Unique Aspects of the Indian Health Delivery System

Presented by:
American Indian Health Commission for Washington State

Indian Health Care Improvement Act and the Special Trust Responsibility

Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—

1. to ensure the **highest possible health status** for Indians and urban Indians and to provide all resources necessary to effect that policy;
2. to **raise the health status** of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;
3. to **ensure maximum Indian participation in the direction of health care services** so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;
4. to **increase the proportion of all degrees** in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population;
5. to require that all actions under this chapter shall be carried out with **active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations**, to implement this chapter and the national policy of Indian self-determination;
6. to ensure that the United States and Indian tribes work in a **government-to-government relationship** to ensure quality health care for all tribal members; and
7. to provide **funding for programs and facilities operated by Indian tribes and tribal organizations** in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

- Indian Health Care Improvement Act (25 U.S. Code §1602), permanently reenacted by PL 111-148.

Indian Health Services System

The Indian Health Service (IHS) was established within the Public Health Service in 1955 to provide health services to American Indian and Alaska Native (AI/AN) people.

IHS provides services directly through a network of 46 hospitals, 10 regional youth facilities, 344 health centers, and 105 health stations and 150 Alaska village clinics - primarily in rural areas on or near reservations.

IHS also awards contracts and grants to non-profit urban Indian organizations that provide health care and referral services to urban Indians. There are 41 UIHOs in 77 locations.

In fiscal year 2017, about 54 percent of IHS funds went to tribal organizations. In certain circumstances, IHS pays for services provided by external providers through its Purchased/Referred Care program (PRC).

In addition to the provision of health care, IHS performs several public health functions, including public health nursing and water sanitation facility construction.

Indian Health Services- Federal Program

- Coordinates and oversees funding of health care for AI/AN through IHS Service Units, tribally administered programs, and urban Indian health programs.
- I.H.S is a system of care-Not considered “insurance coverage”
- Eligibility based on geography
- Two buckets of funds:
  - Direct Care
  - Purchase and Referred Care

Direct Care

- Originally, all facilities were operated by Indian Health Services (the agency)
- Eligibility to access care at an IHS operated facility is based on 42 CFR

Tribal Health Programs

- Tribe enters into a contract or compact with the IHS agency.
- Tribe takes responsibility to comply with various federal requirements that are attached to IHS funding.
- Tribe’s records are audited by U.S. Office of the Inspector General.
- Tribe determines eligibility requirements; some tribal health programs serve everyone in the community, others serve only tribal members.
- Direct Care: 27 tribes
- Purchased and Referred Care: 29 tribes

Urban Indian Health Programs

- Nationwide, 70% of American Indians and Alaska Natives live in urban areas, with 25% of them residing in counties served by Urban Indian Health Programs created and funded through Public Law 94-437.
- In addition to receiving IHS funding, most Urban Indian Health Programs also receive funding from the U.S. Health Resources and Services Administration (HRSA) as Federally Qualified Health Centers.
- Due to HRSA requirements, Urban Indian Health Programs serve everyone, while focusing on American Indians and Alaska Natives.
- Two Urban Indian Health Programs in Washington State: Seattle Indian Health Board and NATIVE Project of Spokane.

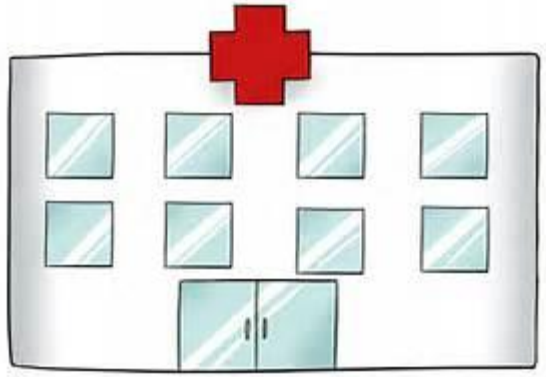
Purchased and Referred Care

Indian Health Care Provider

- Health Care
- Mental Health
- Substance Use
- Dental

Referral & Coordination

Non-Indian Health Care Provider



- Specialty Care
- Inpatient Care

Indian Health Care = Patient Centered Care

- Goal is to preserve, support, enhance Indian health care and improve coordination with non-Indian health care

- Why?
  - Science/evidence-based practice tells us patient-centered care → high quality, effective care that produces better health outcomes
  - The patient centered medical home for an American Indian or Alaska Native person is the Indian health clinic

Indian Health Care = Patient Centered Care

- Indian Health Care Providers serve their people from birth to death, even if the patient is non-compliant with care plans.
- Indian Health Care Providers have an investment and a lifetime commitment to that individual and to the health of American Indian and Alaska Native people.
- Effective coordination requires having good procedures in place between the Indian and non-Indian systems of care.

Complex Payer Requirements for AI/ANs and Tribes

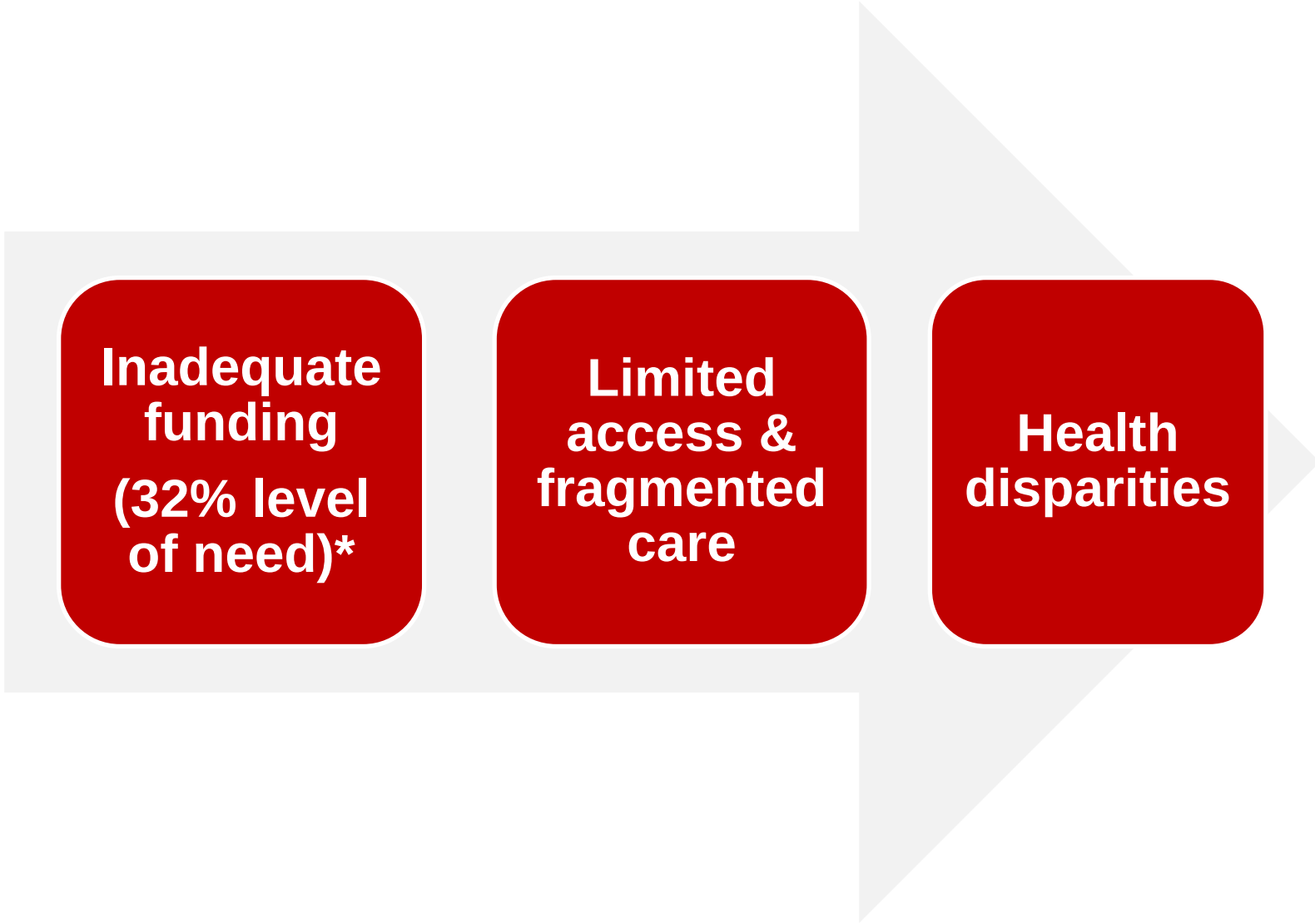
Federal government fails to fund IHS adequately

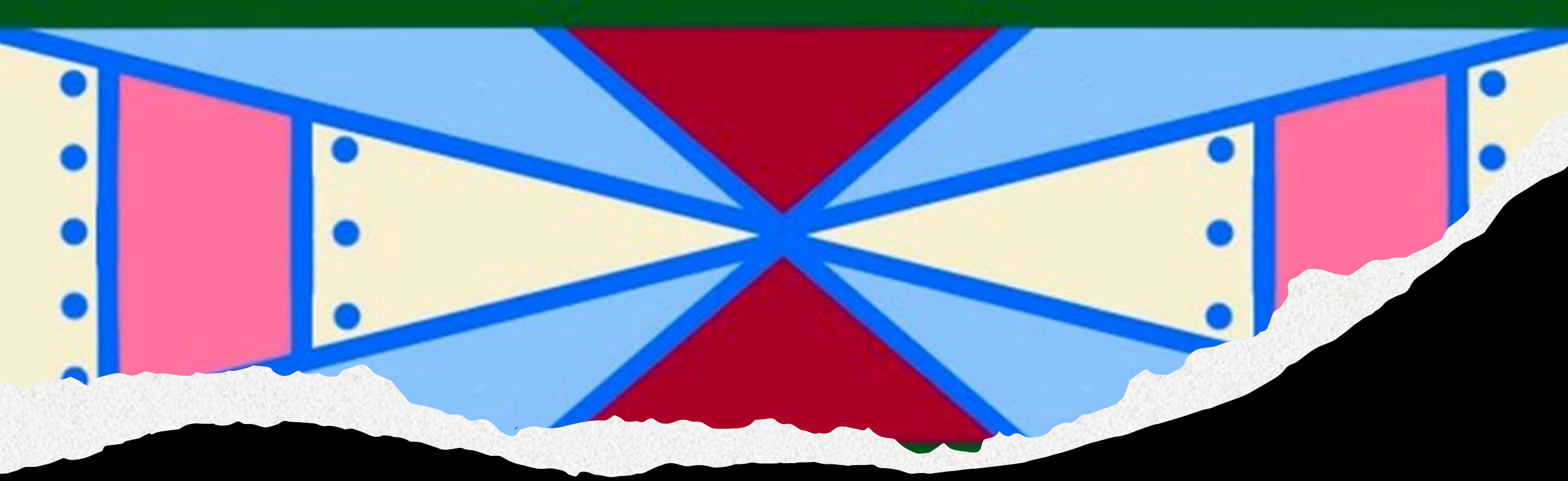
Federal government requires AI/ANs to use other resources first*

Tribes/UIHPs forced to fill in the gaps

**42 CFR 136.61 – IHS is payer of last resort.*

Effects of Underfunding of the Indian Health Service





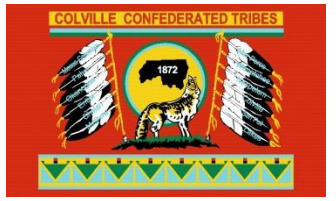
American Indians and Alaska Natives

Federal Entities working within State Structures

Plateau Parfleche by Jon Shellenberger, Yakama

Government-to-Government Relations

Governments



Stakeholders

Tribal Sovereignty & Sovereign Immunity

Under federal law, Tribal governments are sovereign governments, like federal and state governments.

