MEDICAID TRANSFORMATION PROJECT
INDIAN HEALTH CARE PROVIDER PLANNING FUNDS PLAN
WASHINGTON STATE
DECEMBER 2017

INTRODUCTION

Medicaid Transformation for Indian Health Care Providers in Washington State

Tribal governments have a paramount commitment to improve and protect the health and safety of their communities. Over the years, Tribes have demonstrated great expertise in designing, implementing and managing a broad array of health and social services to address their communities' needs with minimum funds. Tribes have built the capacity and performed many of the functions now assigned to Accountable Communities of Health (ACH). With appropriate funding, Tribes are uniquely poised to successfully implement Medicaid transformation strategies. A direct investment in Washington State's Indian Health Care Delivery System will result in the greatest cost efficiencies and measurable improvements in health outcomes.

Over 20 years ago, the Tribes and two Urban Indian Health Programs (UIHPs) in Washington State created a tribally driven organization to address statewide health issues for AI/AN: the American Indian Health Commission for Washington State (AIHC). Through the AIHC, over the past two years, the Tribes and UIHPs have worked to address the impacts of Medicaid Transformation on programs and services at each local Tribe and UIHP. Within every region, each local Tribe and UIHP were invited to engage with the newly-created Accountable Community of Health (ACH), as an opportunity for each entity to learn more about the others. These meetings highlighted that there exists much capacity and expertise within the Tribes and UIHPs to address health disparities for AI/AN. As newly created entities, ACHs have yet to build this capacity and they may never reach the cultural competencies required to effectively improve population health for AI/AN.

In recognition of the Tribes' and IHCPs' expertise and the government to government relationship, the Medicaid Transformation Project supports the Tribes', IHS facilities', and UIHPs' planning efforts by allocating a total of $5,400,000 of Demonstration Year One incentive payment funds to support the planning and various infrastructure investments related to IHCP-specific projects. This plan outlines how working directly with the Indian Health Care Providers (IHCPs) – the Tribes, UIHP, and Indian Health Service (IHS) clinics – in Washington State can achieve improved population health.

Target Population

In July of 2016, the US Census Bureau estimated 249,764 AI/ANs residing in Washington State. Many feel this number does not accurately reflect the number of AI/ANs in Washington State, especially those receiving healthcare from Indian Health Care Providers. As of November 2017, the Washington State Health Care Authority (HCA) shows 66,190 AI/ANs enrolled in Washington's Medicaid.

American Indian/Alaska Native populations are disproportionally affected by diseases, such as cancer, heart disease, tooth decay, and diabetes. In Washington State, AI/ANs experience the highest age-adjusted death rates when compared to other racial and ethnic groups.[i] This underlines the need for appropriate funding to address health disparities for the AI/AN population and supports the need to implement tribally driven practices to effectively resolve them. Addressing the population with the highest health disparities will have the biggest impact on improving overall population health in our state - a critical goal in implementing Medicaid transformation.

In Washington, the Tribes, UIHPs and IHS clinics have developed a mature health care delivery system to provide care for AI/AN. Despite the high level of expertise and capacity, this system is constrained by chronic underfunding and lack of flexibility to provide care in the way IHCPs know will truly address health disparities. The Medicaid Transformation Project provides a singular opportunity to enhance the Indian Health delivery system, allowing it to operate at higher levels of efficacy and efficiency.

Washington State Indian Health Care System Overview

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 healthcare 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 for 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.

There are twenty-nine federally recognized Tribes and two Urban Indian Health Programs (UIHPs) in Washington State, with 37 clinics. Four are operated by the Indian Health Service, 31 are operated by Tribes and two UIHP serve the major metropolitan areas of Seattle and Spokane. (For a map of clinics see Appendix A).

Specialty care that cannot be provided within Tribal clinics is purchased from private health care providers in nearby communities. Each Tribe receives a fixed annual amount of Purchased and Referred Care (PRC) funding, which is based on the number of eligible users, the availability of direct care services, and other historical factors. Funding for PRC has never been adequate to provide all needed services. Tribes use a priority system to determine what care is purchased for eligible AI/ANs and what care is deferred until additional funding is available or, at times, until the medical condition escalates to risk loss of life or limb.

Federal policy dictates that Indian Health Service is 'a payor of last resort.' If an AI/AN requires care outside the Indian Health Care Delivery System and is eligible for Medicaid, Medicare, private insurance, or if there is any other payor, they must sign up for and use that coverage before the Indian health program is obligated to pay out PRC funds. Each Tribal health program and each clinic is unique.

Washington State Tribes have become notably successful in generating revenue through third-party collections. This 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 the state federal Medicaid program. The stability of this revenue-generating source is vital to clinic operations. Any reduction in this source of funding would result in cuts to basic Tribal health services; planning an innovation happen as a response to lack of funds. Tribes and the American Indian Health Commission work with the state Medicaid office (Washington State Health Care Authority) to identify and implement improvements to the Medicaid system for AI/AN access and Tribal provider reimbursement.

I. STATEWIDE INVENTORY OF INDIAN HEALTH AND HEALTH CARE

A. INVENTORY: HEALTH NEEDS OF AI/ANS

About AI/AN Data in Washington State

Data cited below is from the Northwest Portland Area Indian Health Board's (NPAIHB) 2014 Washington State Report, accessible at www.npaihb.org/idea-nw/.

