all other groups for teenage mothers, late or no prenatal care, maternal obesity and smoking during pregnancy
- ◆ Together with Black females, AI/AN females had significantly higher rates than all the remaining groups for heart disease and all cancers.
- ◆ American Indians and Alaska Natives had higher rates of infant mortality and prematurity.

What Does It Take to Eliminate AI/AN Health Disparities?

In order to ensure that the remaining health disparities among AI/ANs are eliminated, the state and Tribes must first renew their commitment to implementing effective public health programs as well as disease prevention and treatment strategies – like those discussed in the plan.

Second, the state should continue to assist Tribes in efforts to assure that adequate levels of resources, both financial and professional, are available. Finally, the ongoing government-to-government relationship should continue to raise the issue of improving the health status of AI/AN as a mutual priority.

The state, Tribes, and the American Indian Health Commission will work collaboratively to begin eliminating AI/AN health disparities over the next four years, and a specific goal to that end has been included and is described in Section V of this plan. There are many challenges and complexities in addressing health disparities, and a strategic framework and plan will be needed to guide this important work. Some of the approaches that have already discussed include:

- ◆ Use of tribally-driven health assessments to determine priorities for services and to design service delivery systems that work in Tribal communities
- ◆ Engagement of Tribal communities in addressing specific health disparities as a community
- ◆ Improved collection and use of community-level data to inform health disparities work
- ◆ Investments in tribal advocacy to heighten awareness within state health-related agencies, the Governor’s Office, and the Legislature of the impacts state health policies have on Indian health and tribal health delivery systems
- ◆ Development and tracking of indicators that can address priority social and environmental determinants of health

III. Opportunities for Change

In the current environment, opportunities exist for strengthening a health agenda for Tribes in Washington. Although the state is in one of the worst economic times ever experienced, the crisis has created an urgent need for change, for streamlining and improving systems and operations, and for more effectively using state dollars. As changes are made and new policies are developed around health and health care, Tribes are in the position to help shape those policies as they relate to the health of AI/AN people. Several initiatives and actions warrant a state-Tribal focus.

A. State-Tribal-Urban Indian Health Workgroup

In January 2009, the American Indian Health Commission received funding to work together with the Washington State Health Care Authority (HCA) to re-establish a State-Tribal-Urban Indian Health Care Collaborative (STU) that began in 2006. On March 26, 2009, the commission's Executive Board met with state officials as a starting point for launching this work. The goal: *"to improve health care access and decrease health disparities of American Indian/Alaska Native citizens in Washington State."* The STU Leadership Team, which will consist of state and Tribal leaders, will identify and implement strategies to meet this goal by aligning its work with Gov. Gregoire's Health Care Priorities Initiative.

The Governor's priorities:

1. Emphasize evidenced-based health care
2. Promote prevention, healthy lifestyles, and choices
3. Provide better management of chronic care
4. Create more transparency in the health care system
5. Make better use of information technology

Four broad areas were identified on which the STU Collaborative could focus its work:

1. Strategies and policy
2. Quality improvement, evidence-based practices, and health technology
3. Wellness and prevention
4. Health systems alignment and funding

The first area, 'Strategies and Policy' was identified as the focus for the STU Leadership Team within the collaborative. The high-level issues identified under this area will be

the framework for the leadership team's functions in assuring the overall goal of eliminating health disparities remains at the policy level:

- ◆ Develop and implement strategies for sustaining this level of state-tribal-urban health partnership
- ◆ Develop, monitor, and evaluate outcomes of the overall work through a strategic action plan with short, mid- and long-term goals
- ◆ Provide ongoing education on tribal health delivery systems to state staff; ongoing education on state health delivery systems, services, programs, and functions for tribal leaders and tribal health staff
- ◆ Identify broad strategies and policies for aligning goals and objectives with the Governor's health priorities;
- ◆ Develop policies to successfully work through the current budget crisis together
- ◆ Identify and match gaps currently found in the Indian Health Service delivery system with current agency initiatives
- ◆ Implement strategies for aligning the work of this partnership with the current state, national, and Tribal health reform movement

The American Indian Health and Health Care Authority staff strategically reviewed and analyzed the ideas generated from the meeting. The task was to identify possible initiatives under the broad health areas which could demonstrate short-term success while the STU continued to work on long-term sustainability strategies. Ideas were reviewed based on: a) areas where tangible progress could be made within a shorter time frame, and b) where potential opportunities were available that could be leveraged in the current environment. A preliminary report on recommended issues was provided to original workgroup participants and no substantive changes were made. Further narrowing the list, four areas were identified as best meeting the criteria identified above for Fiscal Year 2010.

1. Electronic Medical Records (EMR) – federal funding availability and work already in progress at the state level provides opportunity to achieve measurable goals for Tribes in their efforts to create and improve health program EMR capability
2. Maternal-Infant-Oral Health Initiative - The commission is currently funded to conduct work on this issue and potential funding may be available to continue. Both health issues are priorities identified by Tribal Leaders at the November 2008 Tribal Leaders Health Summit. The Washington State Department of Health is in the process of developing its first Collaborative State Oral Health Improvement Plan and has invited Tribes and the commission to assure inclusion of Tribal oral health

care access and needs; potential funding to address recommendations identified by Tribal leaders may be possible

3. Licensing/Certifying Tribal Health Facilities and Long-term Care Programs Long-term care service delivery was another priority area identified at the commission's 2008 Tribal Leaders Summit. Tribes want to provide their own long-term care services and have the ability to be reimbursed for providing such services, yet the state does not have authority to license tribal programs on trust and reservation lands. One Tribe is in the process of developing other options and concurrent efforts are already underway to evaluate existing state and federal laws and regulations to identify and remove specific barriers for Tribes to deliver home and community based services.
4. Raise Awareness of Urban Indian Health Issues – The commission is currently working towards this goal, and has provided a more in-depth look at health concerns experienced by Indian people living off the reservation in this Health Care Delivery Plan. Through work of the collaborative and other AI/AN health disparities initiatives underway, tangible outcomes can be achieved in a short timeframe.

The leads of this collaborative effort, the Health Care Authority Administrator and the American Indian Health Commission Chair, met to discuss the priorities and agreed the initiatives identified were in-line with the collaborative's intent.

Next Steps

In FY10, the STU Collaborative, Health Care Authority, and the commission will continue its work. A preliminary work plan has been developed and will be revised accordingly as collaboration increases and input is received from additional Tribes.

B. Indian Health Data Collaborative

Comprehensive data on the health of AI/AN in Washington is severely lacking as AI/AN race is often underreported or misclassified. Estimation of disease rates often relies on the use of vital records, including birth and death certificates, disease registries, and census data. Errors and/or inaccuracies occur when data for AI/AN communities are reported incompletely or are not reported accurately.

A closely related problem arises due to the fact that each data system may record race differently. The impact of this differential recording of race on the completeness and accuracy of the numbers and rates of health events for AI/ANs is difficult, if not

impossible, to quantify. The various entities that manage specific AI/AN health data sets often employ differing methods for collecting, adjusting, and distributing data. A greater effort is needed to collaborate across agencies and institutes that are conducting research and collecting data in order to begin accurately portraying the true extent of Indian health disparities.

Several agencies, organizations, and institutions have expressed a renewed interest in coming together to begin a conversation on how this might be achieved. Accurate data is necessary to support assessment and policy development to improve service delivery and health status of Indian people. Without painting a more thorough picture of Indian health in Washington today, the ability to plan or improve services, monitor quality, and analyze costs is severely impaired.

Tribal governments must be intricately involved in such efforts to assure the use of the data is culturally appropriate, acceptable, and meaningful in improving the health of their people. By reinstating efforts that began in 1997 between the commission and the Washington State Department of Health through an American Indian Data Committee, an updated framework can be developed for addressing priority health issues for AI/AN.

There are several entities that consistently conduct research and collect and interpret data on AI/AN. Over the next two years, the commission will partner with the Department of Health, the Northwest Portland Area Indian Health Board, the Urban Indian Institute, and other epidemiology/research-based centers with a goal of developing a more comprehensive understanding of the current-day health of the AI/AN population and providing Tribes, Tribal organizations, and the state more accurate information needed to address public health policy issues important to Tribal communities.

C. Health Reform

Tribes, Urban Indian Health Organization, and National/Tribal Health Reform

As our state continues collaborative efforts with Tribes to address worsening tribal health disparities, our Governor's involvement with National Health Care Reform may provide an opportunity to address health disparities at the National level. The following report was written by Jim Roberts, Policy Analyst, Northwest Portland Area Indian Health Board, to provide the most current update on national level health reform, and most importantly for this plan, how these reform activities relate to/ impact Tribes in Washington.

“The Congress and Administration are in the process of developing health reform options to address rising health care costs, quality of care issues, and the growing number of uninsured and under-insured in this country. The proposals that are currently being discussed will have a profound effect on the Indian health system that provides care to AI/AN people that reside in Washington State. Most receive health care through the Indian Health (IHS) and Tribally-operated health programs. In developing the health reform framework, Congress will delegate a number of responsibilities to the states to implement health reform policy options. It is important that the State of Washington work with Tribes, the AIHC, and other tribal partners to carry out health reform objectives as to recognize the special relationship that the United States and Washington State has with Tribal governments and the federal and state duty to provide health care services. Implementation of health reform options must support and strengthen the current Indian health care delivery system in order to preserve and protect the fragile health care system that most AI/AN people rely on to receive health care services.