- Tribes and States are both sovereigns.
- Tribes are not subject to State law; States are not subject to Tribal law.

Tribal governments have sovereign immunity.

- Tribes are presumptively immune from state law.
- Tribes cannot be sued unless they consent to the lawsuit or they waive their sovereign immunity.

State-Tribal Relations: Medicaid Requirements

For *Medicaid matters that are likely to have a direct effect on Indian health care providers or American Indians/Alaska Natives*, state Medicaid agencies must:

- **Seek advice** on a regular, ongoing basis for its Medicaid, Medicaid-related, and Children's Health Insurance Plan programs.
- **Notify** Tribal leaders, Tribal clinic directors, Urban Indian Health Program executive directors, and other Tribal organization leaders of state plan amendments, waivers, and other projects.
- Schedule in-person meetings if requested.

See Social Security Act §1902(a)(73) (codified at 42 U.S.C. §1396a(a)(73)).

State-Tribal Relations: SAMHSA Requirements

To receive a grant from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), the state will:

- Describe in the grant application the proportion of the AI/AN population to the total population;
- Allocate that proportion of the grant for use for the Indian population; and
- Take reasonable efforts to collaborate with each tribe in the state to carry out youth suicide prevention and treatment measures for members of the tribe.

Tribal governments are not required to waive sovereign immunity to receive block grant funds or services.

See Indian Health Care Improvement Act §724(a)(4)(B) (codified at 25 U.S.C. 1667c).

IHS CHSDAs by County and RSA

	Clallam	Jefferson	Kitsap	Whatcom	Island	San Juan	Skagit	Snohomish	King	Pierce	Mason	Thurston	Grays Harbor	Pacific	Lewis	Wahkiakum	Cowlitz	Clark	Skamania	Chelan	Douglas	Grant	Okanogan	Ferry	Lincoln	Pend Oreille	Spokane	Stevens	Kittitas	Klickitat	Yakima
	Peninsula RSA			North Sound RSA					RSA	RSA	M-T RSA		Timberlands RSA					SW RSA		North Central RSA				Spokane RSA					Gr. Columbia RSA		
Chehalis												x	x		x																
Colville																				x	x	x	x	x	x			x			
Cowlitz									x	x		x			x	x	x	x	x										x		
Hoh		x																													
Jamestown S'Klallam	x	x																													
Kalispel																										x	x				
Lower Elwha	x																														
Lummi				x																											
Makah	x																														
Muckleshoot									x	x																					
Nisqually										x		x																			
Nooksack				x																											
Port Gamble S'Klallam			x																												
Puyallup									x	x		x																			
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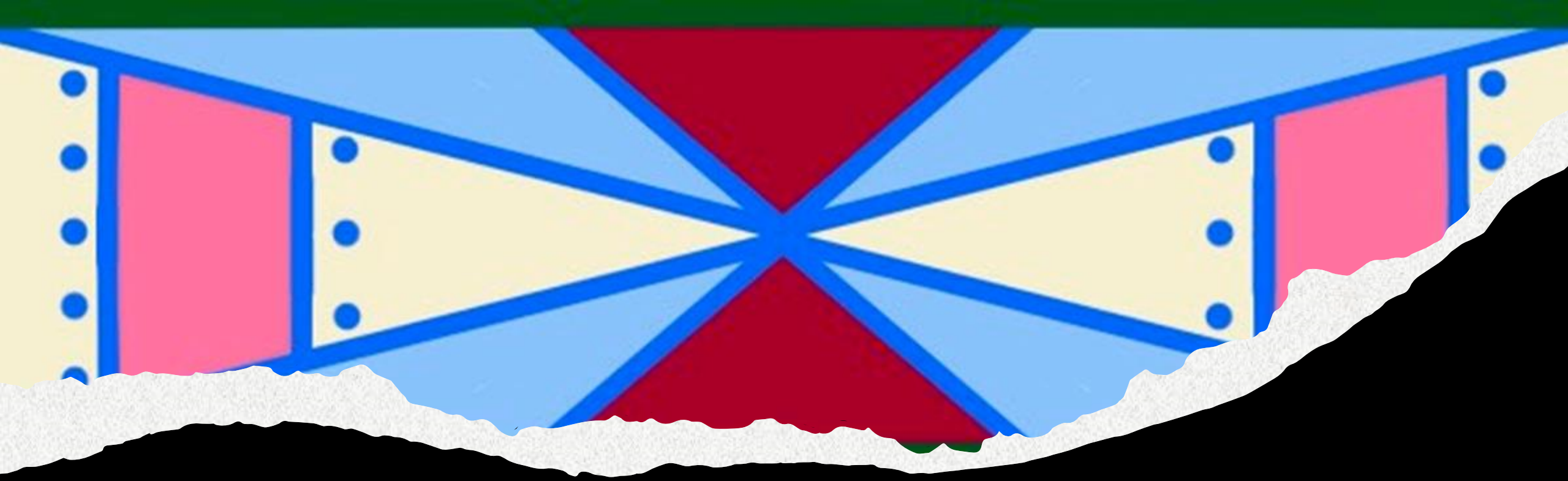
Quinault		x											x																		
Samish	x	x	x	x	x	x	x	x	x	x																					
Sauk-Suiattle							x	x																							
Shoalwater Bay														x																	
Skokomish											x																				
Snoqualmie					x			x	x	x	x																				
Spokane																								x	x			x			
Squaxin Island											x																				
Stillaguamish								x																							
Suquamish			x																												
Swinomish							x																								
Tulalip								x																							
Upper Skagit							x																								
Yakama															x				x											x	x

x = Tribal facility located in county/IHS service delivery area



American Indians and Alaska Natives

Federal Rules impacting coverage in the
Washington State Medicaid Program

Requirement to Apply for Medicaid

- Federal Regulation* requires American Indians and Alaska Natives (AI/AN) to sign up for and use alternate resources, including Medicaid, Medicare and Private Insurance before Purchased and Referred Care (PRC) funds can be used
- Under Federal Regulation, IHS/PRC is payor of last resort when an AI/AN has any other coverage- Medicaid, Medicare, Private Insurance.

42 CFR 136.61- Payor of last resort

Federal Regulations for AI/AN and Medicaid Managed Care

- The state must ensure it will not require AI/ANs to enroll in an MCO, PCCM or PCCM entity

- AI/ANs enrolled in an MCO have the right to select an Indian Health Care Provider (IHCP) for primary care**

***42 C.F.R. 438.50(d)(2)-State plan requirements**
****42 U.S.C. 1396u-2(h)(1))- Special rules with respect to Indians Enrollees, Indian Health Care Providers and Indian Managed Care**

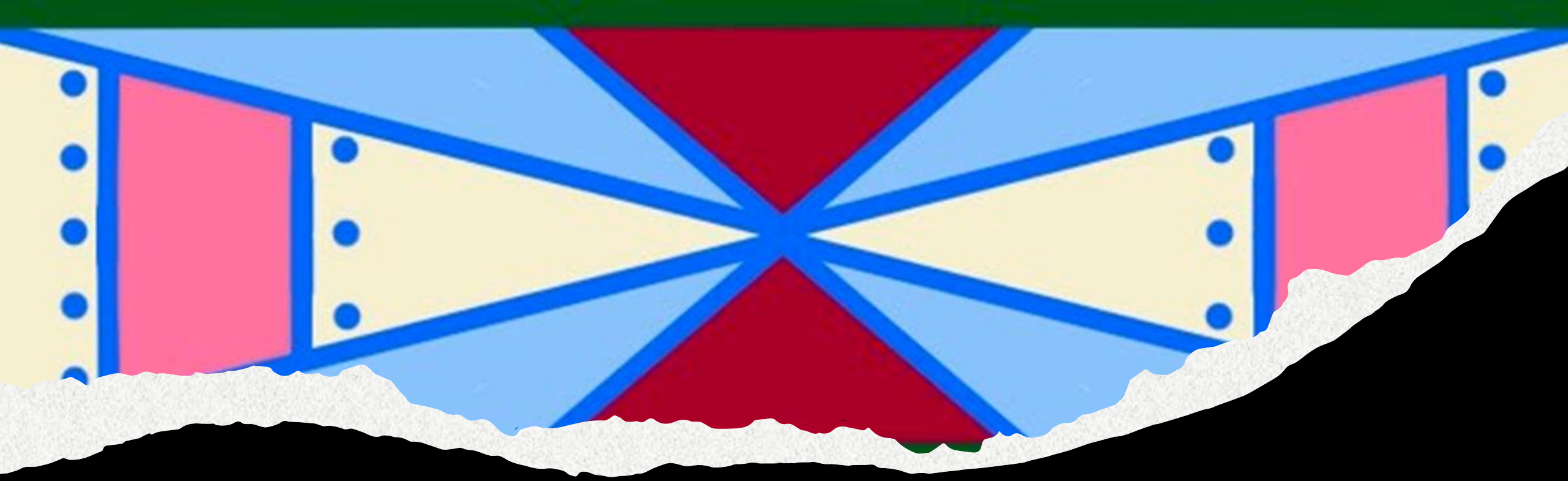
AI/AN Exemptions from Cost-Sharing

Under Federal regulations AI/ANs are exempt from:

- Medicaid premiums and cost-sharing*

- CHIP premiums and cost-sharing **

***42 C.F.R. 447.56(a)(1)(x) Limitations on premium cost sharing**
****42 C.F.R. 457.125(b) Provision of child health assistance to AI/AN children**



Federal Rules for Indian Health Care Providers

Payments, licensure and malpractice coverage

Right of Recovery

- Except as provided in subsection (f), the United States, an Indian tribe, or tribal organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges billed by the Secretary, an Indian tribe, or tribal organization in providing health services through the Service, an Indian tribe, or tribal organization, or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities, to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such charges or expenses if—

  (1)such services had been provided by a nongovernmental provider; and

  (2)such individual had been required to pay such charges or expenses and did pay such charges or expenses.

25 USC 1621(e) Reimbursement of certain third parties of costs of health services

Right of Recovery (continued)

c) Nonapplicability of other laws:

No law of any State, or of any political subdivision of a State and no provision of any contract, insurance or health maintenance organization policy, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program entered into or renewed after November 23, 1988, shall prevent or hinder the right of recovery of the United States, an Indian tribe, or tribal organization under subsection (a).