IHCPs do not have access to data that have a high degree of accuracy, are specific to their community, and are timely. These are essential to understanding population health needs, making informed decisions, and monitoring the efficacy of interventions – the pillars to data sovereignty.

Most data available in Washington regarding the health status of AI/ANs are from State systems. Examples of these include the State's cancer registry, hospital discharge data, etc. These secondary data sources are known to have a high degree of racial misclassification for AI/AN, resulting in an undercount.

Data linkage projects like the Northwest Tribal Epidemiology Center's (NWTEC) Northwest Tribal Registry Project help to improve the quality of available data. Data provided by the NWTEC, may not match the State generated data because NWTEC data is obtained by probabilistic linkages with known registries of AI/AN people and State data sets. Unlike Washington State, which counts only individuals who self-identify as AI/AN-only, NWTEC uses counts that include individuals who report as one or more races with AI/AN.

Mortality

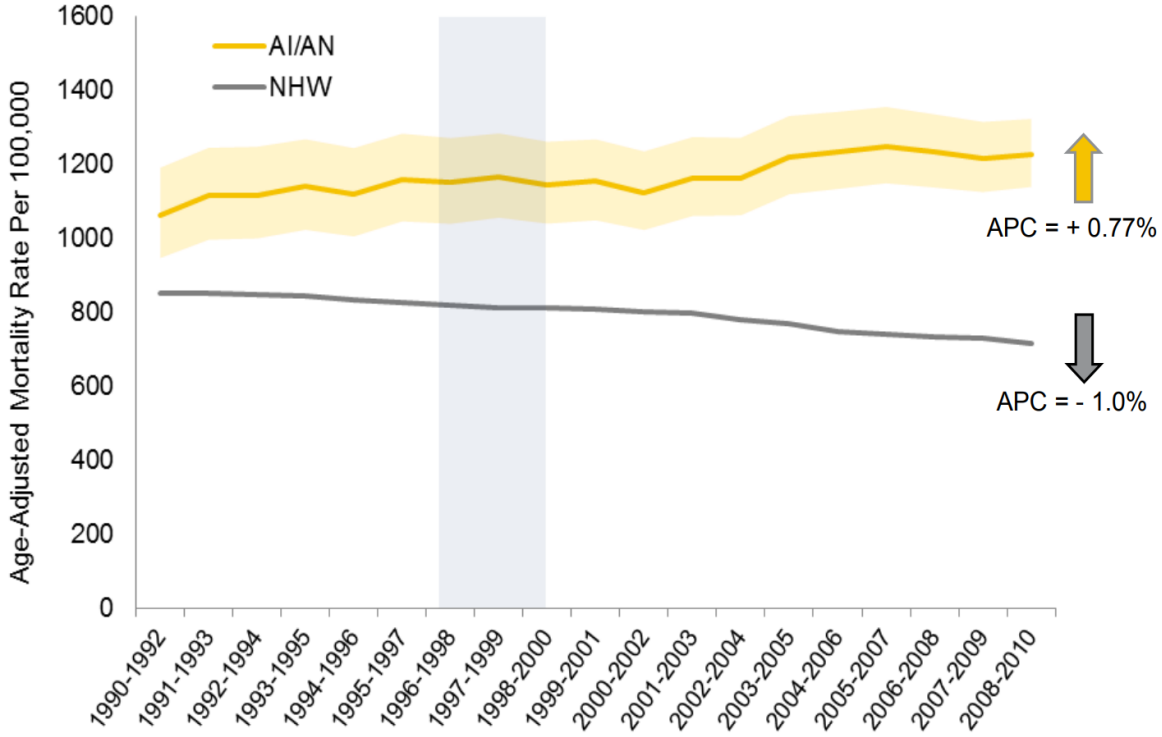
Top 10 Leading Causes of Death, 2011-2015, ages over 1 year old[ii]	
Cardiovascular Disease 23.5%	Diabetes 4.6%
Cancer 19.4%	Suicide 3.5%
Unintentional Injury or accident 11.4%	Alzheimer's Disease 2.1%
Chronic Liver Disease and Cirrhosis 6.1%	Influenza and Pneumonia 1.6%
Chronic Lower Respiratory Disease5.9%	

In Washington, the all-cause mortality rate for AI/ANs was 1,233.6 per 100,000. This is about 71% higher than the rate for non-Hispanic whites (NHW) in Washington and higher than the rate of AI/AN in both Idaho and Oregon States.[iii] Cardiovascular disease, cancer and unintentional injury are the top three leading causes of death for AI/AN greater than 1 year of age.[iv]

Heart disease, diabetes, and cancer pose heavy burdens for tribal communities. From 2006-2010, diabetes was the fourth leading cause of death among AI/AN in Washington. Diabetes mortality rates for AI/AN were almost three times higher than for NHW, the fourth leading cause of death among AI/AN in Washington from 2006-2010. Unintentional injuries are also high, particularly among children and young adults. Rates of suicide, binge drinking, and drug and alcohol associated deaths are higher among AI/AN than NHW. AI/AN infant mortality rates have increased since 1994, and the gap relative to NHW is growing over time.