Many tribal leaders and tribal health advocates, national and regional tribal organizations—such as the Northwest Portland Area Indian Health Board - have examined the components of health care reform proposals currently under consideration and developed recommendations around these ideas. These recommendations have been provided to Congress and should be adhered to when states implement those aspects of health reform that they will be responsible for. These recommendations are summarized as follows:

- 1. Include Tribes on key commissions and boards created by health reform legislation and direct HHS Secretary to consult with Tribes on a government-to-government basis on any health reform policies and regulations so they are developed in a way that will create positive changes in the diverse Indian communities.*
- 2. Indian tribes perform several roles in a health care context: They are governments, employers, health care providers, patient advocates, and beneficiaries of the U.S. trust responsibility for health. All of these roles must be respected, together with the recognition that Indian people are a unique and distinct political group, not merely a minority classification.*

3. *Exempt AI/ANs from mandates and penalties. AI/ANs have already paid for their health care coverage. Failure to acknowledge that Indian people are different from other groups needing health care coverage will result in an abrogation of the federal trust responsibility or denial of their right to fully participate in health reform. It is not appropriate to subject AI/ANs to the individual mandate, especially the penalty for failing to acquire or purchase health insurance.*
4. *Tribal government exemption from employer penalties. The employer mandate provisions must also exempt Indian tribes, as employers, from penalties. Indian tribes are sovereign nations and should not be subject to federal penalties in their roles as employers.*
5. *AI/ANs should be eligible for insurance subsidies. Permit AI/AN to participate in subsidized insurance and explicitly permit tribes to pay premiums and cost sharing on their behalf.*
6. *Portability of health care is essential. In order to guarantee portability between health insurance and the Indian health system, include explicit language which allows AI/ANs to enroll in an insurance plan at any time without assessment of late enrollment penalties or other negative consequences. Without this protection Indian people may be denied options to which they are entitled as United States citizens. Indians should not be forced to choose between the Indian health system and other options; both should be available to them.*
7. *Indian tribes must retain the authority to decide whether or not to serve non-Indians at their health facilities and extend the Federal Tort Claims Act coverage now provided to Indian Self-Determination and Education Assistance Act (ISDEAA) contractors to include coverage for services to non-Indians.*
8. *Health care reform in Indian Country will create a short term financial burden on the already seriously under-funded Indian health system and financing must be provided to assist in policy analysis and rule making and at the tribal level staff to build the local systems that are needed to effectively educate, enroll, and coordinate patient participation in a reformed system.”*

IV. 2007-2009 Accomplishments

Many accomplishments have been achieved since the publication of the 2007-2009 American Indian Health Care Delivery Plan. Below are highlights of successes of the American Indian Health Commission and its member Tribes and Urban Indian Organizations over the last two years.

Collective Successes

- ◆ Implementation of “Medicare Like Rates” which produce significant savings for Tribal Contract Health Services Program
- ◆ Facilitation of a Tribal planning meeting to prepare for a Centers for Medicare and Medicaid Services (CMS) Tribal consultation on Medicaid Administrative Match program
- ◆ Officially commented on negative effects of the new CMS case management rules on Tribes
- ◆ Tribal briefing paper on the Non-Native Division of Alcohol and Substance Abuse (DASA) Medicaid Match issue provided to Tribes to assist in developing comments during a formal consultation period
- ◆ Worked with Northwest Portland Area Indian Health Board to request a Tribal Consultation on the 1915(b) Regional Support Network (RSN) waiver
- ◆ Participated in planning efforts with the University of Washington and DSHS’ Indian Policy Advisory Committee (IPAC) for the 2008 Behavioral Health Conference
- ◆ Initiated work with Health Care Authority to implement Public Employees Benefits Board (PEBB) legislation that authorized Tribal participation; three Tribes are now participating
- ◆ Initiated Tribal discussions regarding the potential of dental therapists working in tribal programs
- ◆ Organized and launched a AI/AN Maternal and Infant health project with Department of Health to address the deplorable health status indicators for AI/AN Maternal and Infant health
- ◆ Brought Indian health issues to the forefront at the 2008 and 2009 Centennial Accord meetings
- ◆ Tribal representatives are now engaged on key state boards and committees:
 - Washington State Mental Health Transformation Grant Project
 - Washington State Public Health Improvement Partnership
 - Governor’s Interagency Council on Health Disparities
 - Washington State Collaborative Oral Health Improvement Plan Partnership Planning Committee
- ◆ Fourteen Tribes are HCA Basic Health Program (BHP) Sponsors

- ◆ Tribes receive ongoing funding for the development of public health emergency preparedness and response programs
- ◆ Tribes receive ongoing funding to address tobacco issues in their own communities
- ◆ 2008 Tribal Leaders Health Summit drew 110 participants representing Tribes, state, non-profits, and other organizations
- ◆ Establishment of the State-Tribal-Urban Indian Health Collaborative to reduce Indian health disparities

Two Tribal governments entered historic agreements with Washington State in 2008-2009, giving both greater control and flexibility in how Tribal members access health services:

The Suquamish Tribe

In an August 25, 2008, press release, the Suquamish Tribe announced an agreement made between the Tribe and the Washington State Department of Social and Health Services (DSHS), Mental Health Division. The signed agreement enables the Tribe to directly access the state mental health system for Suquamish Indian youth residing in Washington who are in need of inpatient mental health treatment. Care will be provided through the state's partnership with Children's Long-Term Inpatient Program Administration. This is the first agreement of its kind in Washington and removes obstacles that limited the Tribe's access for treatment.

Leonard Forsman, tribal chairman, acknowledged that "this is a big accomplishment on behalf of the State and the Tribe." "We look forward to future collaboration with the State under this Agreement," Forsman said. Doug Porter, DSHS assistant secretary appreciated the work that went into the agreement and believes that "we will learn a lot from this process." Other officials from the state involved in the process appreciated the pleasant and respectful negotiations with the Tribe in the face of resolving difficult issues. Both parties acknowledged that this agreement reinforces the government-to-government relationship between the Tribe and the state as contemplated under the Centennial Accord.

The Port Gamble S'Klallam Tribe

"S'KLALLAM GIVEN OK TO MAKE MEDICAID, FOOD AID DECISIONS"⁸

⁸ Press Release. "S'Klallam Given OK to Make Medicaid, Food Aid Decisions." Kitsap Sun Newspaper, May 26, 2009

A recent agreement among tribal, state and federal officials allows the Port Gamble S'Klallam Tribe to make basic food and Medicaid eligibility decisions for tribal families, instead of channeling the requests through a state office and its own social services. The agreement, the first of its kind in the nation, is seen as a pilot project. The agreement has been in the works for years.

"We recognize the tribes are in the best position to help their families," Troy Hutson, assistant secretary for the state Department of Social and Health Services' Economic Services Administration, said in a statement. "The ability to offer vital programs and services here, where tribal families are located, provides a powerful tool for fighting poverty and hunger on the reservation."

In the past, the tribe has had to channel these eligibility decisions through a DSHS branch office, even though that involved duplication of tribal social service efforts.

V. 2010-2013 Goals and Objectives

Through the Tribal Leaders Health Summit held in November 2008 and strategic planning activities of the American Indian Health Commission, five priority goals have been identified for 2010-2013. Four of these goals address specific health equity issues: Maternal-Infant Health, Oral Health, Behavioral Health, and Long-Term Care. The remaining goal addresses the broader need for a stronger policy and advocacy forum for tribes and the state to effectively collaborate on eliminating health disparities and provide Tribes with health resource information. The outcome of this broader goal will be a sustainable framework from which other priority health issues can be addressed over time.

For each health issue, the problem is described, supporting data is provided, and specific objectives have been identified. These goals and objectives will be more thoroughly vetted by Tribes through the commission resulting in a 2010-2013 Indian Health Strategic Plan by the end of 2009.

1. Tribal Forum

Goal One: *Improve the ability of Tribes and UIHO to influence state health policy that impacts AI/AN, remain current on health information and*

opportunities, and work collaboratively with the state and others in reducing Indian health disparities

Tribal Forum Problem Statement

The American Indian Health Commission was originally created in 1994 by Tribal leaders as a way for Tribes to have a collective and cohesive voice in the formulation of state health policy and resource allocation. It has been a successful forum for addressing important health issues, often in collaboration with state health-related agencies. Much has been accomplished, yet over time, the commission's effectiveness has diminished given the enormity of Tribal leaders' work in their own communities, within the state, as well as at the regional and national levels. Core functions identified in the early 1990s by Tribal leaders are no longer funded, and AIHC resources have dwindled to a few project-specific contracts with the Department of Health rather than providing Tribes an essential health policy forum.

A window of opportunity currently exists for Tribes to be coordinated and actively engaged in sweeping health reform that may assure the quality health of AI/AN people is recognized, prioritized, and finally addressed. State government does not always consider Tribal health issues when shaping health policy, and the 'shovel ready' pace of reform puts Tribal governments at a disadvantage given all the issues on the collective plates of Tribes. An adequately funded American Indian Health Commission is needed to support the organizational strength necessary for ensuring tribal health issues will be incorporated into federal and state reform strategies now and into the future.

Supporting Data

Overall health data consistently demonstrates AI/ANs have the worst health outcomes of all Washington state populations. Because the Indian Health Service is so severely under-funded, Tribes must rely more than ever on other sources of health insurance for their members. The state funds many health services, programs, and functions in which Tribes and AI/ANs must be able to participate both at the program level and the policy/decision-making level to honor the government-to-government relationship Tribes have with the state. Most Tribes do not have the resources to have a consistent presence in Olympia resulting in an inability to have adequate opportunity to weigh in on health policy decisions. The AI/AN health care delivery system is little understood by many, and Tribes need to have the capacity to consistently advocate and educate at the state level to assure health needs of Indian people are understood and addressed appropriately. The American Indian Health Commission was created by Tribes to serve in that role. The following table describes in greater detail the functions the commission serves for Tribes, as well as for state government.

Function	Activities
Policy and Legislation	<ul style="list-style-type: none"> ○ Provide forum to shape collective tribal positions on priority health issues ○ Develop relationships w/ legislature to assure full understanding of AI/AN health issues ○ Develop relationships w/ state agencies, organizations, Governor’s Policy Office to assure Tribes, issues, inequities are considered prior to implementing policy/state health reform initiatives ○ Work with state agencies/initiatives to facilitate maximum reimbursement to Tribal health programs for culturally-appropriate provision of state-funded services ○ Facilitate coordination of Tribal consultation as requested by Tribes ○ Monitor, analyze state health policy to assess impact on Washington Tribes ○ Facilitate annual development of health legislative agenda; advocate on behalf of Tribes ○ Provide Tribes legislative updates, alerts, recommendations for action ○ Provide advocacy tools for Tribes to respond in timely manner to legislative/policy issues ○ Review, analyze, make recommendations to Tribes on Governor’s budget proposals
Tribal Technical Assistance	<ul style="list-style-type: none"> ○ Serve as resource center for Washington State Tribes on: <ul style="list-style-type: none"> - health related topics/conditions - service delivery systems issue - culturally-relevant promising practices and innovations - health funding, third party reimbursement opportunities - health research outcomes - health workforce shortage issues and opportunities ○ Link Tribes to appropriate organizations, resources for specific Tribal issues/interests ○ Provide forum where state can effectively collaborate and communicate w/ Tribes on tribal-state health issues ○ Build relationships with Tribal leaders and health programs to understand/accurately Work on real-time Tribal health issues, challenges
Addressing Indian health disparities	<ul style="list-style-type: none"> ○ Work with Tribes, Washington State, other stakeholders to move from public dialogue on health disparities to strategically, creatively improving AI/AN health status ○ Provide capacity building assistance for Tribal community engagement in identifying/ changing health outcomes; “addressing health disparities has to come from within Tribal communities” ○ Serve as link between Tribes, state in improving existing health care system in WA as it relates to AI/AN access and health care reform ○ Facilitate systematic collection/analysis of Indian health data in culturally/Tribal acceptable manner to ID current/emerging Indian health needs, provide baseline data from which to monitor improvements over time, initiate demonstration projects to address issues, develop evidence-based practices of care are accepted in Tribal communities