25 USC 1621(e) Reimbursement of certain third parties of costs of health services

Provider Enrollment: Licensing Exemption

- Health care professionals employed by a Tribal health program are exempt from the licensing requirements of the state in which the services are performed, provided the health care professional is licensed in any state.
  - Similar to Veteran's Administration licensing requirements under 38 U.S. Code 7402

25 U.S. Code §1621t - Licensing

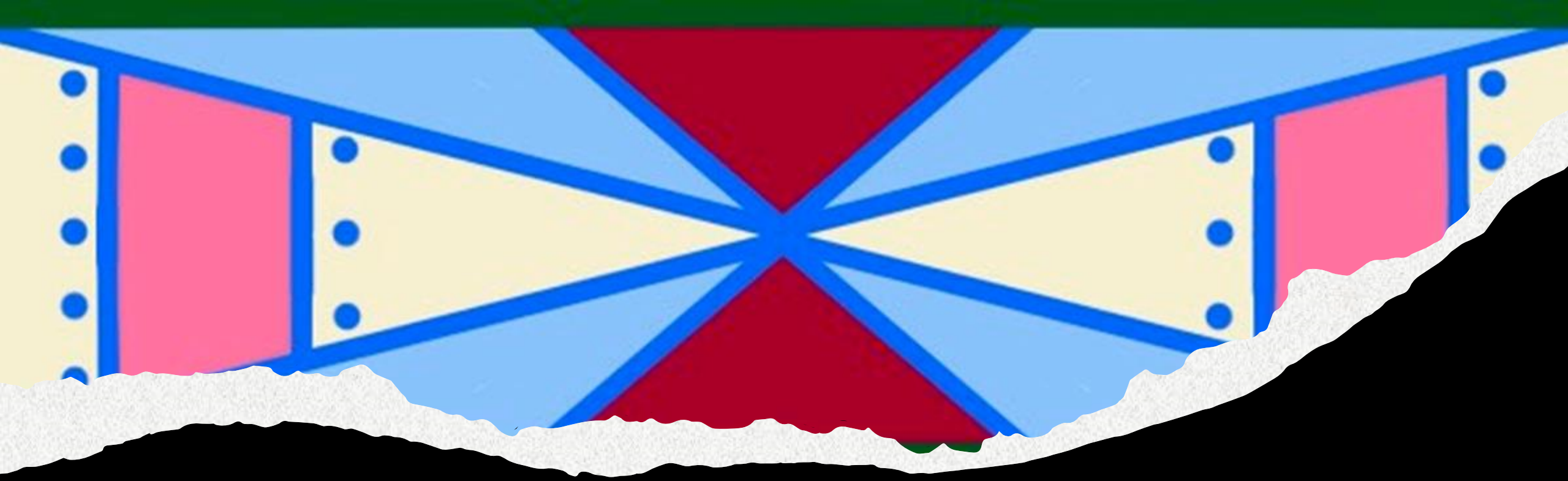
Provider Enrollment: Insurance & FTCA

- Tribal health providers are covered by the Federal Tort Claims Act (FTCA)(25 C.F.R. Part 900)
  - The federal government becomes responsible for the negligent or wrongful acts of Tribal health providers unless the claim is for:
    - On-the-job injuries which are covered by worker's compensation;
    - Breach of contract rather than a tort claim; or
    - Acts performed by employee outside the scope of employment.
  - WACs 182-502-0006, -0010, -0012, -0016 reflect this.
  - Tribal health providers are not required to obtain professional liability insurance or other insurance coverage for tort claims to the extent covered by FTCA.

HIPAA: PHI Disclosures to Tribal Governments

HIPAA (45 C.F.R. 164.512) provides that covered entities may disclose public health information (PHI), without written authorization of the individual, to a Tribe as either:

- A public health authority that is authorized by law to collect and receive such information for the purposes of preventing or controlling disease, etc., or
- A health oversight agency that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance.



Payments to Indian Health Care Providers

All Inclusive Rates and FMAP

I.H.S. All-Inclusive Encounter Rate

- Indian Health Services All-Inclusive Rate (AIR or “The Encounter Rate”) was a payment established by CMS to Direct Care facilities and Tribal 638 facilities that choose to be IHS facilities for Medicaid-covered services provided to Medicaid enrollees.
- This rate is reviewed annual and has regularly increased since implementation.
- The A.I.R. is cost based and helps offset the underfunding of I.H.S. by the Federal Government.
- Tribal Leaders continue to work at the federal level to get full funding for I.H.S., but until that happens, the AIR is critical to clinic operations for our Tribes in Washington State.

100% Federal Medical Assistance Payments

For Medicaid-covered services provided by IHS Direct facilities or Tribal 638 facilities to AI/AN Medicaid enrollees in fee-for-service, the Federal Medical Assistance Percentage (FMAP) is 100%

- For comparison:
  - Medicaid Expansion FMAP: currently 90%
  - Presumptive SSI FMAP: currently 80%
  - Classic Medicaid/Other MAGI-Based Medicaid FMAP: 50% currently

42 U.S.C. 1396d(b) Payments to States

100% FMAP Payments
Received through an I.H.S. or Tribal Facility

- In 2016, CMS established that the 100% FMAP can be extend through an I.H.S. or Tribal facility to contracted provider.

- Through this process, 100% FMAP can be extended to specialty care claims , expanding the network in the FFS program.

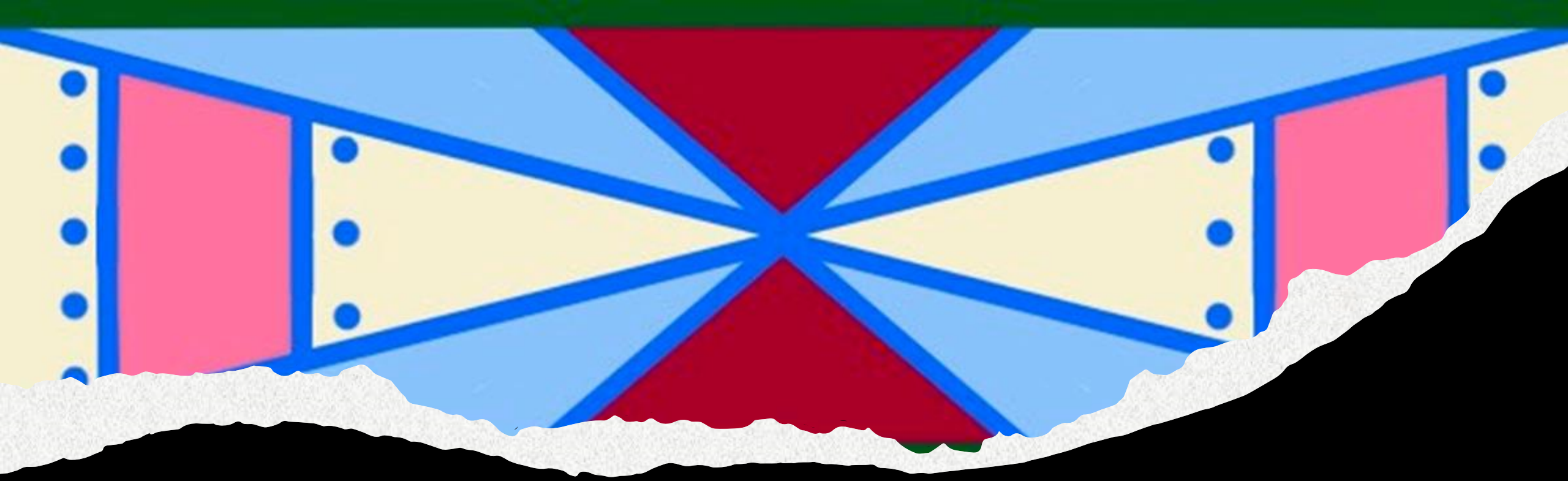
- The Tribal clinic can be paid the A.I.R and then pay the contracted provider a negotiated rate.

SHO #16-02- Federal Funding for Services “Received Through” an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives

100% FMAP Payments To Urban Indian Health Programs

- Part of the American Rescue Plan (ARP)
- 2 year pilot project
- For all claims, Indian and non-Indian patients
- UIOs working nationally to keep this is place

SHO# 21-004 RE: Temporary increases to FMAP under sections 9811, 9814, 9815, and 9821 of the ARP and administrative claiming for vaccine incentives



Impacts of Managed Care on Fee for Services Programs

Specifically for AI/AN and IHCPs

FFS in a Managed Care Environment

Washington State's has focused efforts to get Medicaid enrollees into managed care.

Managed Care Entities can pay more for services than the Medicaid Fee for Services Rates.

Many specialty providers do not to contract with the Fee for Services program.

This has caused access barriers for AI/AN patients needing care outside the Tribal clinic:

- The focus on managed care causes misunderstanding about coverage.
- Lack of providers= long wait times and travel for specialty services.

Thank you

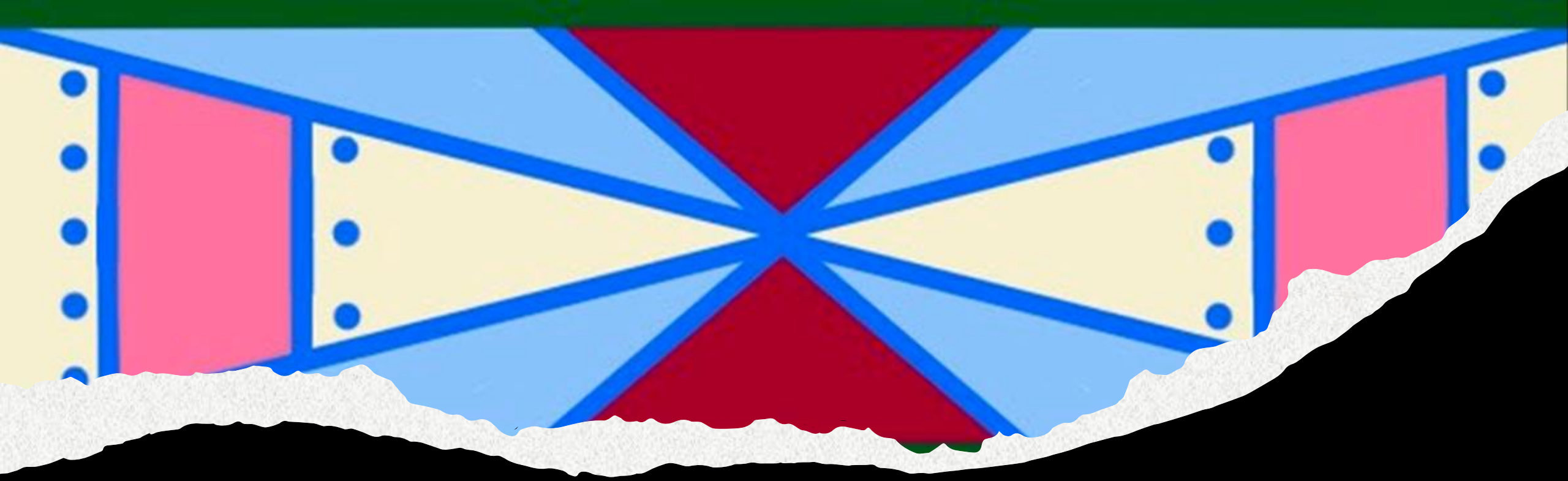
American Indian Health Commission for Washington State

Vicki Lowe

Executive Director

vicki.lowe.aihc@outlook.com

Dragonfly baskets by Bobbie Bush, Chehalis



AI/AN Maternal and Infant Health

Pre-Contact There Was Tribal Health Care

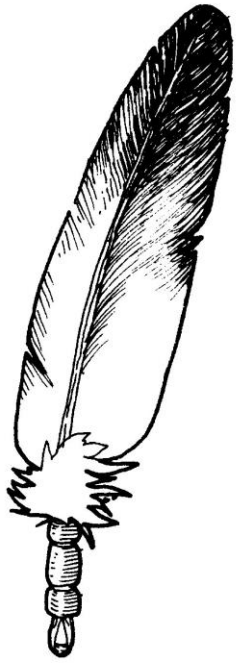
Tribes have always had their own systems of traditional medicine and health care

"Pre-contact civilizations had extensive knowledge of diseases, medicines, surgery and health promotion." (Weatherford, 1988)

"Indigenous knowledge from the Western Hemisphere has contributed much to modern Western medicine."(Weatherford, 1988)

"Traditional healing is still practiced among many AI/AN communities despite a continuing attack on several fronts, including political attempts to destroy it, demonization by Western religions viewing these practices as "savage" or even "demonic", and distortion by outsiders seeking enlightenment is a form that is virtually unrecognizable to AI/AN people."