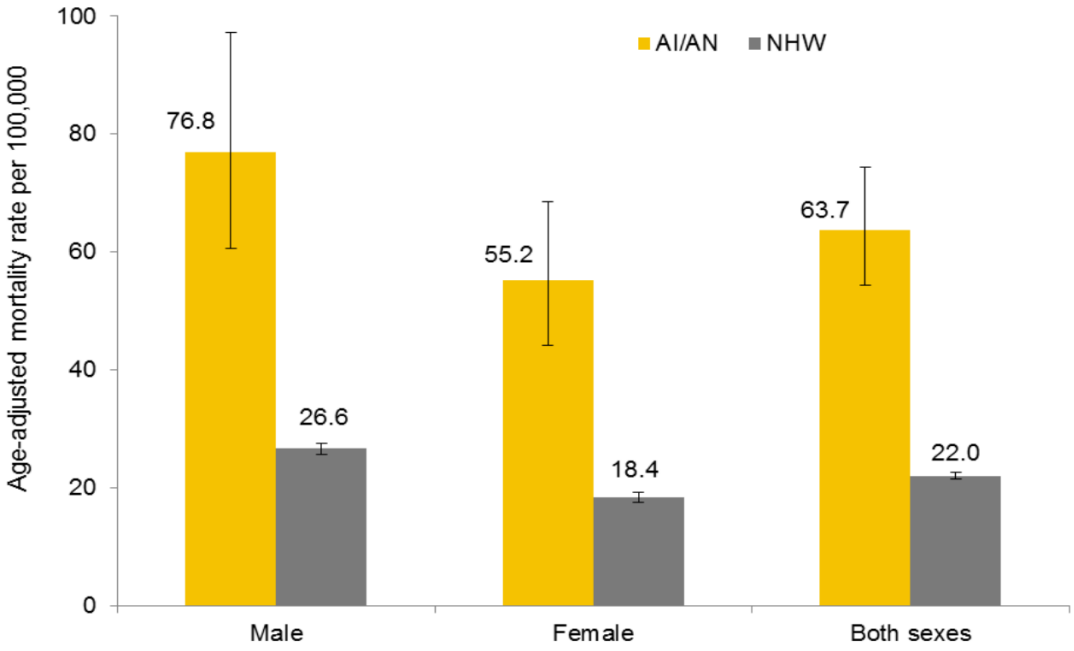
The statistics reported here only show percentages; what they fail to capture is the profound impact each preventable or early death has on tribal communities. The loss of each young person who will never have the opportunity to grow into the leader he or she could be is a tragedy. The death of a middle-aged person may have the widest spread impact, as they are vital members of the community upon whom both children and elders rely for support and care. And, of course, the premature passing of every elder results in a loss of the history, language, and knowledge of their Tribe.[v]

AI/AN and NHW all-cause mortality rates, Washington; three-year rolling averages 1990-2010



Note: The shaded rectangle indicates the year cause of death coding changed from ICD-9 to ICD-10. Any abrupt changes between 1998 and 1999 should be interpreted with caution.

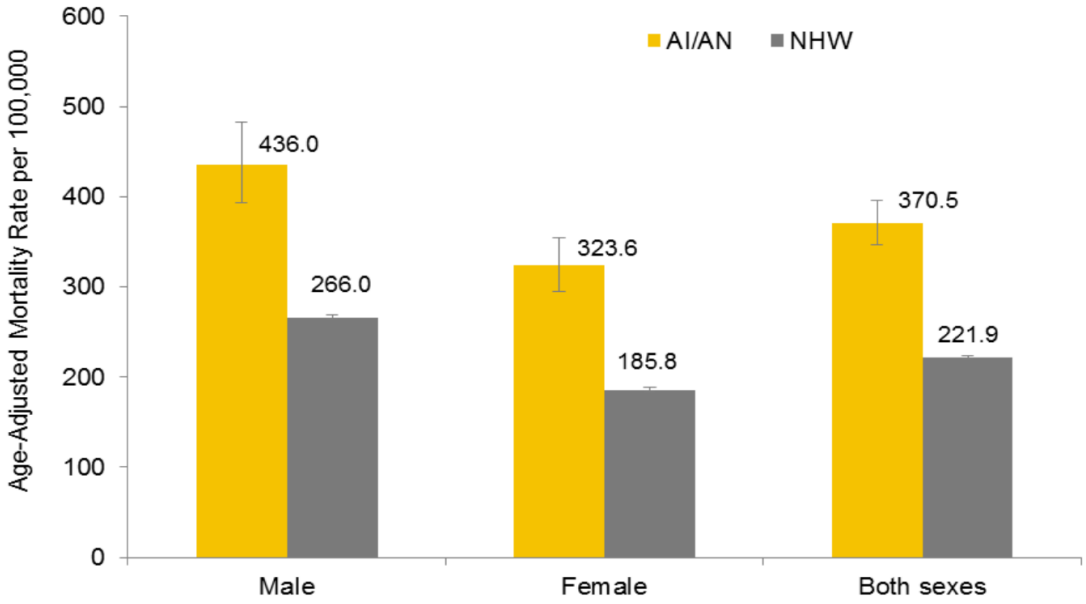
Age-adjusted diabetes mortality rates by race and sex, Washington 2006-2010



Heart Disease

Heart disease was the leading cause of death for AI/AN in Washington from 2006-2010. The figure below shows the age-adjusted mortality rates for heart disease among AI/AN between 2006 and 2010 in Washington were 67% higher, compared to NHW.