Goal One Objectives

Objective 1.1: Identify American Indian Health Commission core functions most needed by Tribes and Urban Indian Health Organization

Objective 1.2: Develop a stable funding base for the commission to serve as the policy/advocacy forum for Tribes and the organization in influencing state health policy issues and resource allocation

Objective 1.3: Improve the ability of the commission to serve as a trusted and comprehensive health resource/technical assistance center for Tribes and Urban Indian Health Organization

- Objective 1.4: Complete an assessment of Tribal community health and social determinants of health, local health priorities, successes/challenges, and desired strategies for increasing healthy behaviors, and providing effective prevention and intervention measures
- Objective 1.5: Strengthen the state-Tribal-Urban Indian Health Collaboration to jointly eliminate AI/AN health disparity
- Objective 1.6: Create a strategic plan for eliminating Indian health disparities
- Objective 1.7: Engage additional stakeholders and experts with similar goals of eliminating health disparities in implementation of the plan

2. MATERNAL-INFANT HEALTH

Goal Two: *Improve the poor health status for AI/AN pregnant women and infants with appropriate, multiple approaches as a shared goal with state government*

Problem Statement

Serious health disparities among pregnant American Indian and Alaska Native (AI/AN) women and their children have been documented in numerous publications including past American Indian Health Care Delivery Plans.

In 2007, the Department of Health and the Department of Social and Health Services released new data on the health status of AI/AN pregnant women and infants in the state⁹. This information reflected an unacceptable level of poor health among AI/AN woman and their children.

Successfully reducing any of these health disparities will require a partnership between the state, the commission, and Tribes. This is a complex problem which needs to be addressed in a unique cultural context.

To initiate this work, the American Indian Health Commission has partnered with Department of Health to begin addressing these issues through a commission-staffed interagency work group. The commission has also been working with the department to develop a more comprehensive funding proposal to sustain commission activities through the next biennium. This is being done through the state's 'Agency Budget

⁹ Cawthon, L., MD, MPH, Anderson, N., MD, MPH. *A Conversation Around Native American Pregnant Women and Infants*. Department of Social and Health Services, Research and Data Analysis. November 2007.

Decision Package' process and will require the support of the Governor and an appropriation by the legislature in 2009.

Supporting Data

The Department of Social and Health Services and Department of Health data showed that of the five racial groups measured, AI/AN women who delivered in 2006 had the following outcomes (compared to the most favorable racial group):

- the poorest and most likely to be enrolled in Medicaid (79.2 percent compared to 30.7 percent for Asian/Pacific Islanders)
- most likely to get late or no prenatal care (12 percent compared to 4 percent for Whites)
- most likely to be obese (33.4 percent compared to 10.9 percent for Asian/Pacific Islanders)
- most likely to smoke (22 percent compared to 2.8 percent for Asian/Pacific Islanders)
- most likely to have been abused by a partner before or during pregnancy (9.6 percent compared to 2.8 percent for Whites) (or 2.1 percent for API)
- most likely to have high blood pressure (8.1 percent compared to 4.2 percent for Asian/Pacific Islanders)
- most likely to die in five years (59.4 per 10,000 compared to 14.4 per 10,000 for Asian/Pacific Islanders) (for women with deliveries 1996-2000)
- most likely to be referred to Child Protective Services (11.1 percent compared to 0.8 percent for Asian/Pacific Islanders) (for women with deliveries in 2005)
- less likely to have graduated from high school, among women who were U.S. citizens (65.7 percent compared to 91.1 percent for Asian/Pacific Islanders) (Hispanic women were least likely at 64.7 percent)
- least likely to be married (29.4 percent compared to 83.1 percent for Asian/Pacific Islanders)
- among those covered by Medicaid, most likely to have a substance abuse problem (24.7 percent compared to 1.4 percent for Asian/Pacific Islanders)
- 39.8 percent of AI/AN woman who gave birth in Washington and were covered by Medicaid were diagnosed with a mental health problem (compared to 4.6 percent for Asian/Pacific Island women).

Indian infants were:

- most likely to die from Sudden Infant Death Syndrome (SIDS) from 1998 - 2004 (0.7 per 1,000 compared to 0.2 per 1,000 for Hispanics in 2004), however in 2005 AI/AN had the lowest SIDS rates of any racial group measured
- most likely to be placed out of home in the first year of life (8.4 percent compared to 0.4 percent for Asian/Pacific Islanders)

AI/AN children are most likely to die from ages 1 – 4 (21.1 per 10,000 compared to 5.4 per 10,000 for Asian/Pacific Islanders) (for children born 1999-2001)

In addition to the issues identified above, one other contributes to the overall poor health status of AI/AN women and their infants – dental health. Evidence shows an association between periodontal (gum) infection and premature delivery and low birth weight. The poor oral health of pregnant women has been identified as a priority by the commission's Oral Health Care Work Group. Please see Goal 4, page 41 for additional details on oral health issues.

Goal Two Objectives

Objective 2.1: Establish a Maternal-Infant Health Work Group to: a) research causes of poor health status and birth outcomes among Indian women; b) identify promising practice models from tribal and urban delivery of MIH services nationally and in Washington

Objective 2.2: Identify specific barriers to tribal/urban Indian health program participation in the Department of Health's Women, Infants, and Children (WIC) Nutrition Program and the Department of Social and Health Services First Steps services (maternity and infant support); develop and implement strategies to improve AI/AN access; and Tribal Health program ability to provide these services

Objective 2.3: Identify options and opportunities for tribes/urban Indian health programs to ensure access for all AI/AN women to high-quality obstetrical care and develop methods to successfully engage them in healthy lifestyles

Objective 2.4: Raise awareness about maternal-infant dental health problems and Indian Health Service, Tribal, and Urban Indian Program (I/T/U) options to enhance dental resources

3. LONG-TERM CARE

Goal Three: *Improve the ability of Tribes to deliver long-term care services for vulnerable adult Tribal members in their own communities*

Problem Statement

Improving and maintaining the health of Tribal elders is fast becoming a priority for Washington State Tribes, yet comprehensive long-term care services are not yet in place. Historically, long-term care was synonymous with nursing homes, and Tribal focus was placed on developing culturally acceptable nursing home facilities for tribal elders and younger AI/AN adults with disabilities. This has never been a feasible option for smaller Tribes, however, as maintaining the volume of patients required for facilities to remain operational is difficult, if not impossible.

In the last 10 to 15 years, options for elders and adults with disabilities to remain as independent as possible in their own setting of choice have increasingly expanded. There are a diverse number of services and supports that now comprise the long-term care service delivery system. Access to primary, specialty, and acute care are critical to overall health. But the continuum of care also includes home and community-based services such as in-home personal care, home health, adult day programs, nutrition, legal assistance, and transportation to medical appointments. Supports for family caregivers are now available, as well as programs that provide information and assistance in how to obtain existing services and navigate the complex long-term care service delivery system. Residential facilities have expanded from traditional nursing homes to include assisted living facilities, boarding homes, and adult family homes.

The Indian Health Service has not historically funded or directly provided long-term care. Tribes lack both technical and financial resources locally to develop the comprehensive delivery systems that can meet the complex medical and physical needs of vulnerable adult tribal members at home or in their communities. As citizens of Washington, American Indians/Alaska Natives should have equitable access to Medicaid and other state-funded long-term care programs, yet barriers exist in accessing services, including, but not limited to, lack of properly trained, culturally competent assessors, insensitive evaluation tools, inadequate transportation, inability to pay for care, and receiving services through regional state sub-contractors rather than directly contracting with the state. Formal long-term care is a somewhat newer issue in Tribal communities; thus, lack of awareness and knowledge of how to access available state services is a significant barrier.

Although the state has been a national leader in developing a system of long-term care that allows older adults and adults with disabilities dignity and choices in how they wish to live, tribal communities have largely been left out. The need of tribal governments to assure appropriate care for their citizens must be respected, and they must have equitable access to state and federal resources, as well as information about existing programs for which AI/ANs are eligible.

Much work needs to be done in long-term care to ensure that the aging Indian population in Washington, as well as AI/AN adult with disabilities, has access to essential services and options when they are needed. Developing strategies for Tribes to provide long-term care services must be a priority of both state and tribal governments.

Supporting Data

There is little data available regarding the long-term care needs of Tribal elders and younger Indian adults with disabilities. Several factors, such as Indian Health Service not historically funding long-term care services, the lower life expectancy of Indian people, and the misclassification and misreporting of Indian data, all contribute to this gap.

What is known, however, is that AI/AN in Washington have the highest rates of chronic diseases, including but not limited to diabetes, coronary heart disease and asthma, than any other group or population.¹⁰ Complications from these diseases can lead to elders, as well as younger adults, no longer able to take care of basic activities of daily living which allow them independence (e.g., walking, eating, dressing, using the toilet, etc.). In, *Improving Health Through Partnerships: The 2007-2009 American Indian Health Care Delivery Plan*, statistical data for AI/ANs in 10 health indicator areas was compared to other population groups, and AI/ANs consistently had the first or second worst health status in each area which, in addition to the chronic diseases mentioned above, included strokes, lung cancer, female breast cancer, and colorectal cancer. Without Tribes having appropriate long-term care service delivery systems in place, elders and adults with chronic disease and disabilities are at high risk for premature institutionalization or death.