Medicine and Ceremony, Prayer and Reverence



It begins with our relationship

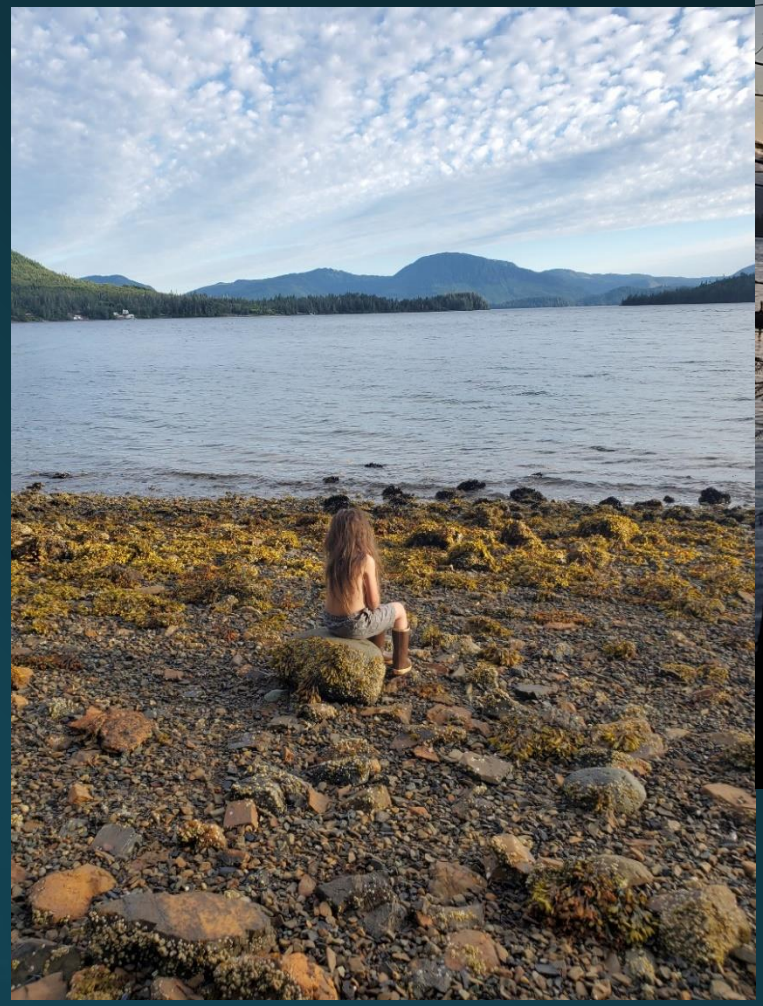
with the land

and all of our

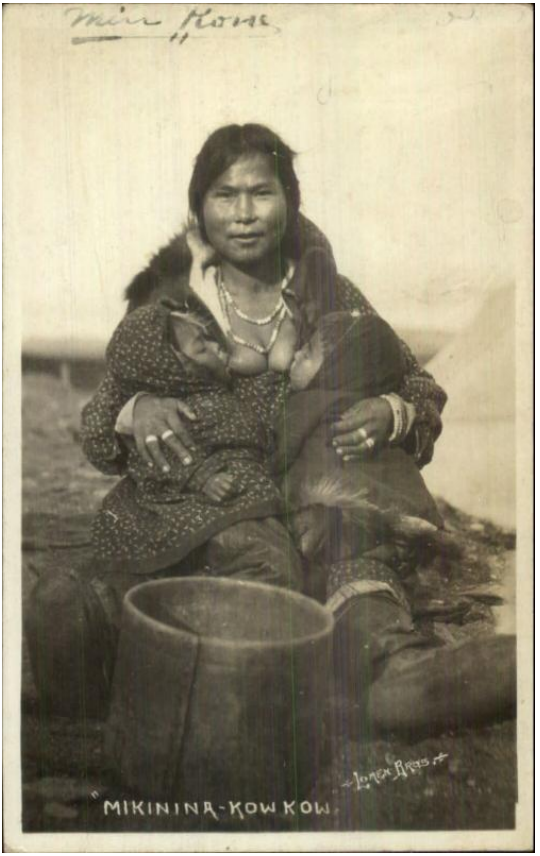
relations-

All of Mother Earth’s

children.



The Birth of a Child Means the People Will Continue



Planning Your Family

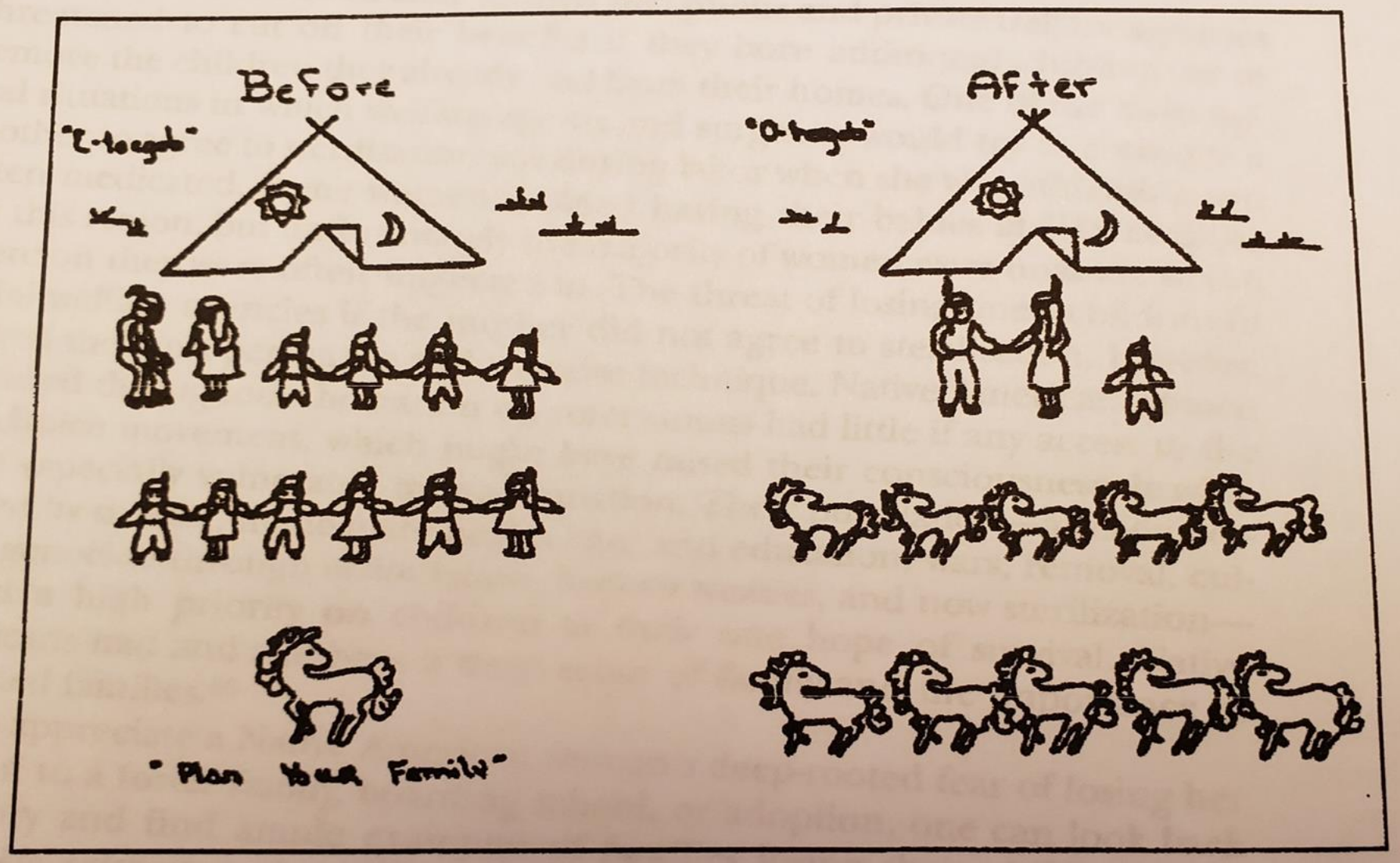


Figure 1 These illustrations are from a family planning pamphlet produced by the Department of Health, Education, and Welfare and are reprinted in *Akwasasne Notes* (1974):6 and *Caduceus* (Winter 1974).

Indian Health Service and Coerced “Womens Health”

“”American Indian women….. (are) targets of the ‘modern form’ of genocide—sterilization.” (N. Cheyenne Chief Tribal Judge Maria Sanchez, 1977)

In the 1960’s and 1970’s, Indian Health Service physicians sterilized Native women of childbearing age without clear understanding of the procedure or informed consent.

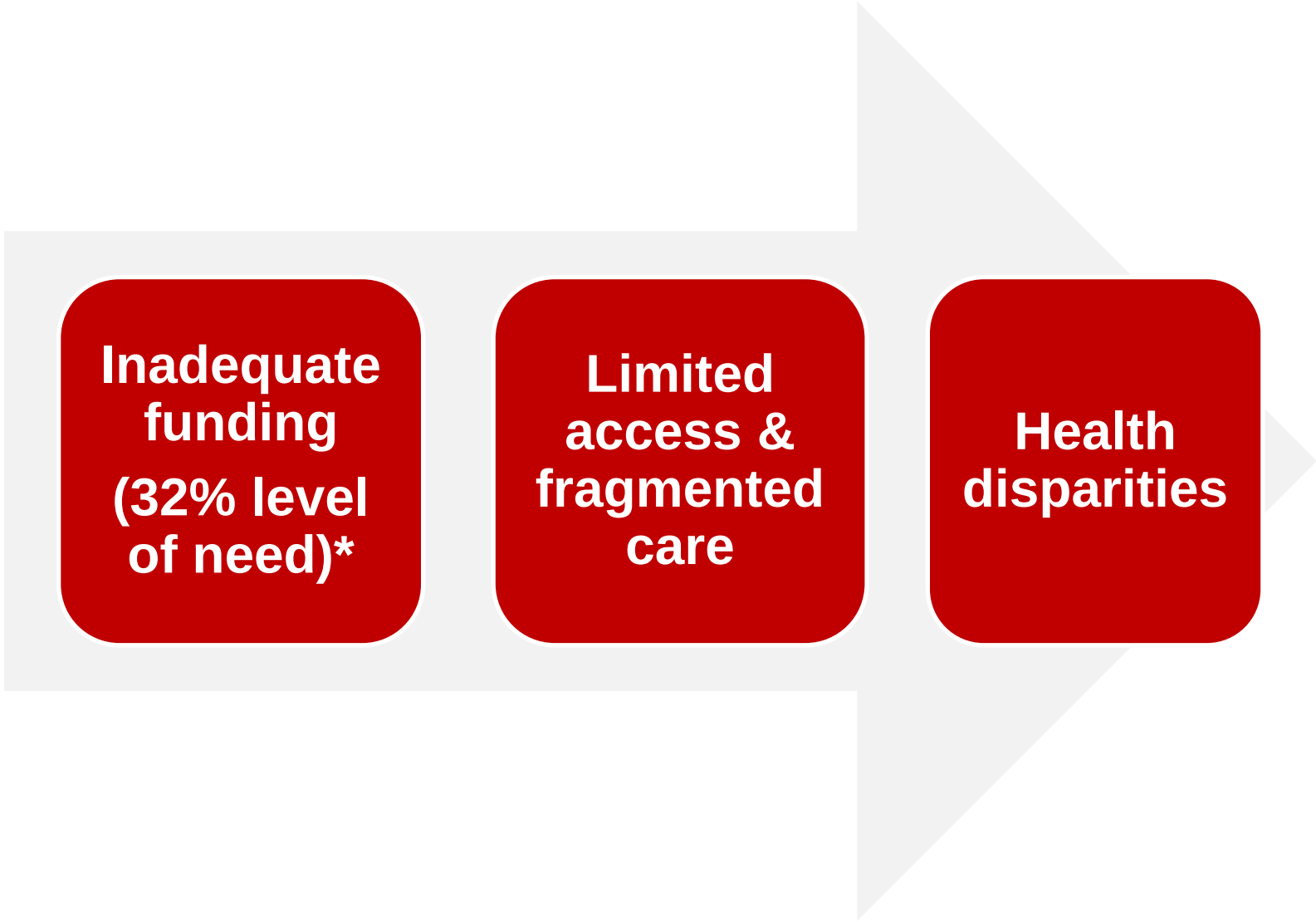
The U.S. Government Accountability Office (GAO) finds that 4 of 12 I.H.S. Areas sterilized 3406 American Indian women without their permission between 1973 to 1976.

Native American organizations and activists believe that 25 -40% of Native women of childbearing age were sterilized during this period.