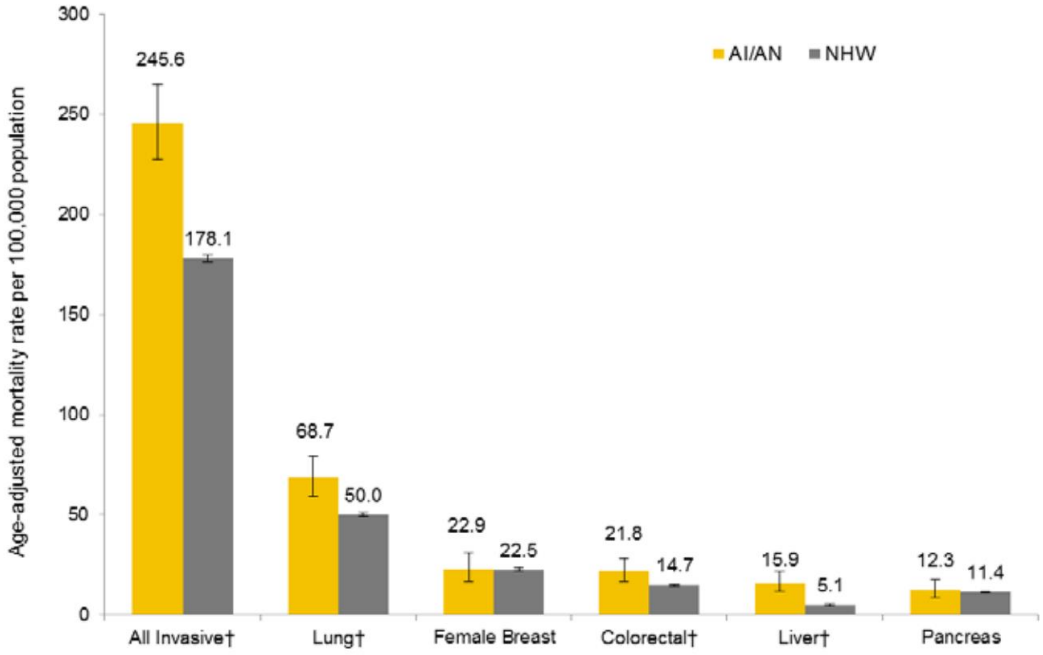
Age-adjusted heart disease mortality rates by race and sex, Washington 2006-2010



Cancer

In Washington, from 2006-2010, AI/AN had cancer mortality rates approximately 38% higher.

Age-adjusted mortality rates for leading cancer sites by race, Washington 2006-2010

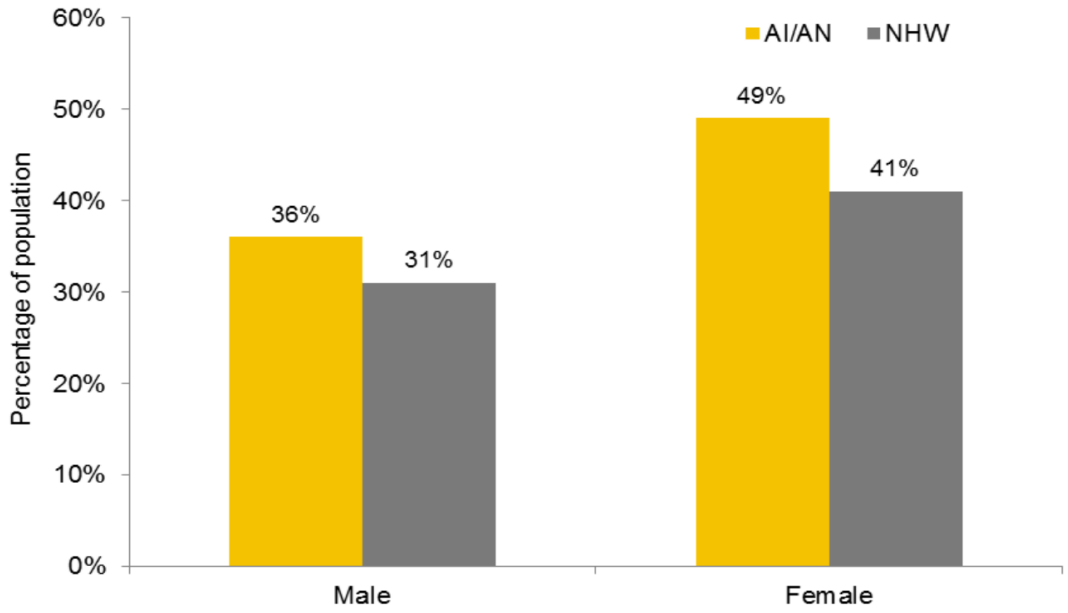


† Indicates a statistically significant difference (p<.05)

Stress, Depression and Problems with Emotions

AI/AN in Washington reported higher rates of poor mental health (self-reported stress, problems with emotions) and depression than NHW in the state. Despite reporting relatively high levels of poor mental health, AI/AN men were less likely than NHW men to receive treatment for these conditions. AI/AN had higher hospitalization rates for mental health conditions and suicide than NHW in the state. From 2006-2012, approximately 36% of AI/AN males and 49% of AI/AN females in Washington reported feeling depressed or in poor mental health for one or more days in the past month. This percentage was higher than for NHW in the state (31% of NHW males and 41% of NHW females).