¹⁰ American Indian Health Care Delivery Plan. *Improving Health Through Partnerships*. August 2007

Goal Three Objectives

- Objective 3.1: Identify existing, ‘promising’ long-term care service practices and service delivery methods provided in Tribal communities
- Objective 3.2: Identify challenges and barriers in providing local Tribal long-term care services
- Objective 3.3: Improve the government-to-government relationship between Department of Social and Health Services Aging and Disability Services Administration (ADSA) and Tribes to develop appropriate policies and delivery systems for providing home and community based services to Tribal elders and adults with disabilities
- Objective 3.4: Educate Tribal programs on all long-term care funding resources available and develop a matrix for local tribal planning purposes
- Objective 3.5: Implement strategies to address regulatory and policy barriers for Tribes to provide and be reimbursed for state-funded long-term care services in their own communities, including licensing/certification challenges and coordination issues with Area Agencies on Aging.
- Objective 3.6: Collect and analyze data and population projections of vulnerable AI/AN adult to enable planning for long-term care needs.
- Objective 3.7: Identify long-term care ‘train-the-trainer’ opportunities, such as Statewide Health Insurance Benefits Advisors (SHIBA) for Tribes to build internal expertise for assisting elders with their needs

4. ORAL HEALTH

Goal Four: *Improve the oral health of AI/AN and the ability of Tribes to provide comprehensive dental services in Tribal communities*

Problem Statement¹¹

The U.S. Surgeon General characterizes good oral health as a prerequisite for people’s general health and quality of life. Yet many barriers prevent some Americans from having optimal oral health. Oral health affects people both physically and psychologically. It influences how they grow, enjoy life, look, speak, chew, taste food, and socialize. Poor oral health brings negative effects to children and adults in all settings— home, school, work, and social activities.

¹¹ This section was developed by the AIHC Oral Health Workgroup as a position paper proposed to and approved by Tribal Leaders at the November 2008 Tribal Leaders Health Summit. Statistical information and additional narrative were added by the Oral Health Program, Washington State Department of Health, Office of Maternal and Child Health, oral.health@doh.wa.gov; Web Site: http://www.doh.wa.gov/cfh/Oral_Health/index.htm.

Oral diseases, such as dental caries and periodontal disease, are important public health issues because they're common and have high socioeconomic costs. Fortunately, most oral diseases can be prevented with simple and effective measures.

Access to dental care remains elusive for those who are poor, lack dental insurance, and live in underserved areas where dental providers are in short supply. Insurance coverage, whether private or public, can help improve access only when dentists are willing to accept insured patients and to offer regular examinations and needed treatment. Not all dentists accept Medicaid thus reducing access, especially for specialty dental care that is often not available in Indian Health Service, Tribal, or Urban Indian clinics.

Impact of Oral Diseases on General Health and Quality of Life

Oral health means much more than beautiful teeth. It means freedom from chronic pain, oral and throat cancers, oral lesions, birth defects (cleft lip and palate), and other oral diseases. The mouth and throat are often taken for granted but are essential to the quality of our daily living.

Poor oral health causes unnecessary pain and discomfort that can affect children's learning, concentration and performance at school, as well as their ability to thrive.¹² Adults can also suffer from poor oral health and fail to be productive at work.

Poor oral health can also worsen diabetes, and has been associated with heart problems and premature birth, among other problems. Other systemic conditions, such as HIV/AIDS, osteoporosis, and drug abuse, have significant impacts on oral health. Therefore, early diagnosis by a dental professional can lead to early referral to the appropriate health professional.

Oral Health Status of American Indians/Alaska Natives

Oral disease is a persistent health issue for American Indians and Alaska Natives (AI/AN). The state Department of Health published a report, "*The Impact of Oral Disease on the Lives of Washingtonians*" that provided the following data on the dental health status of AI/AN in WA:

¹² National Maternal and Child Oral Health Resource Center, *Oral Health and Learning: When Children's Health Suffers, So Does Their Ability to Learn* (2nd ed.) © 2003.

Dental Caries

Dental caries (cavities) are the most common chronic disease across all age groups. Children and adults can develop caries in the crowns of their teeth, but adults may also present it on the root surfaces after gingival recession. Fortunately, dental caries is completely preventable by measures that are widely available (water fluoridation, school sealants, healthy diet, topical fluorides, and oral hygiene). Every five years, the State Smile Survey looks at the prevalence of caries in low-income preschoolers, second and third graders, and children in tribal communities. This survey was initially developed in Washington in 1994, and repeated statewide in 2000 and 2005.

- ◆ Minority and low-income pre-school children experience higher levels of dental caries, untreated caries, early childhood caries, and incipient dental caries, when compared to White non-Hispanic children.
- ◆ AI/AN Native American pre-school children have a higher prevalence of untreated caries, rampant caries, and early childhood caries than their White counterparts.
- ◆ Native American elementary school-age children are significantly more likely to have a history of dental caries, and they are more than twice as likely to have untreated dental caries as White children
- ◆ Native American and African American women are less likely to visit a dentist during their pregnancy when they have a dental problem. In Washington, Native American pregnant women had fewer preventive visits (58.5 percent) than did White and other minority women.
- ◆ In 2004, 70 percent of adults in Washington had visited a dentist within the past 12 months, compared to only 34 percent of AI/AN adults.
- ◆ The prevalence of gingivitis is highest among American Indians and Alaskan Natives, Hispanics, and adults with less than a high school education. Although not all cases of gingivitis progress to periodontal disease, all periodontal disease starts as gingivitis.

Oral Disease and Chronic Disease

Oral diseases, like dental caries (cavities), periodontal disease such as gingivitis (gum disease), and periodontitis (loss of tissue and bone that support the teeth) can cause significant health concerns. Studies have shown a link between poor oral health and diabetes. There is also a potential relationship between poor oral health and cardiovascular disease, respiratory diseases, osteoporosis, and other chronic illnesses. For instance, people with diabetes are more susceptible to periodontal disease and diabetics with periodontal disease have greater difficulty controlling their blood sugar

thus worsening the diabetes. Therefore, treatment of dental/oral diseases needs to be comprehensively integrated into the prevention and treatment of these diseases.

Oral Health and Maternal-Infant Health

Poor oral health can negatively impact a pregnant woman and her baby. Evidence shows a potential association between periodontal (gum) disease in a pregnant woman and premature delivery and low birth weight. Toxins or other products generated by oral bacteria in the mother may reach the general circulation, cross the placenta, and harm the fetus. In addition, the complex hormonal and physiological changes during pregnancy can lead to inflammation in the gums, known as pregnancy gingivitis. Dental caries are considered infectious only during early childhood, when they can be passed from caregivers to young children when sharing utensils, kissing, etc. While some studies have shown that interventions to treat periodontal and other oral health diseases can improve pregnancy outcomes, conclusive clinical interventional trials are not yet available to confirm preliminary results. Nevertheless, control of oral diseases improves a woman's quality of life and has a potential to reduce transmission of oral bacteria from mothers to young children.

Reimbursement for Dental Hygienists

AI/AN have limited access to dental treatment at Tribal- and Indian Health Service-operated clinics. Indian Health Service funding has not kept pace with inflation or population growth; thus, demand for services far exceeds capacity. With strained financial resources and a shortage of available dentists, as well as referral sources for specialty care, Tribes' ability to resolve dental problems and establish preventive practices are severely inhibited.

Tribal- and Indian Health Service-operated clinics can bill third party resources including private insurance and Medicaid, with Medicaid being a very important revenue source for Indian dental services. Tribal- and Indian Health Service-operated clinics can bill the state for categorically needy Medicaid recipients and be reimbursed at the IHS encounter rate if the service is provided by a dentist. Urban Indian programs can bill and be reimbursed at the Federally-Qualified Health Clinic (FQHC) rate for services provided by a dentist or a licensed hygienist.

The state Medicaid plan does not consider dental hygienists as reimbursable providers under the encounter rate; therefore, to bill an encounter rate for routine hygiene services, there must be a face to face encounter between the patient and a dentist, resulting in an inefficient use of a dentist's skill and time. Private insurance does not require this level of contact to pay for services normally and routinely provided by a

licensed hygienist nor does the Washington State Medicaid Plan require the involvement of a dentist to reimburse FQHC clinics for prophylactic services provided by a licensed hygienist. A change in the state Medicaid plan to allow this reimbursement for dental hygienists would result in increased dental services for AI/AN served at Indian Health Service and Tribal clinics, increased efficiency of clinic operation and result in appropriate revenue to clinics because of the increased service available.

Provider Shortages

Short staffing within Tribal, Indian Health Service, and urban Indian clinics also affects AI/AN access to dental care. IHS reports nationally that 100 dentist positions are vacant, but a recent survey of Washington State Tribes found that 54 percent had unfilled dentist capacity and 44 percent had need for additional dental hygienist services. In 2001, nearly 57 percent of Washington's rural general dentists said they plan to retire by 2013 (Department of Health Oral Disease Burden Document, 2007). If this occurs, the ability of Tribes to recruit and retain dentists will become a long term problem.

A best practice example in Washington is demonstrating success in reducing this shortage of trained professionals. A partnership between the Yakima Valley Farm Workers Clinic and University of Washington has resulted in two dental residency programs: one in General Dentistry; the other in Pediatric Dentistry. This Northwest Dental Residency is an Advanced Education in General Dentistry residency program that teaches comprehensive dentistry emphasizing practice in rural communities, public health, cultural competency, and multidisciplinary health. It also enhances residents' ability to use dental auxiliaries in an expanded-duty capacity.

The Department of Health manages the Washington State Health Professional Loan Repayment and Scholarship program. Increased amounts in this program would be an important step to address the shortage of dentists and hygienists in Tribal and other underserved communities in the state.