This has had devastating effects on individuals, families, communities and Tribes

This also influences the lack of trust in the I.H.S. system

Effects of Underfunding of the Indian Health Service



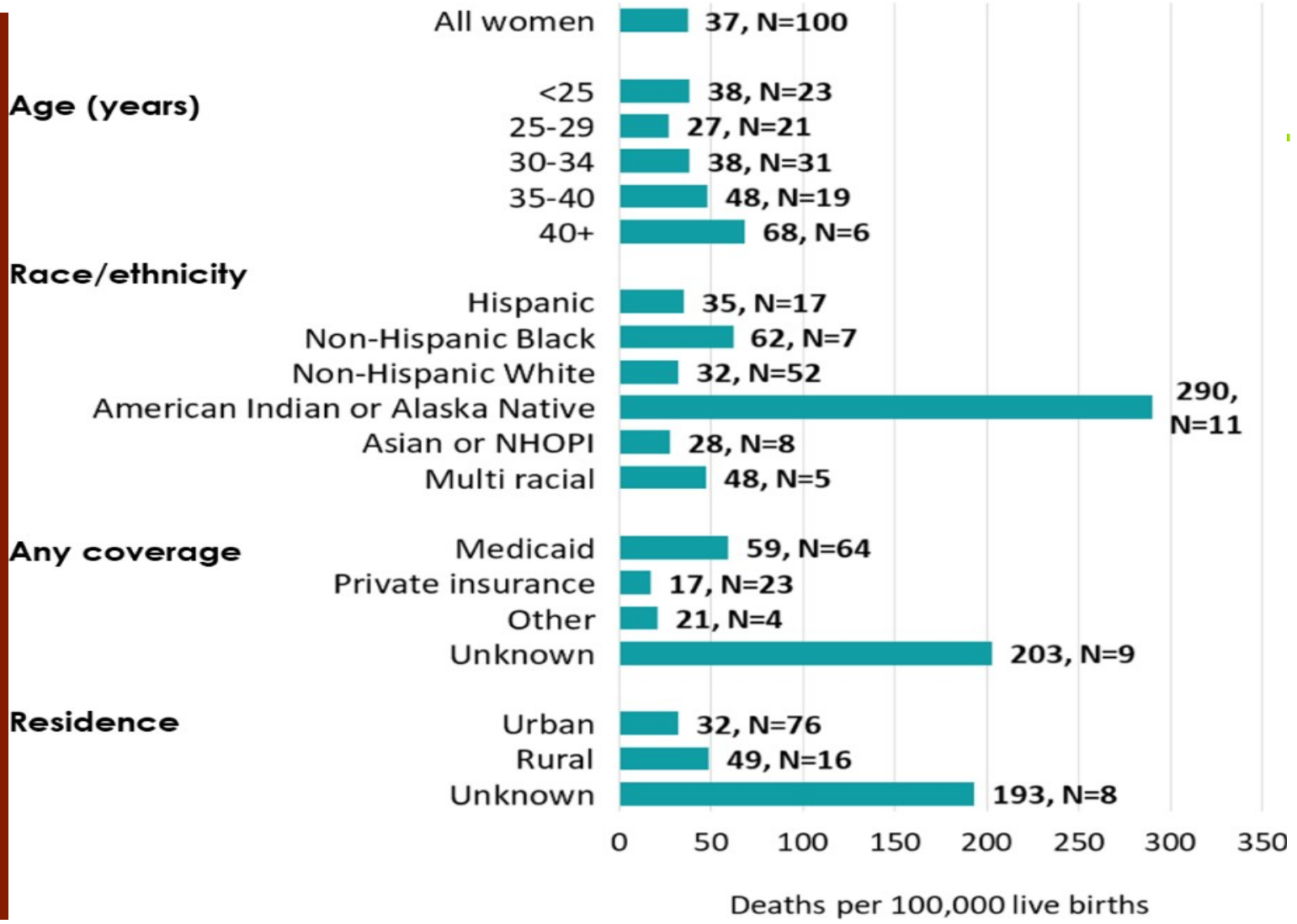
We Are Still Feeling the Effects

- Native people in the United States experience maternal mortality at a rate 4.5 times higher than their non-Hispanic white peers
- American Indian/Alaska Natives have 1.6 times the infant mortality rate as non-Hispanic whites.
- American Indian/Alaska Native babies are twice as likely as non-Hispanic white babies to die from sudden infant death syndrome (SIDS).
- American Indian/Alaska Native infants are 70 percent more likely than non-Hispanic white infants to die from accidental deaths before the age of one year.
- In 2014, American Indian/Alaska Native mothers were 2.5 as likely to receive late or no prenatal care as compared to non-Hispanic white mothers

American Indian/Alaska Native Rates

MMRP report examines maternal deaths between 2014 and 2016 and includes data from the previously published report. The growing understanding of the complex role that behavioral health issues play in pregnancy led the Panel to examine maternal deaths from suicide and substance overdose for this report.

https://aihc-wa.com/report-wa-state-maternal-mortality-review-panel-maternal-deaths-2014-16/



“A nation is
not conquered until the hearts of its women are on the ground.
Then its finished; no matter how brave its warriors or how strong their weapons.”

Cheyenne proverb

Gunalcheesh,
Thank you

Cindy Gamble,
Tribal Community Health Consultant
American Indian Health Commission

AIHC Tribal and Urban Indian Health Immunization Coalition

MONITORING VACCINE AND INFECTIOUS DISEASE ISSUES WITH TUIHIC MEMBERS AND COLLABORATING WITH PARTNERS, SERVING AS A TRUSTED SOURCE OF INFORMATION SHARING

JanMarie Ward (*Chumash*) is a lineal descendant Santa Ynez and Barbareño, California Mission Indians. She serves as a Senior Tribal Public Health Policy and Project Advisor, AIHC, Leads the development and alignment to the Pulling Together for Wellness framework; Co-leads the development of Tribal/Urban Indian health Immunizations and the AIHC Tribal 10-year+ Continuum of immunization work addressing tribal vaccination, immunization and infectious disease; and development of lessons from Tribal-driven processes. Jan, for many years, has promoted culturally relevant models and strategic thinking rooted in health equity in a public health context. She also serves on multiple boards and committees to address systemic racism and historic inequities in support of community-driven capacity building in health and wellness systems change for American Indian and Alaska Native and BIPOC communities.

Wendy Stevens, MNPL, MSS serves the American Indian Health Commission in support of tribal immunizations and health, Co-leads the AIHC Tribal Urban Indian Health Immunization Coalition, and the development of the AIHC TUIHIC, and the AIHC Tribal 10-year Continuum immunization work addressing tribal vaccine and immunization and emergency preparedness work addressing systemic disparities and equity in access to services. Wendy has served TUIHIC by identifying and provide expertise in key topic areas in response to COVID-19 related to immunizations systems and practice, vaccines hesitancy, and building community confidence.

aihc
AMERICAN INDIAN HEALTH COMMISSION FOR WASHINGTON STATE

PULLING TOGETHER FOR WELLNESS

FOR THE HEALTH OF INDIGENOUS PEOPLE TODAY, TOMORROW, AND INTO THE FUTURE

STRENGTHENING TRIBAL SOVEREIGNTY THROUGH TRIBALLY-DRIVEN SOLUTIONS

Tribal and Urban Indian Health Immunization Coalition

PTW Model Establishing Continuity through Seven Generations Strategic Planning

The TUIHIC coalition is a network of dedicated partners and community members, health care providers, elders, and tribal leaders working together to increase immunization rates and prevent infectious disease.

PURPOSE: To improve American Indian / Alaska Native immunizations and vaccine access, surveillance, practices, infectious disease prevention and health literacy

Tribally-Driven Prevention & Support for Immunizations and Infectious Disease

- Tribally-Driven Strategic Planning
- Network of Partners
- Historical and Cultural Context
- Based on a continuum of over a decade of Immunizations work

IMMUNIZATION COALITIONS
SERVE A KEY ROLE IN THE FIGHT AGAINST INFECTIOUS DISEASE

After we controlled for Latino ethnicity and Medicaid, we found that children enrolled in the program were 53% more likely to be up-to-date (adjusted odds ratio = 1.53; 95% confidence interval = 1.33, 1.75) and to receive timely immunizations than were children in the control group (t = 3.91). **The coalition-led, community-based immunization program was effective in improving on-time childhood immunization coverage**. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636428/

"Coalition development is a major strategy to increase immunization rates." *"However, **if local and state coalitions are to succeed, their staffs need training and technical assistance in coalition development, community planning, and program implementation**."* https://pubmed.ncbi.nlm.nih.gov/10187081/

PULLING TOGETHER FOR WELLNESS

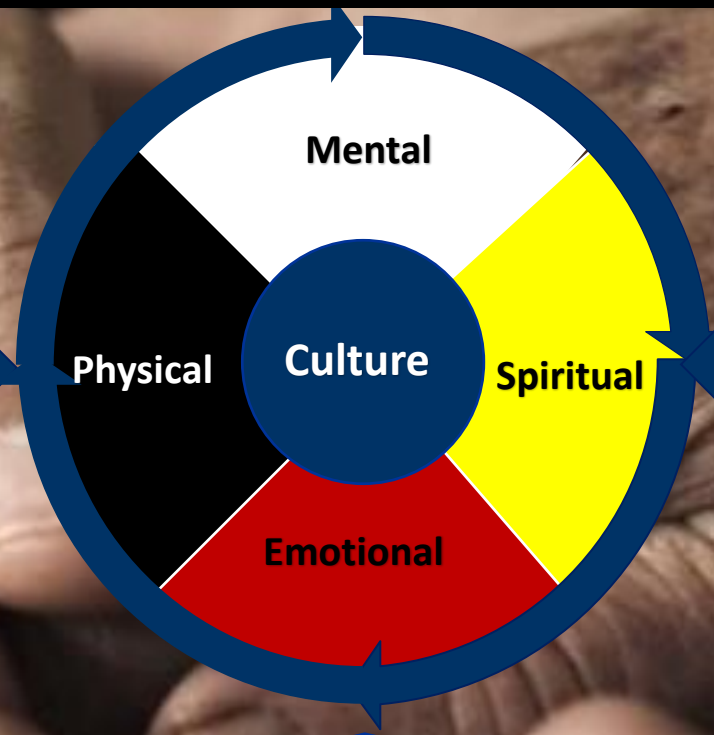
Pulling Together for Wellness - A Tribally-driven Framework

ADDRESSING IMMUNIZATIONS THROUGH AN EQUITY LENS

AMERICAN INDIAN AND ALASKA NATIVE HISTORICAL INEQUITIES

Components of the PTW framework:

- Mobilizing at the Tribal/Community Level
- Leadership and Community Engagement
- Recruit and Retain Partners
- Specific Outreach to Youth and Elders
- Engagement of Cultural Resources and Traditional Healers
- Inclusion of Cultural Consideration in the Planning Process
- Use of Storytelling – Balance of Data and Stories
- 7 Generation Strategies – Strength-based
- Integrates Trauma Informed Strategies



Tools of the PTW Framework:

- Definition, Vision and Values of the PTW Framework
- Partnership Development Inventory and Process
- Community Health Assessments and Environmental Scans
- Inventory of Cultural Appropriate Strategies
- Matrix: Vision, Goals, Indicators, Strategies (including PSE, EB, PB, PP)
- 21 Competence Domains (knowledge, skills, and abilities)

Generational Clarity

H E A L

Historical and Intergenerational Trauma effect

Equity, Health Disparities and Social Justice (Social Determinants of Health)

Adverse Childhood Experiences (NEAR)

Lateral Violence and Oppression, on-going Discrimination, and Racism

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AIHC Tribal/Urban Indian Health Immunization Coalition

TUIHIC'S ROLE TO ADDRESS INFECTIOUS DISEASE

Provides Continuity In Support Of Tribal And Urban Indian Health Immunization Systems