Prevalence of self-reported stress, depression and/or problems with emotions in the past month by race and sex, Washington 2006-2012

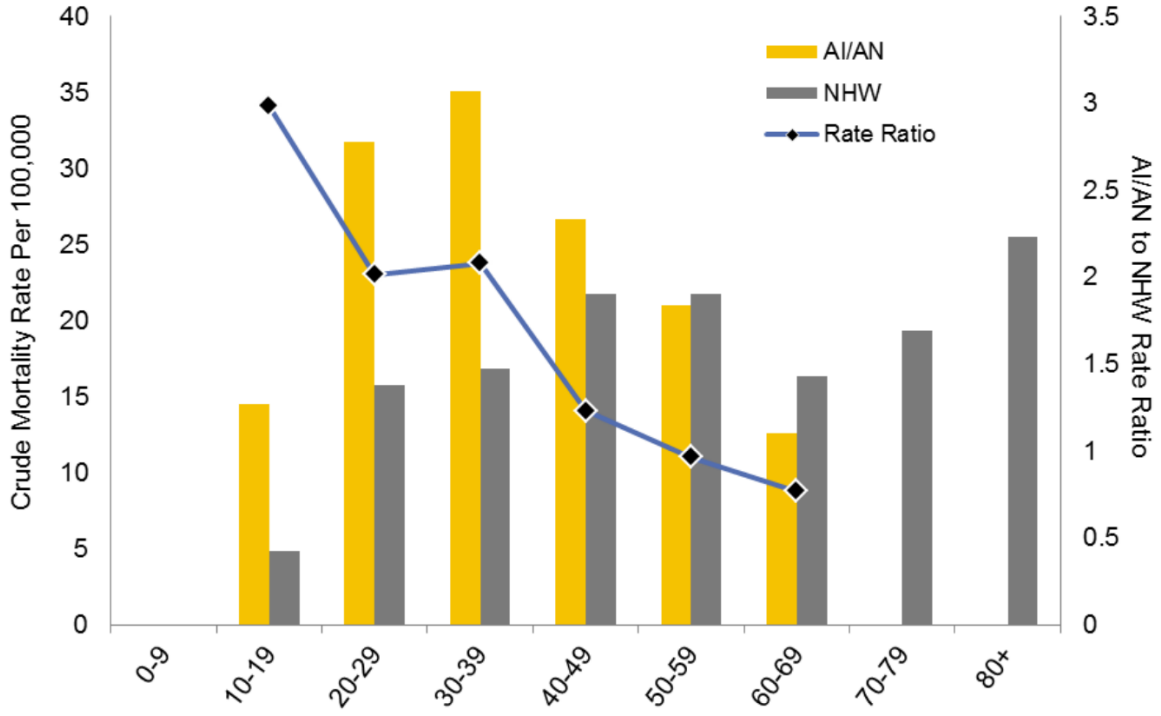


† Sample sizes (n): AI/AN males=783; AI/AN females=1,148; NHW males=49,342; NHW females=77,177.

Suicide

Suicide was the eighth leading cause of death among AI/AN in Washington from 2006-2010. AI/AN males and females had higher mortality rates from suicide than their NHW counterparts in the state. For both males and females, suicide mortality rates were higher in AI/AN than NHWs. Youth suicide rates among AI/AN 10-19 years old were three times higher than NHW. The mortality rate for AI/AN in the age range of 20-49 is significantly higher than for NHW. This disparity has a devastating impact on Tribal communities, as these years are typically the most productive years of life and of greatest contribution to one's community.