Supporting Data

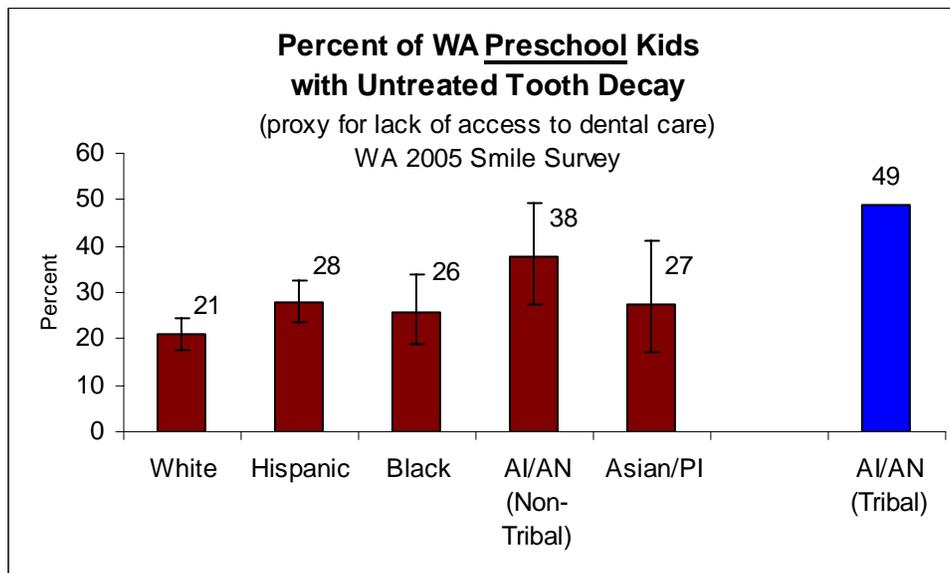
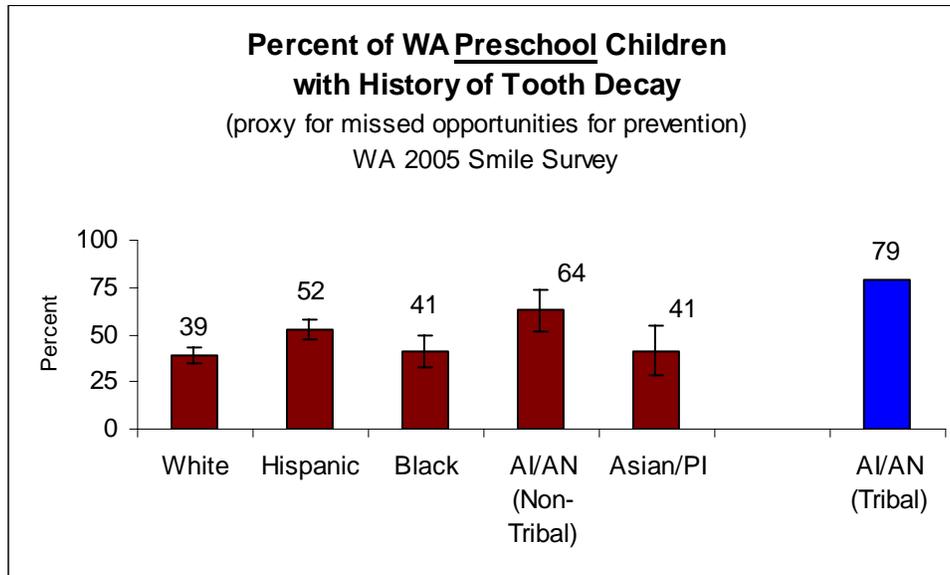
Low-income preschool children (Head Start and Early Childhood Education and Assistance Program)

- **Caries experience.** Caries experience among Head Start and Early Childhood Education and Assistance Program (ECEAP) children has significantly increased since 1994. In 2005, 45 percent of these preschoolers had experienced dental caries, a level that is significantly higher than the national HP2010 target of 11 percent and significantly higher than WA 1994 levels (38.3 percent).

- **Treatment needs.** Washington experienced a significant decrease in the percent of low-income pre-school children needing early dental care, from 21.5 percent (20.0, 23.1) in 2000 to 18.0 percent (17.1, 18.9) in 2005.
- **Untreated caries.** In 2005, 25 percent of low-income preschool children had untreated caries. Untreated caries, rampant caries, and early childhood caries decreased from 2000 to 2005 but are still higher than 1994 levels.
- **Disparities.** Minority and low-income pre-school children continue to experience the highest levels of caries, untreated caries, early childhood caries, and incipient dental caries, when compared to White non-Hispanic children.

The two graphs below show the results of the Smile Survey conducted by the Indian Health Service (IHS). The 2000 and 2005 surveys included a convenience sample of approximately six pre-school programs (Head Start or ECEAP) and 9 elementary schools located in Tribal country. These schools were chosen from different areas of the state as an effort to make the tribal sample more representative. All preschoolers and students enrolled in the selected schools were surveyed. The 2000 survey included 149 preschool and 293 elementary school children and the 2005 survey included 139 preschool and 310 elementary school children. Because all children participated in the survey, Indian Health Service did not provide margins of errors for their estimates. Nonetheless, there is likely to be some margin of error in the estimates due to the sampling of the schools and other random factors.

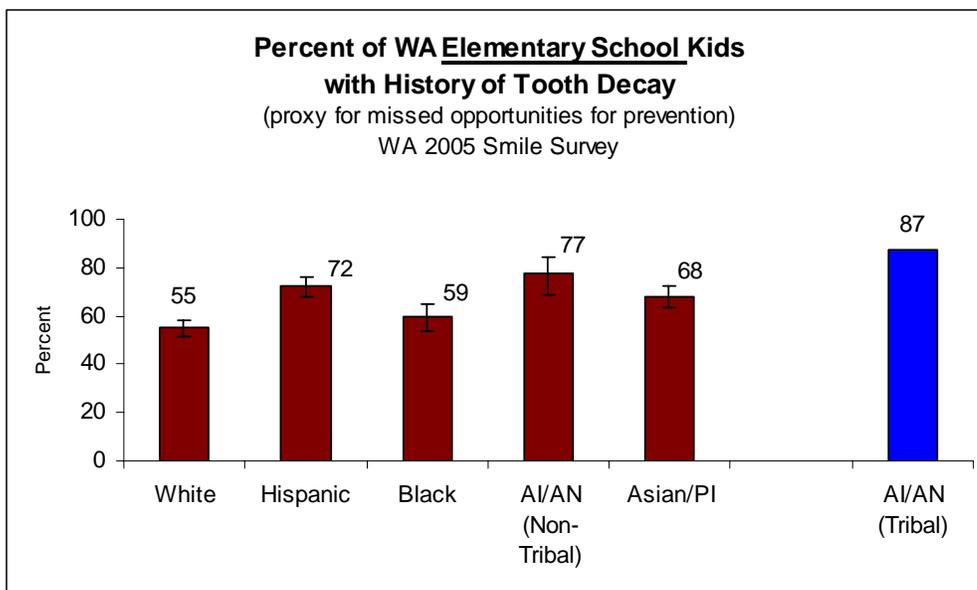
A national tribal oral health survey in 1999 showed that the oral health of tribal individuals in the state tended to be very consistent among Northwest tribes. Therefore, the Northwest Portland Area Indian Health Board recommends that the results of the Tribal Smile Surveys be used to infer to the whole tribal community in Washington.



Elementary school-age children (second and third graders)

- **Caries experience.** The prevalence of caries experience in this age group significantly increased since 2000, along with the prevalence of rampant caries compared to previous years. In 2005, 59 percent of elementary school-age children had experienced dental caries, a significantly higher level than the national HP2010 objective of 42 percent.
- **Treatment needs.** Early and urgent treatment needs decreased from the levels seen in 2000, with those needing treatment showing a significant decrease. In 2005, 15 percent needed dental care, and three percent needed urgent dental care.

- **Untreated caries.** The percent of untreated caries and early childhood caries decreased in 2005 from the 2000 level. The state has met the HP2010 objective of 21 percent in this indicator for White children.
- **Disparities.** In 2005, minority, low-income, and non-English speaking children continue to experience the highest levels of dental disease.
 - ◆ Elementary school-age children eligible for federal free and reduced-price meal programs were more likely to have a history of dental caries and untreated caries compared to children from higher-income households.
 - ◆ Of elementary school-age children, 20 percent of had untreated caries, compared to the HP2010 objective of 21 percent. However, 28 percent of children from minority racial and ethnic groups had untreated caries.
 - ◆ Children from minority racial and ethnic groups and non-English speaking families had a significantly higher prevalence of caries experience, untreated caries, rampant caries, and dental treatment needs.



Tooth Loss

Full dentition is defined as having 28 natural teeth, exclusive of third molars and teeth removed for orthodontic treatment or as a result of trauma. As teeth are lost, a person's ability to chew and speak decreases, and social functioning may be compromised. Oral diseases such as dental caries and periodontal disease are the primary reasons for tooth loss.¹³ Tooth loss can also result from infection, unintentional

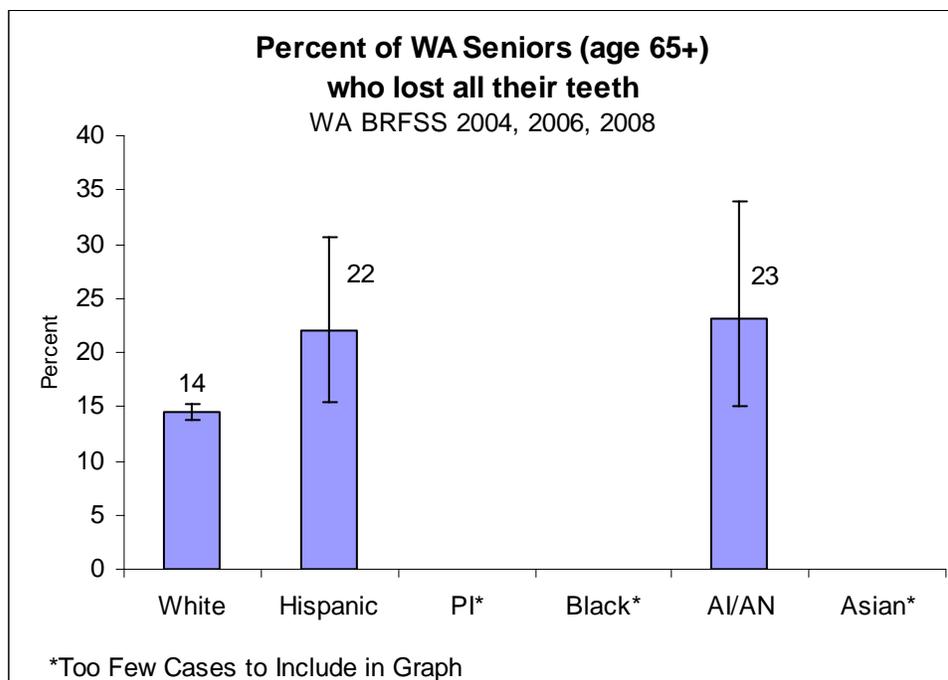
¹³ Total tooth loss among persons aged > or =65 years--selected states, 1995-1997. MMWR Morb Mortal Wkly Rep, 1999. 48(10): p. 206-10.

injury, and head and neck cancer treatment. In addition, certain orthodontic and prosthetic services sometimes require the removal of teeth.

Despite an overall U.S. trend toward losing fewer teeth, not all groups have benefited to the same extent. Low educational attainment has been found to have the strongest and most consistent association with tooth loss.

Adults Who Have Lost All Natural Teeth

In Washington, complete tooth loss is most prevalent among smokers, those with less than a high school education, Pacific Islanders, followed by African Americans and Native Americans.