FOCUSED WORKGROUP CONTENT AREAS

- Cross Borders Issues
- Engagement: Youth, Elders, Family, and Community
- Technology/Research/Data
- Healthcare Workers (Workforce Development, etc.)
- Childhood Immunization/School Requirements
- Vaccine Confidence/Hesitancy

PULLING TOGETHER FOR WELLNESS

AIHC Tribal and Urban Indian Health Immunization Coalition

MONITORING VACCINE AND INFECTIOUS DISEASE ISSUES WITH TUIHIC MEMBERS AND COLLABORATING WITH PARTNERS, SERVING AS A TRUSTED SOURCE OF INFORMATION SHARING

TUIHIC's role in Addressing Infectious Disease

- Provides **continuity in support of Tribal and Urban Indian health immunization systems** to increase immunization rates and prevent infectious disease.
- **Helps stop the spread of Infectious Disease**, including COVID-19 by
  - **Increasing equitable access to the vaccines** by addressing barriers.
  - **Building confidence in the vaccines and vaccination systems**.
  - **Providing credible information via trusted messengers**.
- Develops **tribally-driven strategies to address vaccine hesitancy** and long-term barriers, including for COVID-19 vaccination.
- Provides vaccine **technical assistance, trainings, materials, fact sheets, and messages.**
- Convenes regularly **TUIHIC quarterly and special workgroup/task force meetings.** Holds an annual meeting.
- Builds and enhances **trusted partnerships to share scientifically accurate data and information through culturally relevant communication to increase vaccine health literacy.**

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COVID-19 Impact Indian Country

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country, with infection rates over *3.5 times higher* than non-Hispanic whites. In addition, AI/AN individuals are over four times more likely to be hospitalized as a result of COVID-19. (reference year 2020 https://www.cdc.gov/mmwr/volumes/69/wr/mm6934e1.htm)

In addition to many public health measures in place, such as social distancing, mandatory curfews and closures, mask wearing and handwashing, *COVID-19 vaccination remains the most promising intervention to further reduce disease, morbidity, and mortality in AI/AN people.* **IHS COVID-19 Vaccine Draft Plan; 2 Version 1, October 2020**

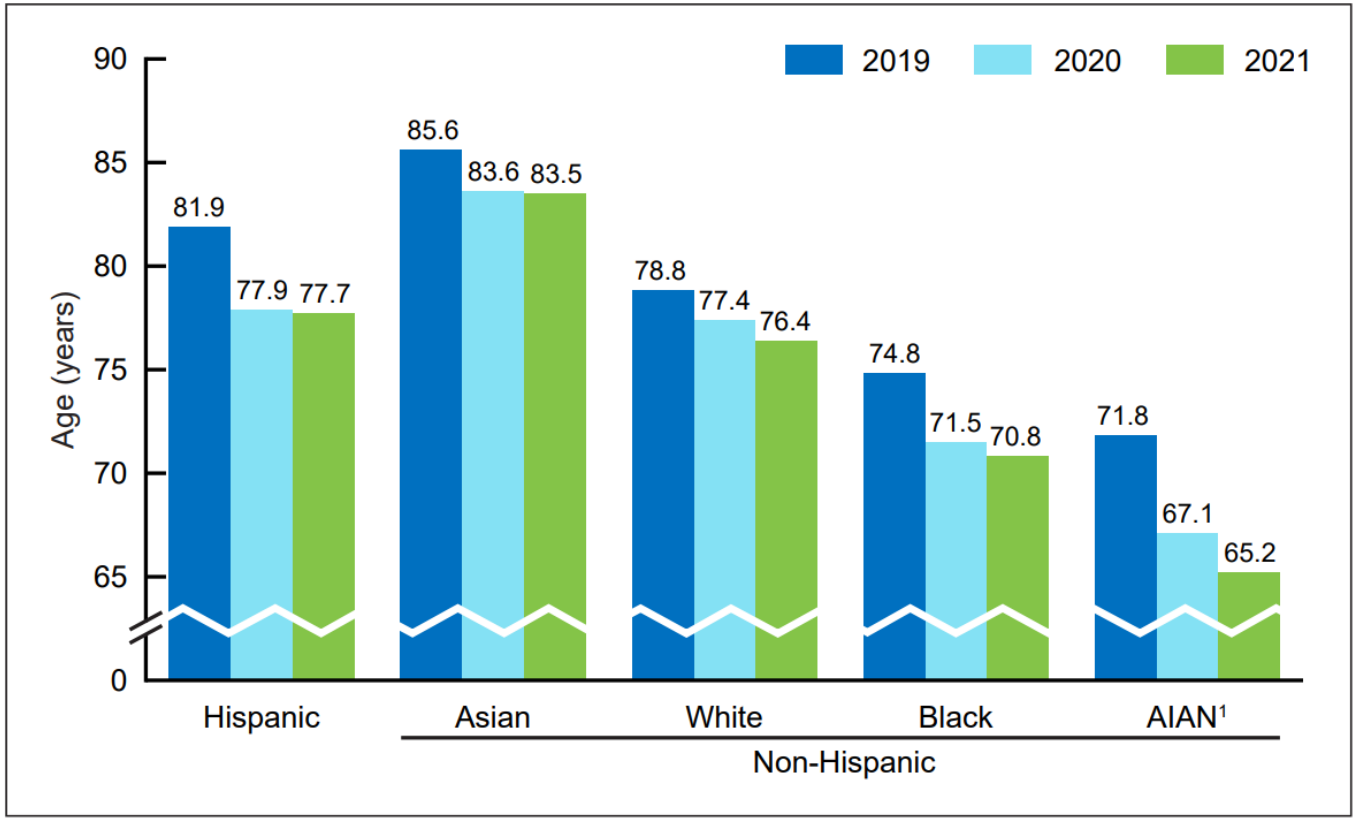
COVID-19 Among American Indian and Alaska Native Persons — 23 States, January 31–July 3, 2020 Weekly / August 28, 2020 / 69(34);1166–1169
https://www.cdc.gov/mmwr/volumes/69/wr/mm6934e1.htm 2 Hospitalization rates per 100,000 population by age and race and ethnicity — COVID-NET, March 1, 2020–September 5, 2020.
https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html

TUIHIC'S ROLE TO ADDRESS INFECTIOUS DISEASE

Provides technical assistance, trainings, materials, fact sheets, and messages

The non-Hispanic AIAN population experienced the largest decline in life expectancy, from 67.1 in 2020 to 65.2 years in 2021, the same life expectancy of the total U.S. population in 1944 (8

Figure 2. Life expectancy at birth, by Hispanic origin and race: United States, 2019–2021



[1]American Indian or Alaska Native.
NOTES: Estimates are based on provisional data for 2021. Provisional data are subject to change as additional data are received. Estimates for 2019 and 2020 are based on final data. Life tables by race and Hispanic origin are based on death rates that have been adjusted for race and Hispanic-origin misclassification on death certificates; see Technical Notes in this report.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

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TUIHIC'S ROLE TO ADDRESS INFECTIOUS DISEASE

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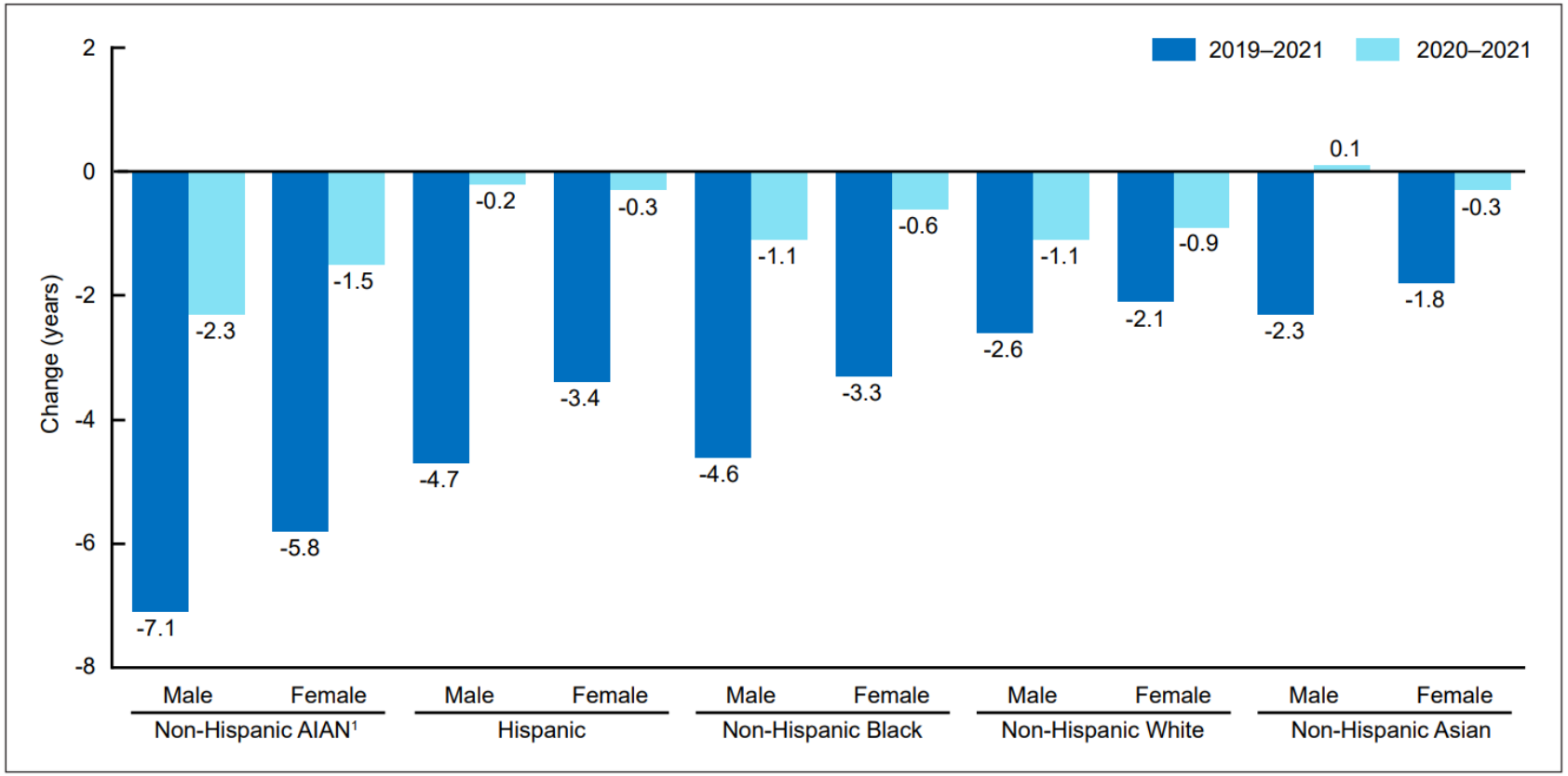
Figure 3. Change in life expectancy at birth, by Hispanic origin and race: United States, 2019–2021 and 2020–2021



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SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

Tribal/Urban Indian Health Immunization Coalition

OFFICIAL TRIBAL AND URBAN INDIAN VACCINATION RECORD CARDS

- Tribes are sovereign nations and identified that their own legitimate AI/AN Tribal & Urban Vaccination Record Cards to identify Covid-19 vaccination status. Currently only the Centers for Disease Control CDC white paper card is the approved formal proof accepted by Federal, State and other entities in the United States. Tribes have the sovereign authority to produce their own vaccination record card.
- Tribes have separate tribal enrollment cards for their citizens. A Tribal Vaccination Record Card is being developed in current pilot projects to support tribal public health system improvements for Tribes and other areas of Tribal public health.