Age-specific suicide mortality rates by race, Washington 2006-2010

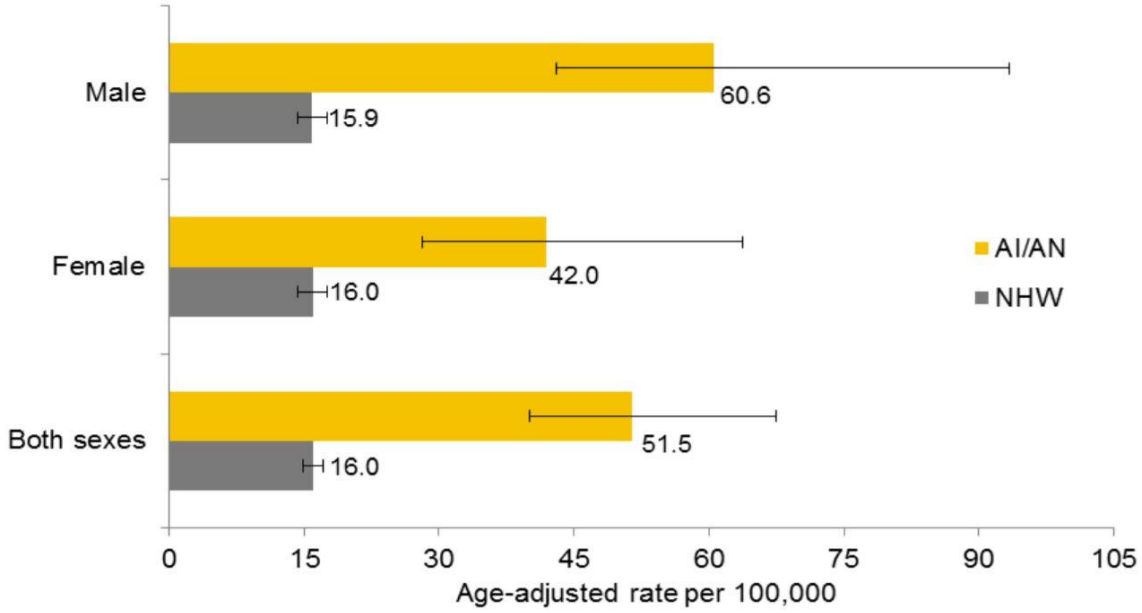


Note: Rate Ratio is a comparison of AI/AN to NHW rates; a value above 1 indicates AI/AN rates are higher than NHW. Black markers are shown for age groups in which the AI/AN rates are statistically significantly higher than NHW rates.

Alcohol and Substance Use Disorders

Compared to NHW, alcohol or substance abuse accounted for a larger proportion of hospitalizations among AI/AN. Compared to their NHW counterparts, the age-adjusted hospitalization rate for alcohol and substance abuse disorders was 3.8 times higher for AI/AN males and 2.6 times higher for AI/AN females

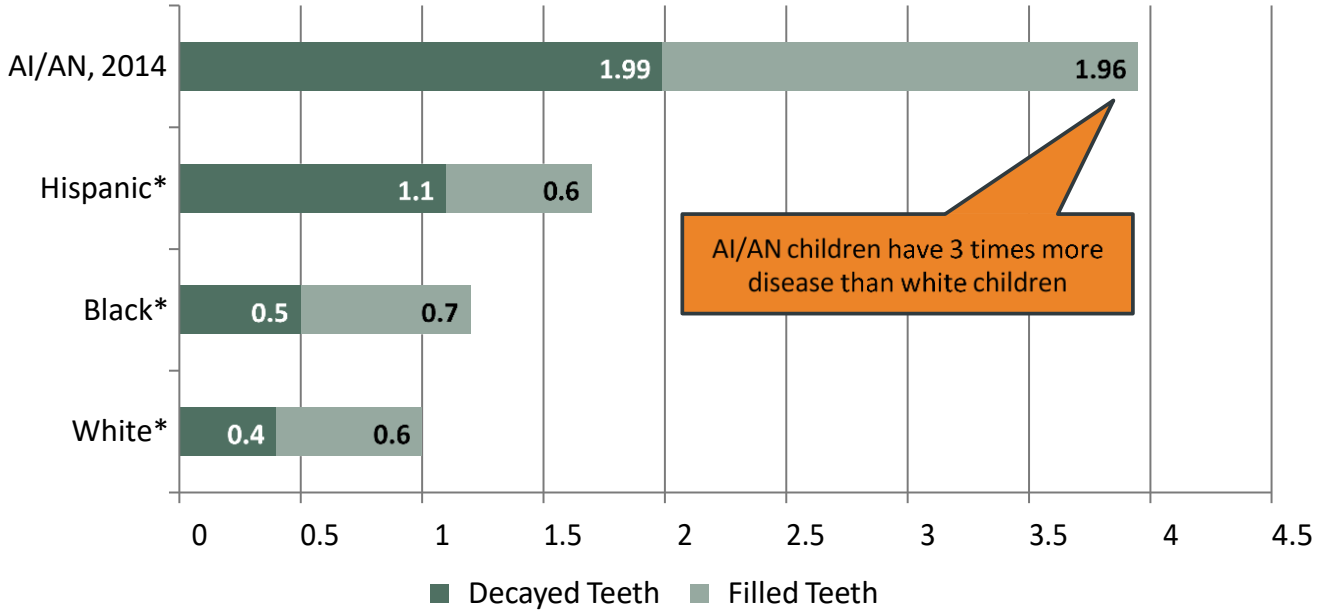
Figure 9.4: Age-adjusted hospital discharge rates for alcohol and substance abuse disorders by race and sex, Washington, 2011.



Oral Health

Tribal communities are struggling under the weight of devastating oral health disparities. Prevalence of tooth decay in American Indian/Alaska Native (AI/AN) children in Washington, Oregon, and Idaho ages 2 to 5 is nearly three times the U.S. average. More than 70% of AI/AN children ages 2-5 have a history of tooth decay experience compared to 23% of white children[vi]. AI/AN adult dental patients also suffer disproportionately, with twice the prevalence of untreated caries as the general U.S. population and more than any other racial/ethnic group. AI/AN adult dental patients are also more likely to have severe periodontal disease, more missing teeth, and are more likely to report poor oral health than the general U.S. population[vii].

Mean Number of Decayed and Filled Primary Teeth (dft) Among Children 2-5 Years of Age



Community Driven Assessments and Planning:

Washington's American Indian Health Care Delivery Plan

Since 1994, Washington State Tribes and UIHPs have worked with the Washington State Department of Health (DOH) on the American Indian Health Care Delivery Plan (AIHCDP) to document and analyze unmet health needs. Tribes have engaged with AIHC and Washington State for over twenty years in this process. Through these efforts, the following approaches have been recommended to address AI/AN health disparities in our state. However, adequate funding has never been available to implement them.