Oral and Throat Cancers

The survival rates for cancer of the oral cavity or pharynx/throat have not improved substantially over the past 25 years. More than 40 percent of persons diagnosed with oral cancer die within five years of diagnosis, although survival varies widely by stage of disease when diagnosed. In contrast, the five-year survival rate is 42 percent once the cancer has spread to regional lymph nodes at the time of diagnosis, and 17 percent for those with distant metastasis.¹⁴

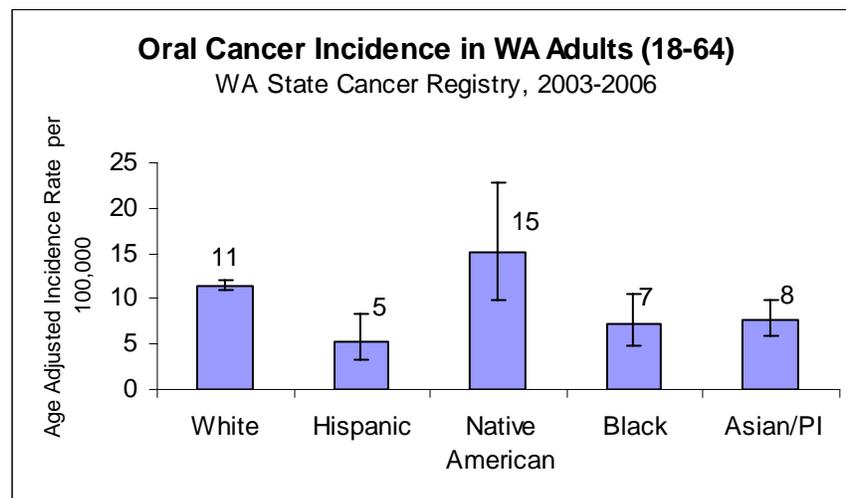
¹⁴ Gloeckler Ries LA, K.C., Hankey BF, Miller BA, Harras A, Edwards BK, *SEER cancer statistics review, 1973-1994. 1997*, US Department of Health and Human Services, Public Health Service, National Institutes of Health: Bethesda, MD.

Cigarette smoking and alcohol use are the major known risk factors for oral cancer in the United States, accounting for more than 75 percent of oral cancers.¹⁵ Using other forms of tobacco, including smokeless tobacco¹⁶ and cigars,¹⁷ also increases the risk for oral cancer. Dietary factors, particularly low consumption of fruit and some types of viral infections, have been implicated as risk factors for oral cancer.¹⁸ Radiation from sun exposure is a risk factor for lip cancer.¹⁹

Incidence and Mortality of Oral and Pharyngeal Cancers

In Washington:

- Oral cancers are relatively rare in individuals younger than 40.
- The oral cancer incidence rate is about 2.5 times higher in males compared to females, which is similar to the national trend.
- From 2004-2006 the incidence rate for American Indian/Alaska Natives was similar to that of Whites.



¹⁵ Blot, W.J., et al., *Smoking and drinking in relation to oral and pharyngeal cancer*. *Cancer Res*, 1988. **48**(11): p. 3282-7.

¹⁶ *The health consequences of using smokeless tobacco: a report of the Advisory Committee to the Surgeon General*. 1986, U.S. Department of Health and Human Services.: Bethesda, MD.

¹⁷ Shanks, T. and D. Burns, *Disease consequences of cigar smoking*. In: *National Cancer Institute. Cigars: health effects and trends. Smoking and Tobacco Control Monograph 9 edition*. 1998, US Department of Health and Human Services, Public Health Service, National Institutes of Health, National Cancer Institute.: Bethesda, MD.

¹⁸ McLaughlin, J.K., et al., *Dietary factors in oral and pharyngeal cancer*. *J Natl Cancer Inst*, 1988. **80**(15): p. 1237-43.

De Stefani, E., et al., *Diet and risk of cancer of the upper aerodigestive tract--I. Foods*. *Oral Oncol*, 1999. **35**(1): p. 17-21.

Levi, F., *Cancer prevention: epidemiology and perspectives*. *Eur J Cancer*, 1999. **35**(14): p. 1912-24.

Phelan, J.A., *Viruses and neoplastic growth*. *Dent Clin North Am*, 2003. **47**(3): p. 533-43.

Herrero, R., *Chapter 7: Human papillomavirus and cancer of the upper aerodigestive tract*. *J Natl Cancer Inst Monogr*, 2003(31): p. 47-51.

¹⁹ Silverman, S., *Oral cancer*. 4th ed. 1998, Atlanta, GA: American Cancer Society.

Goal Four Objectives

The Washington State Department of Health is developing its first State Oral Health Plan. This collaborative planning process includes representatives from Washington tribes. Collaborative strategies to improve the oral health of all Washington residents (including tribes) are being developed, and could be incorporated or adapted to the American Indian Healthcare Delivery Plan 2010-2013.

Objective 4.1: Raise awareness about maternal infant oral health problems and options to enhance resources for dental services.

Objective 4.2: Develop a partnership with Community Health Centers working on infant/child oral health care to build a coalition for political advocacy to increase services available

Objective 4.3: Explore options and resources for integrating oral diseases into prevention and treatment of chronic diseases

Objective 4.4: Increase access to preventative dental services by working to amend the state Medicaid plan to include dental hygienists as a category of health care providers that Tribes can bill for and receive the all-inclusive encounter rate

Objective 4.5: Explore options for the use of trained/certified expanded- function personnel in order to increase oral health care services in Tribal communities

Objective 4.6: Encourage the Washington State Higher Education Coordinating Board, the Governor, and the Legislature to increase the Health Professional Loan Repayment and Scholarship Program budget

Objective 4.7: Establish a dental residency program that places residents in Tribal and urban Indian dental clinics in cooperation with University of Washington

5. BEHAVIORAL HEALTH

Goal Five: *Address the disproportionate mental health disparities experienced by AI/AN improved state delivery systems, ability of Tribes to provide appropriate, relevant services themselves and collaboration among Tribes and state agencies funding these services*

Problem Statement

Concerns about mental health issues have always played a prominent role in Tribal Leaders Health Summits and many other Tribal health meetings. Despite ongoing

efforts made by Tribes, the state of Washington has done little to improve mental health access for American Indians and Alaska Natives (AI/AN) since the original Regional Support Networks (RSN) were created in the early 1990s. Although the state is required by federal law and Centers for Medicaid and Medicare Services (CMS) policy to inform Tribes about all Medicaid waivers and renewals, in 2007, the state failed to allow adequate time for Tribal review of the RNS waiver. As a result, Tribes were pressured into abdicating their right to engage in a meaningful Tribal Consultation process. No changes to improve AI/AN access were made to the Regional Support Networks.

In May 2006 the state held several Tribal forums to discuss mental health issues among AI/AN. These issues were included in the 2006 Washington Mental Health Transformation Plan: Phase 1. Later that year, the 2006 Tribal Leaders Health Summit included a position paper which incorporated this information and developed recommendations in the following areas:

- The importance of tribal consultation;
- Recognition of special considerations needed by Tribes participating in “evidence-based” grants and programs;
- The importance of embracing and accommodating the holistic approach of many Tribes toward people with co-occurring disorders;
- Regional Support Networks reform;
- Clarifying licensure and certification requirements for tribal mental health providers;
- Training and jurisdiction of tribal law enforcement when dealing with people who are mentally ill;
- Encouraging maximum Medicaid coverage for mental illness;
- More emphasis should be placed on youth prevention activities;
- The state should facilitate meaningful Tribal participation in the mental health transformation work.

The 2006 American Indian Health Commission position paper also stated: “While the involvement of Tribes and inclusion of Tribal priorities in the state’s plan is an encouraging first step, the state must continue to work with Tribes on a government-to-government basis to ensure that the recommendations from the Tribal-specific chapter are addressed in Washington’s mental health transformation process.” The state’s mental health transformation plan must include a consultation process with the 29 Tribes in Washington to address specific recommendations that were made in the initial survey across the state.

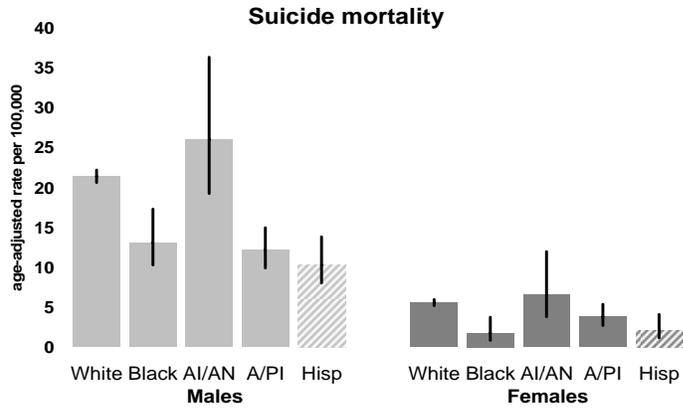
Although the commission and the member Tribes supported the state's Mental Health Transformation grant, there has been little follow-up work done on the tribal recommendations that appear in the 2006 Washington Mental Health Transformation Plan: Phase 1. The Prevention Report completed by the state Board of Health is one example of work that did not even mention Tribes or AI/AN. This was unfortunate because the recommended model was termed a "public health approach", yet there was no acknowledgement of this actually being a Tribal mental health model currently used in the state.

One of the difficulties facing Tribes in effectively improving mental health services for AI/AN statewide is lack of effective technical resources. The complexity of Medicaid regulations, the entrenchment of the Regional Support Networks system, the misunderstandings about available state dollars and access to them, the numerous state committees and initiatives that Tribes ought to be effectively involved in all point to why Tribes face significant barriers in addressing where they can make a difference on very important mental health issues.