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Tribal and Urban Indian Health Immunizaion Coalition

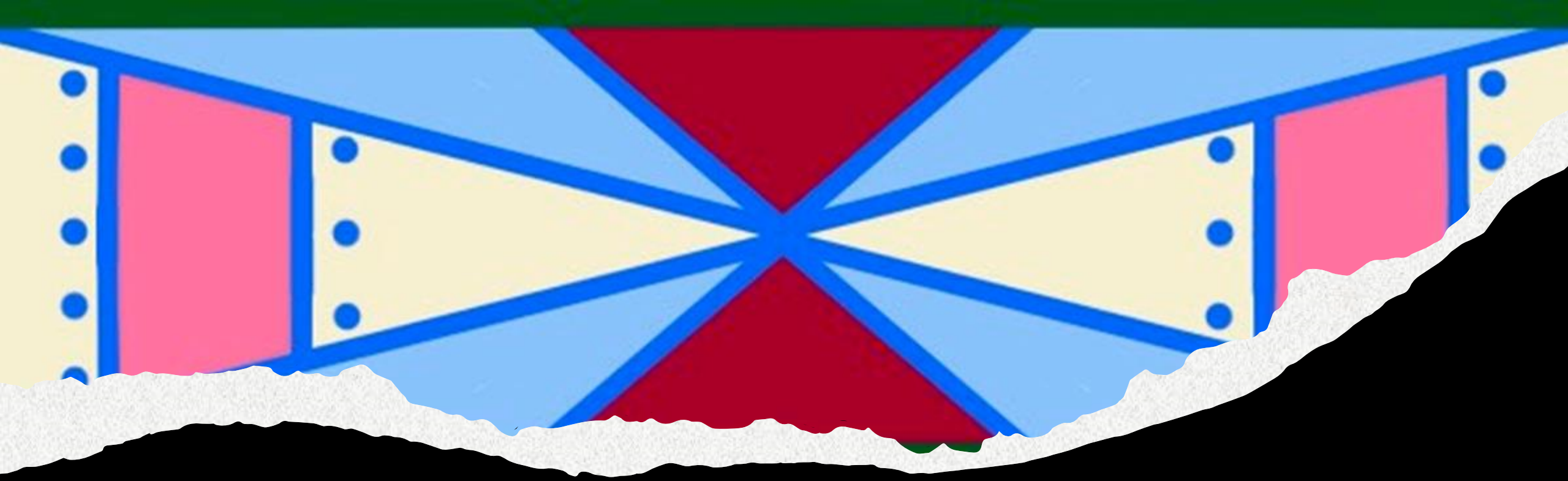
SAVE THE DATE
ANNUAL MEETING
11-16-22 – TUIHIC ANNUAL Meeting
Notice and Meeting Invitation will go out soon.

VISIT OUR FACEBOOK PAGE
https://www.facebook.com/pullingtogetherforwellness/

Immunization Materials are available online on the AIHC TUIHIC's webpage:
https://aihc-wa.com/pulling-together-for-wellness/immunizations/
If you need assistance, contact Ashley at ashleyolmstead91@gmail.com

THANK YOU,
AIHC TUIHIC TEAM
JanMarie Ward, janolmstead@gmail.com
Wendy Stevens, ws.aihc@gmail.com
Ashley Olmstead, ashleyolmstead91@gmail.com

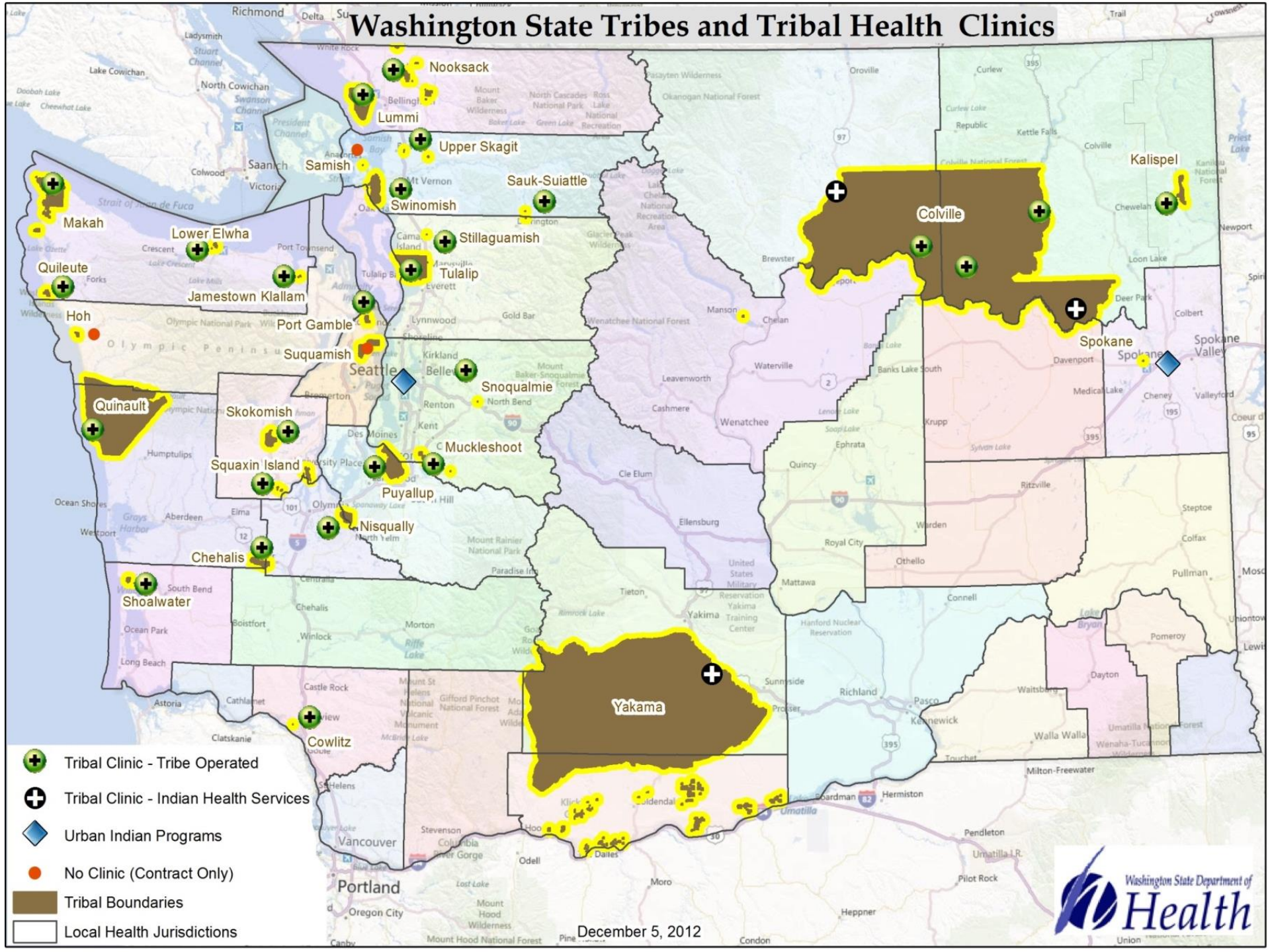
PULLING TOGETHER FOR WELLNESS 60



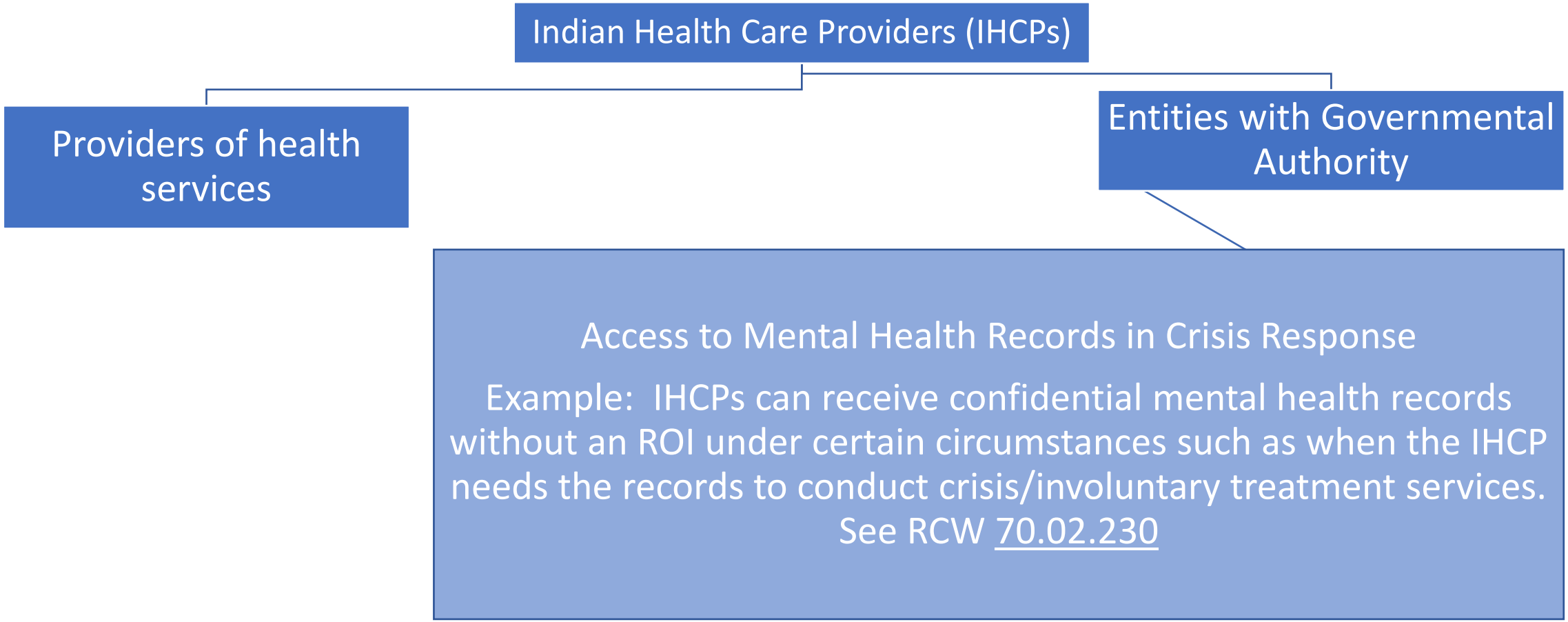
Tribal BH System Aspects

Integration and BH Crisis Response

Washington State Tribes and Tribal Health Clinics



Dual Role of Indian Health Care Providers in Behavioral Health



In 2020, the Washington Indian Health Improvement Act, SB 6259, added Indian health care providers to the list of qualified professional persons who are allowed to receive confidential mental health records under certain circumstances.

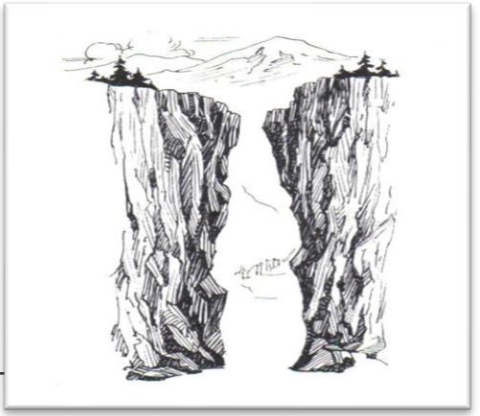
History of Tribal Efforts to Improve Access

When it come to mental health crisis services, Washington State and the behavioral health system have treated Tribes as providers instead of governments. The managed care system often conflicts with federal laws on tribal sovereignty and the federal trust responsibility. Failure to recognize Tribes as governments and to comply with state and federal laws results in delay in or lack of AI/AN access to behavioral health services.

The 2013 Tribal Centric Behavioral Health report to the legislator addressed the failures of managed care in Indian country and identified key strategies to improve the coordination between Tribes and the (then) Mental Health Crisis system in our state. However, by 2016, these strategies had yet to be implemented. Instead, the State was applying for a Medicaid Waiver to incorporate substance use disorder services into a system that Tribal Leaders said was not working for the AI/AN population in Washington State. Tribes fought to ensure that AI/AN would be exempt from the Medicaid managed care system.