- Use of tribally driven health assessments and tribal best practices 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[viii]

These recommendations are the foundation for the Tribal Medicaid Transformation Project efforts.

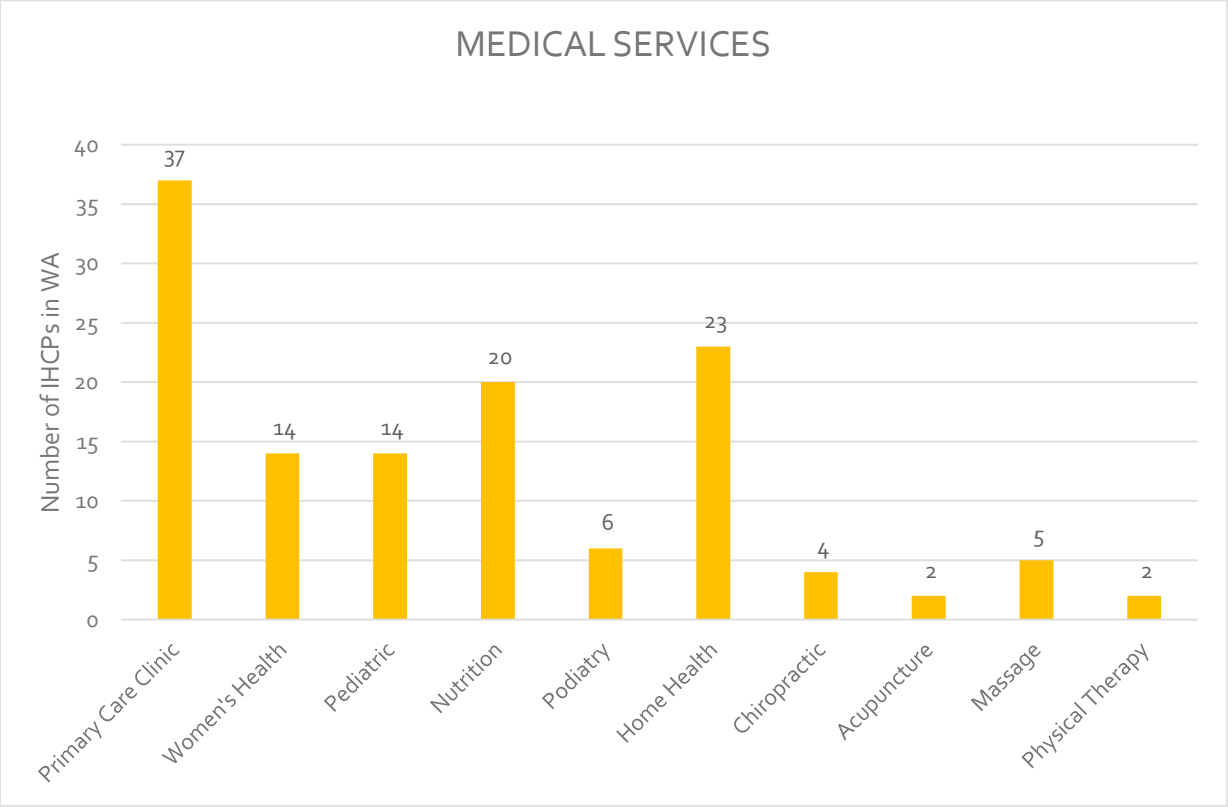
B. Inventory: Health Care and Social Services Available at IHCPs

Despite inadequate and unstable funding, IHCP have developed great capacity for a broad array of integrated services designed to address community specific needs. IHCP efforts regarding Medicaid Transformation will leverage this capacity in unprecedented ways.

To inform Medicaid Transformation efforts with the most current information regarding services provided by IHCPs, the AIHC collected data throughout 2017 from 27 of the 29 Tribes and both UIHPs.

Medical Services

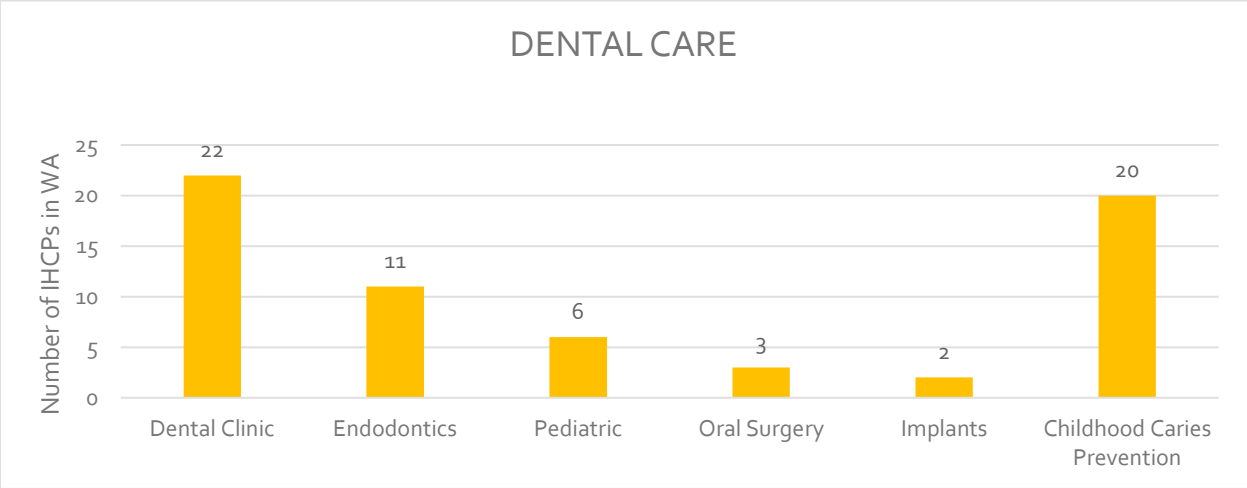
In Washington, there are 31 ambulatory primary care clinics operated by Tribes, 2 operated by UIHP, and 4 by the Indian Health Service (IHS). Over time, many of these clinics have added a variety of specialty care options to address community-specific needs. In addition to specialties listed below, other specialties offered at IHCP clinics include traditional healing practices, naturopathy, nephrology, and orthopedics.