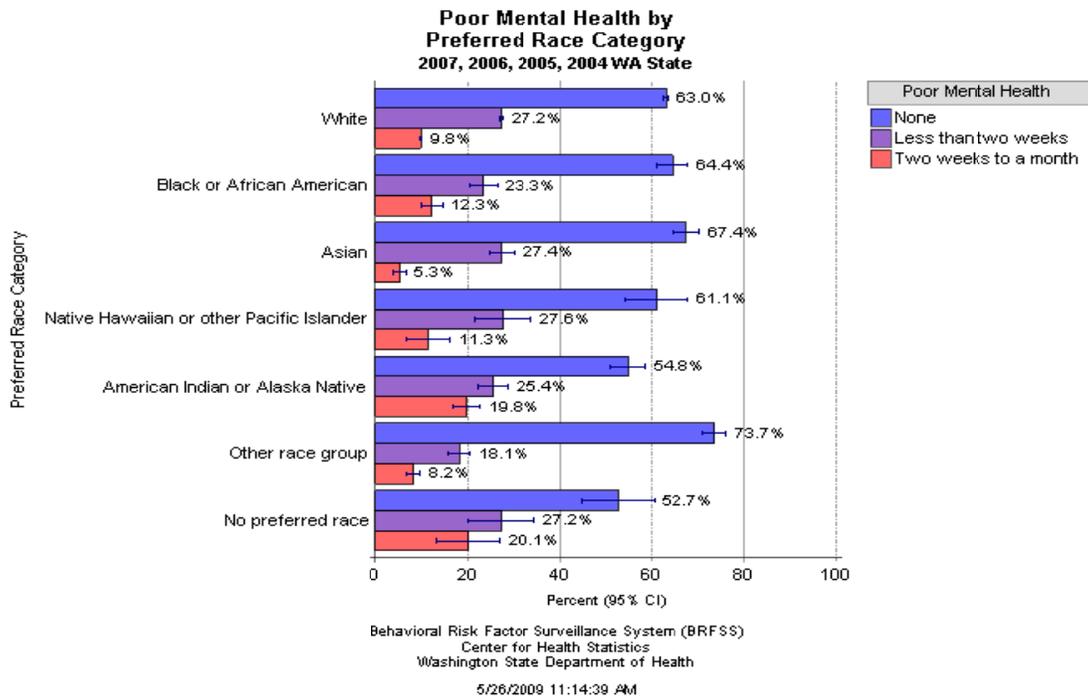
Key to making mental health services more accessible in tribal communities is the government-to-government relationship between the state and Tribes. Tribes believe mental health services can only be improved if the state of Washington provides available mental health funding directly to Tribal governments. Although this is done with various other funding sources, for example chemical dependency treatment, and Department of Social and Health Services has a mechanism through consolidated contracts, some mental health funding remains unavailable to Tribes and AI/AN suffer as a result.

Supporting Data

According to the Vital Statistics Annual Report published by the Department of Health, between 2002 and 2006, 66 male and 18 female AI/ANs died from suicide. AI/AN man had a higher suicide rate than Black, Asian/Pacific Islander and Hispanic men in Washington. The suicide rate in AI/AN women was similar to that found in other female racial and ethnic groups.



In 2005–2007, AI/ANs reported significantly higher rates of poor mental health (19.5% ±3%) than other racial and ethnic groups:



Goal Five Objectives

- Objective 5.1: Establish a Task Force comprised of tribal health administrators and tribal health policy experts to review and develop options for direct state/federal mental health funding for Tribes as governments
- Objective 5.2: Educate Tribal programs on all public funding for mental health prevention and treatment services in the state and identify options to resolve or address limitations Tribes face in accessing these funds
- Objective 5.3: Identify, negotiate, and implement options work improved Tribal working relationships with the RSN system
- Objective 5.4: Set a schedule for RSN waiver Tribal consultation meetings in 2009, beginning in January
- Objective 5.5: Conduct a comprehensive survey of mental health professional shortage issues in tribal communities and identify ways to allow state loan repayment programs to be used for tribal medical mental health provider recruitment and retention
- Objective 5.6: Coordinate a mental health conference to further work on implementing Chapter 3 of the MH Transformation Project Plan
- Objective 5.7: Change licensure/certification criteria needs to be changed to deem Tribally-certified professionals and facilities as eligible to be reimbursed for services, including where desired, direct state contracts.

VI. Tribal Health Programs in Washington State

A. Tribal Health Programs

1. Chehalis Tribe

Chehalis Tribal Health Clinic

P.O. Box 536

Oakville, WA 98568

Phone: 360-273-5911

<http://www.chehalistribe.org>

Health Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Grays Harbor, Thurston, Lewis Counties
Services Provided	Ambulatory/Medical; Dental; Alcohol and Substance Abuse; Behavioral Health

2. Confederated Tribes of the Colville Reservation

Colville Indian Health Center

P.O. Box 150

Nespelem, WA 99155

Phone: 509-634-2942

<http://www.colvilletribes.com>

Health Clinic	Yes – 4; Health Centers in Omak (pharmacy and dental only), Inchelium, Keller, Nespelem
IHS or Tribally Operated	Omak, Inchelium, Keller, Nespelem – IHS Operated
Contract Health Service	Yes; the Nespelem clinic manages the Contract Health Services program for all eligible beneficiaries
Contract Health Service Delivery Area	Chelan, Okanagon, Douglas, Grant, Ferry, Lincoln, Stevens, Grant Counties
Services Provided	Ambulatory/Medical; Dental; Alcohol and Substance Abuse; Behavioral Health; Pharmacy

3. Cowlitz Tribe

Cowlitz Health Clinic
1555 9th Avenue, Suite A
Longview, WA 98632
Phone: 360-575-8275
<http://www.cowlitz.org/health>

Health Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	King, Pierce, Thurston, Lewis, Cowlitz, Clark, Skamania Counties
Services Provided	Ambulatory/Medical; Alcohol and Substance Abuse; Behavioral Health; Sexual Assault; Vocational Rehabilitation

4. Hoh Tribe

Hoh Tribe
2464 Lower Hoh Road
Forks, WA 98331
Phone: 360-374-6582

Health Clinic	No
IHS or Tribally Operated	P.L. 93-638 Contract for Tribal Health Administrator and Community Health Representative
Contract Health Service	Yes
Contract Health Service Delivery Area	Jefferson County, Part of Clallam County
Services Provided	Direct care from a doctor, dentist, and nurse practitioner one day a week at the health station in Queets or from the Roger Saux Health Center in Taholah

5. Jamestown S'Klallam Tribe

Jamestown S'Klallam Health Administration, Community Health and Contract Health Services
 1033 Old Blyn Highway
 Sequim, WA 98382
 360-683-1109

Jamestown Family Health Center (Medical Clinic)	Jamestown Family Dental Clinic
777 N. 5 th Avenue	1033 Old Blyn Highway
Sequim, WA 98382	Sequim, WA 98382
Phone: 360-681-4625	Phone: 360-681-4657

<http://www.jamestowntribe.org/familyhealthclinic.htm>

Medical Clinic	Yes
Dental Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Clallam and East Jefferson County
Services Provided	Family Practice Medical and Women's Health and OB/GYN Services; General and Specialty Dentistry Services, Community Health Services including health and nutrition education, exercise and activity programs, WIC, Chemical Dependency Services, Mental Health Services

* Clinic is affiliated with the University of WA Department of Family Medicine

6. Kalispel Tribe

Kalispel Tribe Community Center *

Box 39

Usk, WA 99280

Phone: 509-445-1147

<http://www.kalispeltribe.com>

Health Clinic	No
IHS or Tribally Operated	P.L. 93-638 Contract
Contract Health Service	Yes
Contract Health Service Delivery Area	Pend Oreille, Spokane Counties
Services Provided	Dental Screenings (Youth); Alcohol and Substance Abuse; Behavioral Health

*Community Health Representative coordinates with local physicians to educate community members on a variety of topics and provides referrals under the Contract Health program; County Health Nurse is contracted to provide WIC services once a month

7. Lower Elwha Klallam Tribe

Lower Elwha Health Clinic

243511 Highway 101 W.

Port Angeles, WA 98363

Phone: 360-452-6252

<http://www.elwha.org>

Health Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Clallam County
Services Provided	Family Practice; Chronic Pain Management; Community Health; WIC; Maternal Support Services; Dental; Alcohol and Substance Abuse; Behavioral Health

8. Lummi Nation

Lummi Nation Health Center
2592 Kwina Road
Bellingham, WA 98226
Phone: 360-384-0464
<http://www.lummi-nsn.org>

Health Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Whatcom County
Services Provided	Ambulatory/Medical; Dental; Alcohol and Substance Abuse; Behavioral Health

9. Makah Nation

Sophie Trettevick PHS Indian Health Center
PO Box 410
Neah Bay, WA 98357
Phone: 360-645-2233
<http://www.makah.com>

Health Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Clallam County
Services Provided	Ambulatory/Medical; Dental; Alcohol and Substance Abuse; Behavioral Health

10. Muckleshoot Tribe

Muckleshoot Health and Wellness Center

17500 SE 392nd Street

Auburn, WA 98092

Phone: 253-939-6648

<http://www.muckleshoot.nsn.us/health/index.htm>

Health Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	King, Pierce Counties
Services Provided	Ambulatory/Medical; Dental; Alcohol and Substance Abuse; Behavioral Health; Pharmacy; CMT; Acupuncture

11. Nisqually Tribe

Nisqually Health Center

4816 She-Nah-Num Drive SE

Olympia, WA 98513

Phone: 360-459-5312

<http://www.nisqually-nsn.gov/>

Health Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Thurston, Pierce, Whatcom Counties
Services Provided	Ambulatory/Medical; Dental; Alcohol and Substance Abuse; Behavioral Health

12. Nooksack Tribe

Nooksack Community Health Center

6760 Mission Road

Deming, WA 98244

Phone: 360-966-2106

<http://www.nooksack-tribe.org/Clinic.htm>

Health Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Whatcom County
Services Provided	Ambulatory/Medical; Dental; Alcohol and Substance Abuse; Behavioral Health

13. Port Gamble S'Klallam Tribe

Port Gamble S'Klallam Health Clinic

31912 Little Boston Road

Kingston, WA 98346

Phone: 360-297-6264

<http://www.pgst.nsn.us>

Health Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Kitsap County
Services Provided	Ambulatory/Medical; Dental; Alcohol and Substance Abuse; Behavioral Health

14. Puyallup Tribe

Puyallup Tribal Health Authority
2209 East 32nd
Tacoma, WA 98404
Phone: 253-593-0234
<http://www.wwpeptha.com>

Health Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Pierce County, part of King County
Services Provided	Ambulatory/Medical; Dental; Alcohol and Substance Abuse; Behavioral Health

15. Quileute Tribe

Quileute Tribal Health Center
P.O. Box 189
LaPush, WA 98350
Phone: 360-374-9035
<http://www.quileutenation.org/index.cfm?page=clinic.html>

Health Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Clallam County
Services Provided	Ambulatory/Medical; Dental; Alcohol and Substance Abuse; Behavioral Health

16. Quinault Nation

Roger Saux Health Center*
P.O. Box 219
Taholah, WA 98587
Phone: 360-276-4405

Health Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Grays Harbor County
Services Provided	Ambulatory/Medical; Dental; Alcohol and Substance Abuse; Behavioral Health; Pharmacy; CMT; Radiology

* JCAHO Accredited; Remote Health Station in Queets

17. Samish Nation

Samish Nation
P.O. Box 919
Anacortes, WA 98221
Phone: 360-293-6404
<http://www.samishtribe.nsn.us/>

Health Clinic	No
IHS or Tribally Operated	N/A
Contract Health Service	Yes
Contract Health Service Delivery Area	San Juan, Island, Clallam, Jefferson, Kitsap, Whatcom, Skagit, Snohomish, King, Pierce Counties
Services Provided	Contract Health; Diabetes Project; Public Health Nursing Home Visits. Mental health, drug / alcohol, tobacco use, behavioral health counseling.