View the 2013 Tribal Centric Behavioral Health Report here: GetPDF (wa.gov)

Gap Examples



- RSN, BHOs and now BH/ASOs are not clear on how to work with FFS patients and Indian Health Care Providers
- Non-Tribal Providers often consider the FFS program as “not having coverage.” This common misclassification is significant since 60% of AI/AN population enrolled in Medicaid are in the Fee for Services Program
- Lack of access to voluntary in-patient treatment impacts the ability to help those in crisis
- Tribes and Indian Health Care Providers are not directly funded to provide crisis care

Why is this so Important?

Washington State Statistics

- Between 2001 and 2016, the rate of suicide mortality for AI/AN in Washington State increased by 58%.
- Recent data on emergency room visits for AI/AN with Suicide Attempt in Washington report 400 suicide attempts between 12/22/2019-1/23/2021.*
- During the COVID-19 pandemic, AI/AN suicide related emergency department visits increased by 23%.*
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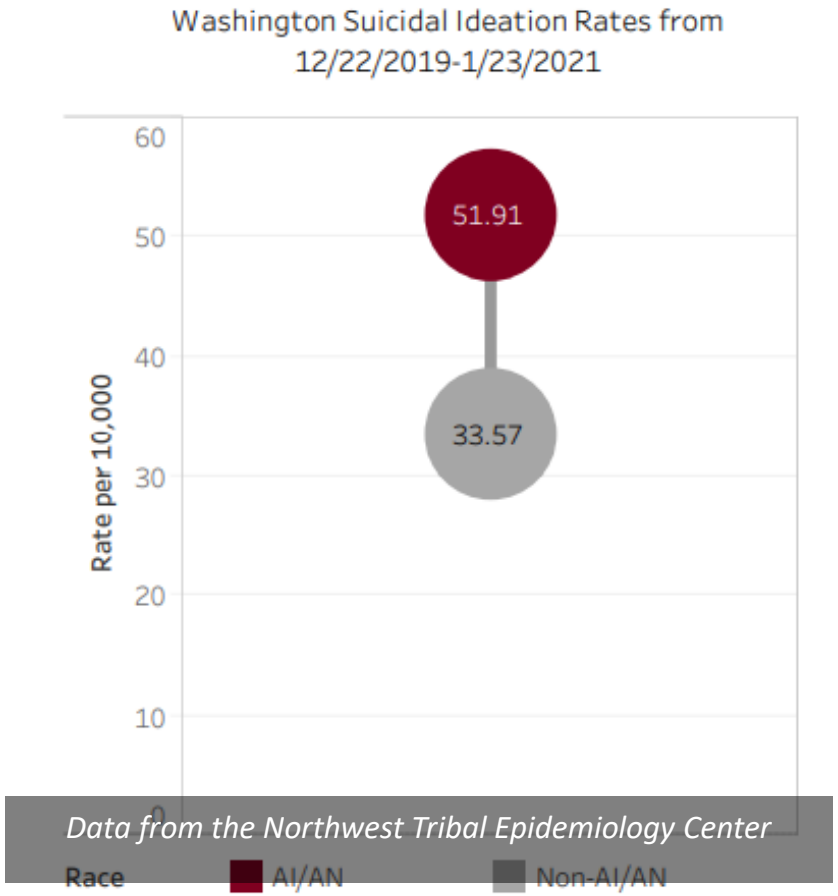
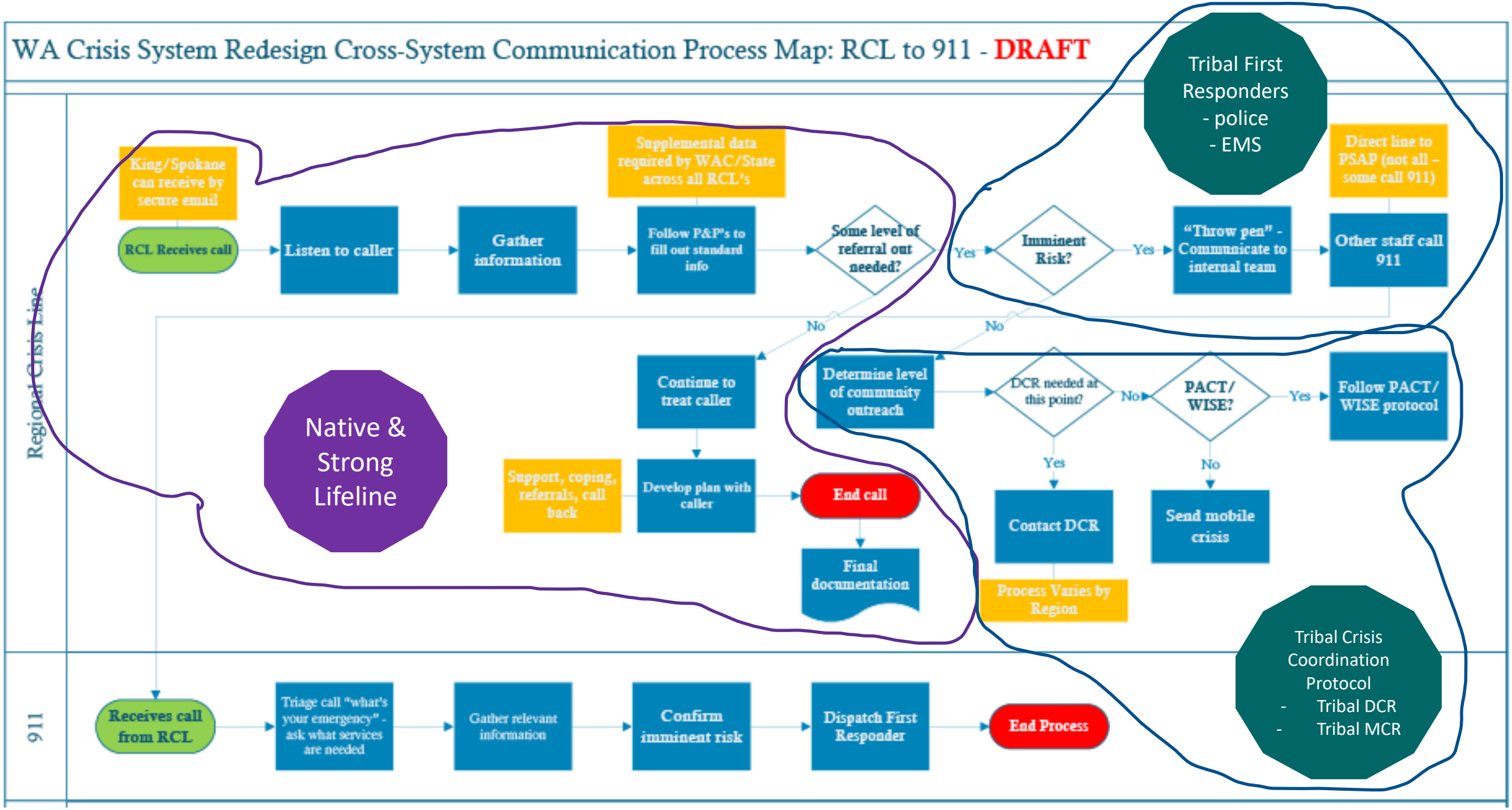


Tribal BH Crisis Response Activities

- Tribal Centric Behavioral Health Advisory Board
- State legislation changes – Washington Indian BH Act
- Trainings – DCR Academy, Forensic Navigators, BH Providers
- Tribal BH Code development
- Washington Indian Behavioral Health Crisis Hub
- Native and Strong Lifeline (Tribal 988)
- DCR Planning Meetings
- Crisis Response Planning
- DCR implementation WACs
- Information gathering with attorneys, judges, evaluation and treatment facilities, plus
- Sustainability planning

WA Crisis System Redesign Cross-System Communication Process Map: RCL to 911 - DRAFT



Thank you

American Indian Health Commission for Washington State

Kathryn Akeah

Tribal Health Consultant

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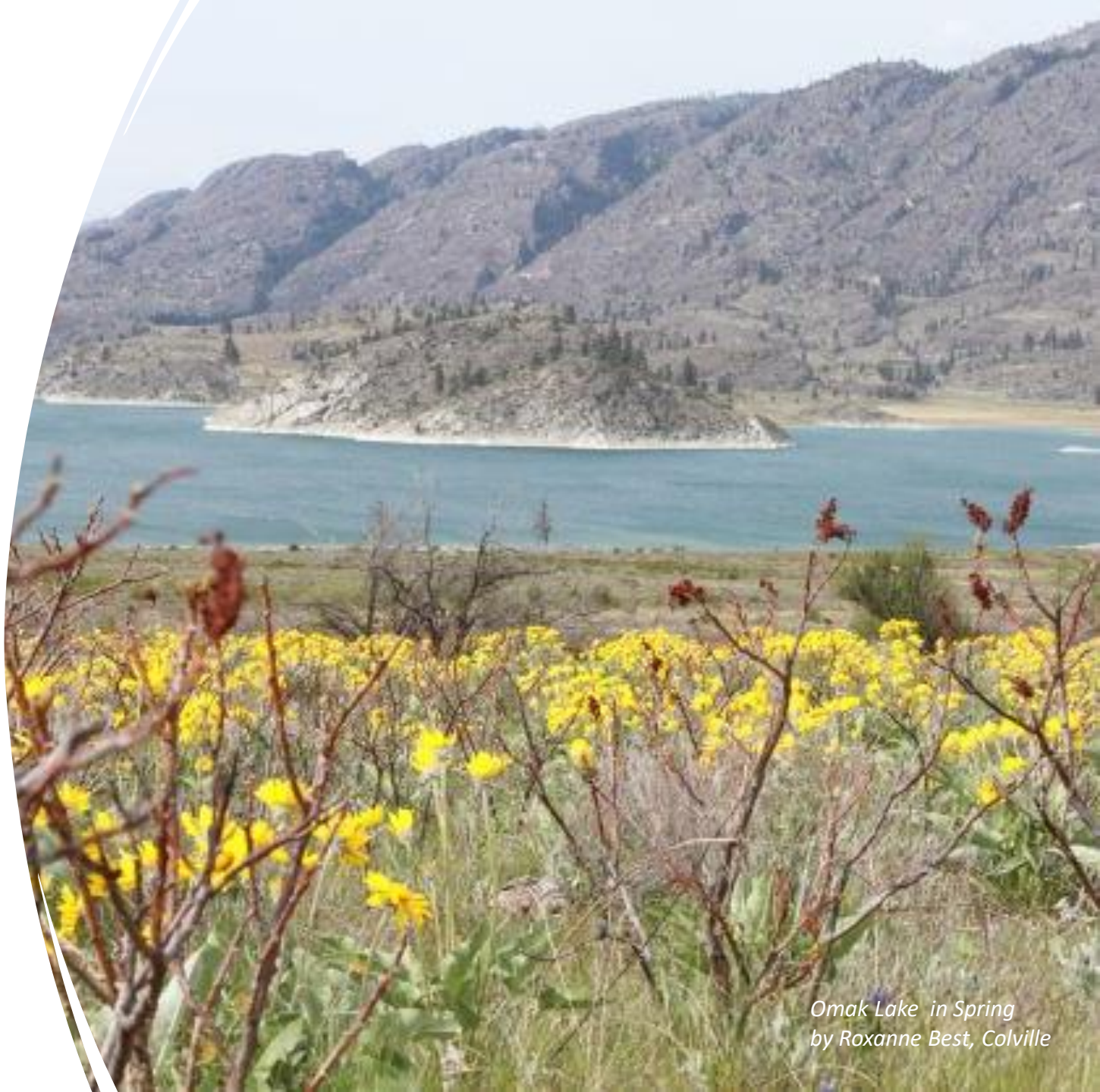

Omak Lake in Spring
by Roxanne Best, Colville