18. Sauk-Suiattle Tribe

Saux-Suiattle Health Clinic
5318 Chief Brown Lane
Darrington, WA 98241
Phone: 360-436-1124
<http://www.sauk-suiattle.com/Healthdept.htm>

Health Clinic	Yes
IHS or Tribally Operated	Tribally-Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Skagit, Snohomish Counties
Services Provided	Ambulatory/Medical; Alcohol and Substance Abuse; Behavioral Health

19. Shoalwater Bay Tribe

Shoalwater Bay Tribal Clinic
P.O. Box 500
Tokeland, WA 98590
Phone: 360-267-0119
<http://www.shoalwaterbay-nsn.gov>

Health Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Pacific County
Services Provided	Certified Chemical Dependency Treatment Program, Mental Health Therapy, Medical Clinic, Dental Clinic

20. Skokomish Tribe

Skokomish Health Clinic
N. 80 Tribal Center Road
Shelton, WA 98584
Phone: 360-426-5755
<http://www.skokomish.org/health.htm>

Health Clinic	Yes
IHS or Tribally Operated	Tribally-Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Mason County
Services Provided	Ambulatory/Medical, Dental, Physical Therapy, Acupuncture, Diabetes Education and Nutrition Counseling, Chiropractic, Community Health, Alcohol and Substance Abuse and Behavioral Health

21. Snoqualmie Tribe

Snoqualmie Tribe
P.O. Box 280
Carnation, WA 98014-0280
Phone: 425-222-6900
<http://www.snoqualmienation.com>

Health Clinic	Yes – North Bend Family Clinic; Tolt Community Clinic in Carnation
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Island, Snohomish, King, Pierce Counties
Services Provided	Ambulatory/Medical; Alcohol and Substance Abuse; Behavioral Health

22. Spokane Tribe

David C. Wyncoop Memorial Clinic
P.O. Box 100
Wellpinit, WA 99040
Phone: 509-258-7502
<http://www.spokanetribe.com>

Health Clinic	Yes
IHS or Tribally Operated	IHS Operated (some programs Tribally Operated)
Contract Health Service	Yes
Contract Health Service Delivery Area	Ferry, Lincoln, Stevens, Spokane Counties
Services Provided	Ambulatory/Medical; Dental; Alcohol and Substance Abuse; Behavioral Health

3. Squaxin Island Tribe

Squaxin Island Health Center
90 SE Klah-Che-Min Drive
Shelton, WA 98584
Phone: 360-427-9006
<http://www.squaxinland.org>

Health Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Mason County
Services Provided	Ambulatory/Medical; Alcohol and Substance Abuse; Behavioral Health

24. Stilliguamish Tribe

Stilliguamish Wellness Clinic

902 East Maple Street

Arlington, WA 98223

Phone: 360-435-9338

<http://www.stillaguamish-wc.com/>

Health Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Snohomish County
Services Provided	Ambulatory/Medical (limited primary care); Alcohol and Substance Abuse

25. Suquamish Tribe

Suquamish Tribe*

Suquamish, WA 98392

Phone: 360-598-3311

<http://www.suquamish.nsn.us>

Health Clinic	No
IHS or Tribally Operated	N/A
Contract Health Service	Yes
Contract Health Service Delivery Area	Kitsap
Services Provided	Chemical Dependency Assessments and Treatment, Mental Health Assessments and Therapy, Prevention and Outreach programs

* Services provided through benefits package with Third-Party Administrator funded through IHS contract

26. Swinomish Tribe

Swinomish Tribal Health Center

P.O. Box 388

LaConner, WA 98257

Phone: 360-466-3167

<http://www.swinomish.org>

Health Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Skagit County
Services Provided	Ambulatory/Medical; Dental; Alcohol and Substance Abuse; Behavioral Health; Domestic Violence Program

27. Tulalip Tribes

Tulalip Health Clinic

7520 Totem Beach Road

Marysville, WA 98271

Phone: 360-651-4515

<http://www.tulaliptribes-nsn.gov/health.asp>

Health Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Snohomish County
Services Provided	Ambulatory/Medical; Dental; Alcohol and Substance Abuse; Behavioral Health

28. Upper Skagit Tribe

Upper Skagit Tribal Health Facility
25944 Community Plaza
Sedro Woolley, WA 98284
Phone: 360-854-7000
<http://www.stillaguamish-wc.com/>

Health Clinic	Yes
IHS or Tribally Operated	Tribally Operated
Contract Health Service	Yes
Contract Health Service Delivery Area	Skagit County
Services Provided	Ambulatory/Medical (limited primary care); Alcohol and Substance Abuse; Behavioral Health

29. Yakima Nation

Yakama Nation Tribal Health Facility*
P.O. Box 151
Toppenish, WA 98948
Phone: 509-865-5121

Health Clinic	Yes
IHS or Tribally Operated	IHS Operated
Contract Health Service	No
Contract Health Service Delivery Area	Lewis, Skamania, Yakima, Klickitat Counties
Services Provided	Ambulatory/Medical (limited primary care); Dental; Alcohol and Substance Abuse; Behavioral Health

*Accreditation Association for Ambulatory Health Care (AAAHC) Accredited; Satellite Clinic in White Swan, WA

B. Urban Indian Health Programs

The N.A.T.I.V.E. Project

1803 West Maxwell

Spokane, WA 99218

Phone: 509-325-5502

<http://www.nativeproject.org>

The NATIVE Project provides a variety of behavioral health and community services as well as medical care through its NATIVE Health Clinic of Spokane.

The NATIVE Project is a state-licensed adolescent substance abuse treatment center, mental health facility, and community services center for families and youth in Spokane County. Services include a sixteen week intensive outpatient substance abuse treatment program for youth 10-17 years old, aftercare, "Clean Teens" Alcoholics Anonymous meetings, transitional living, and pregnant/parenting teen treatment. Mental health services are also available for individuals, groups, or families. Dual diagnosis treatment and case management, with a focus on suicide prevention and intervention, is available for clients ages 10-17. Prevention programs include youth leadership camps, summer youth programs and cultural self-actualization classes. The NATIVE Project also operates an Indian Child Welfare Program and is one of three collaborating partners in Teen PEACE, which is designed to reach youth at the earliest stage possible and provide effective intervention for families exposed to violence.

The NATIVE Health Clinic of Spokane is a Federally Qualified Health Center (FQHC) and in 2006 served 6,200 individuals and provided over 25,000 encounters. Services include primary care, minor surgeries, diabetes management, CLIA lab, pharmacy, dental, adult behavioral health, and referrals to specialized health providers.

The NATIVE Project also coordinates four major community events each year to conduct health screenings, outreach, and education for over 1,000 people. These community events have proven an effective strategy for educating the Indian Community about the Healthy People 2010 goals of increasing the quality and years of life and eliminating health disparities, especially in the areas of diabetes, chemical dependency and mental health, and violence/accidents.

The NATIVE Project is a non-profit 501(c) (3) organization and also is recognized as an Urban Indian Organization that serves youth and families in Spokane County. Founded in 1989, the NATIVE Project advocates for all children and families but specifically serves as a resource regarding Indian issues. The organization's vision is to encourage community that promotes balance and harmony in the pursuit of: drug and alcohol free lifestyles; spiritual, cultural, and traditional Native values; wellness and balance of mind; respect and integration of all healing

paths to wellness for self and others; lifestyles that encourage and are supportive of prosperity; education; and awareness. By creating a circle of care using one team/one voice, individuals, staff, families, and agencies learn to utilize skills, leadership, cultural, and spiritual consciousness to give back to their community by living as Warriors, Nurturers, Scholars, and Community Activists.

Seattle Indian Health Board

P.O. Box 3364

Seattle, WA 98114

Phone: 206-324-9360

<http://www.sihb.org>

The Seattle Indian Health Board (SIHB) is a non-profit, multi-service community health center chartered in 1970 to serve the health care needs of AI/ANs living in the greater Seattle/King County region.

The Seattle Indian Health Board is governed by a 15-member Board of Directors, the majority of who are of AI/AN heritage. Services are managed by the Executive Director, Associate Director, Medical Director, Operations Coordinator, and division managers and supervisors.

The Seattle Indian Health Board divisions include:

- Health Care Services (medical, dental, lab, pharmacy, mental health, nutrition programs, and the Family Medicine Residency Program)
- Clinic Support Services
- Chemical Dependency Services, Thunderbird Treatment Center, and outpatient CD counseling services
- Fiscal and Administrative Services
- Urban Indian Health Institute
- Human Resources

Direct care services are provided on a sliding fee basis. Many public and private insurance plans are accepted. Additional funding is received from public and private sources including federal, state, and local government agencies. The Seattle Indian Health Board is a Federally Qualified Health Center for Medicaid and Medicare services. Some programs have restricted enrollment based on grant or contract provisions. The Seattle Indian Health Board is not an Indian Health Service facility, though it does contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act (PL 94-437).

All SIHB programs are state-licensed and nationally accredited by the AAAHC. Direct care providers are state-licensed, and many are board certified in their respective fields.

ATTACHMENT A: Acronyms Reference

Acronym	Reference
AI/AN	American Indians/Alaska Natives
AIHC	American Indian Health Commission for Washington State
CHS	Indian Health Contract Health Services Program
CMS	U.S. Centers for Medicare and Medicaid
DOH	Washington State Department of Health
DSHS	Washington State Department of Social and Health Services
HCA	Washington State Health Care Authority
IHCIA	Indian Health Care Improvement Act
IHS	Indian Health Service
I/T/U	Indian Health Service, Tribal, Urban Indian health delivery system
LTC	Long-Term Care
MIH	Maternal-Infant Health
NIHB	National Indian Health Board
NPAIHB	Northwest Portland Area Indian Health Board
PEBB	Washington State Public Employee Benefits Board
POA	Portland Area Indian Health Service
RSN	Washington State Regional Support Networks [behavioral health service delivery]
STU	State-Tribal-Urban Indian Health Collaborative
“The Plan”	American Indian Health Care Delivery Plan
UIHO	Urban Indian Health Organizations