Dental Care

In Washington, access to dental care continues to be a struggle for many due to provider shortages and lack of insurance coverage. According to the Washington State Department of Health (DOH), "Dental care remains the top unmet health care need for low income adults, older adults, and children with special health care needs."[ix] As documented in the March 2016 Indian Health Service Data Brief, AI/AN continue to suffer disproportionately from dental disease.[x]

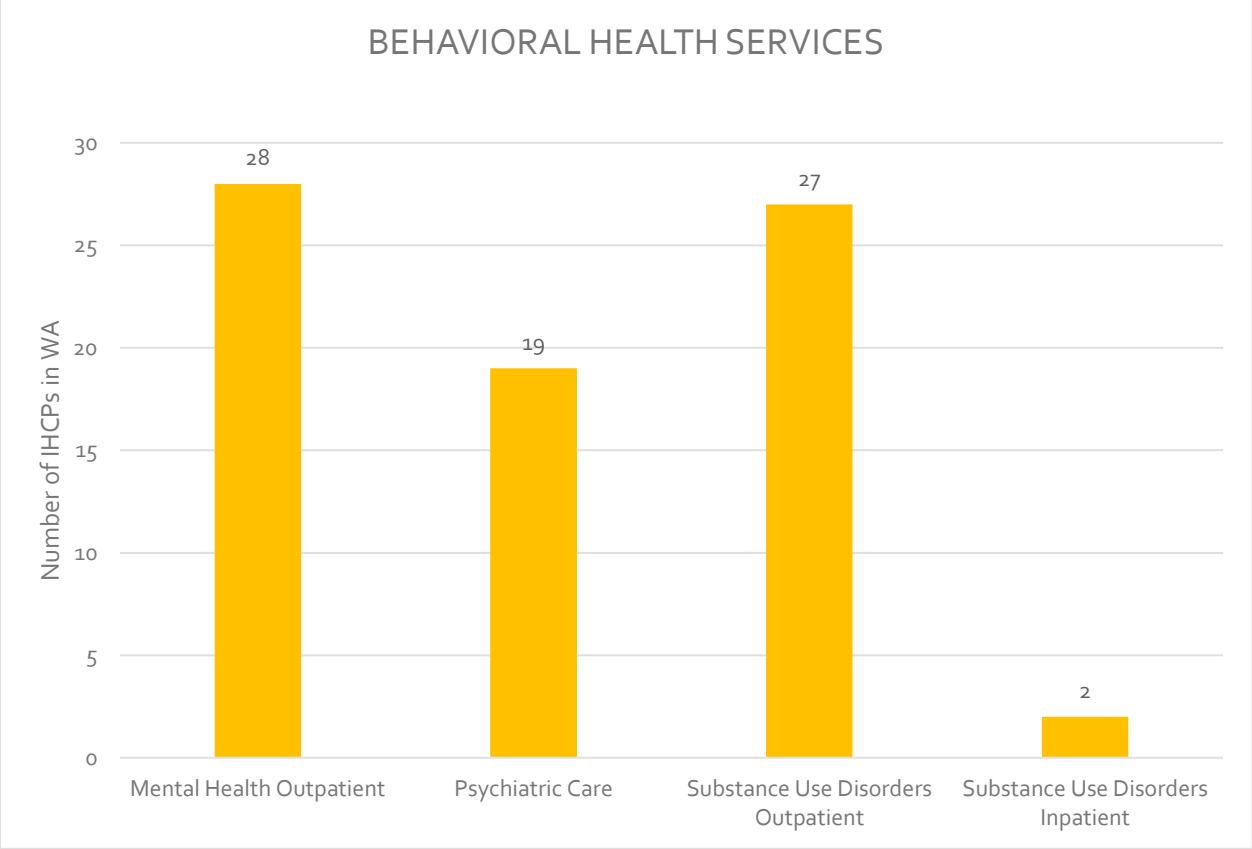
Most (22 of 32) IHCPs provide dental care. In 2017, Tribes achieved an important victory with the passing of the Dental Health Aide Therapy (DHAT) Law. With this new law in place, IHCPs will be able to expand the availability of care and offer dental services as part of their integrated system of care. The DHAT program is a clear example of IHCPs utilizing innovation to expand access to care in cost effective ways. Through opportunities provided by Medicaid Transformation, IHCPs will identify and implement additional innovative strategies to reduce costs and access barriers created when referring specialty care outside the Indian Health Care Delivery system.



Behavioral Health Services

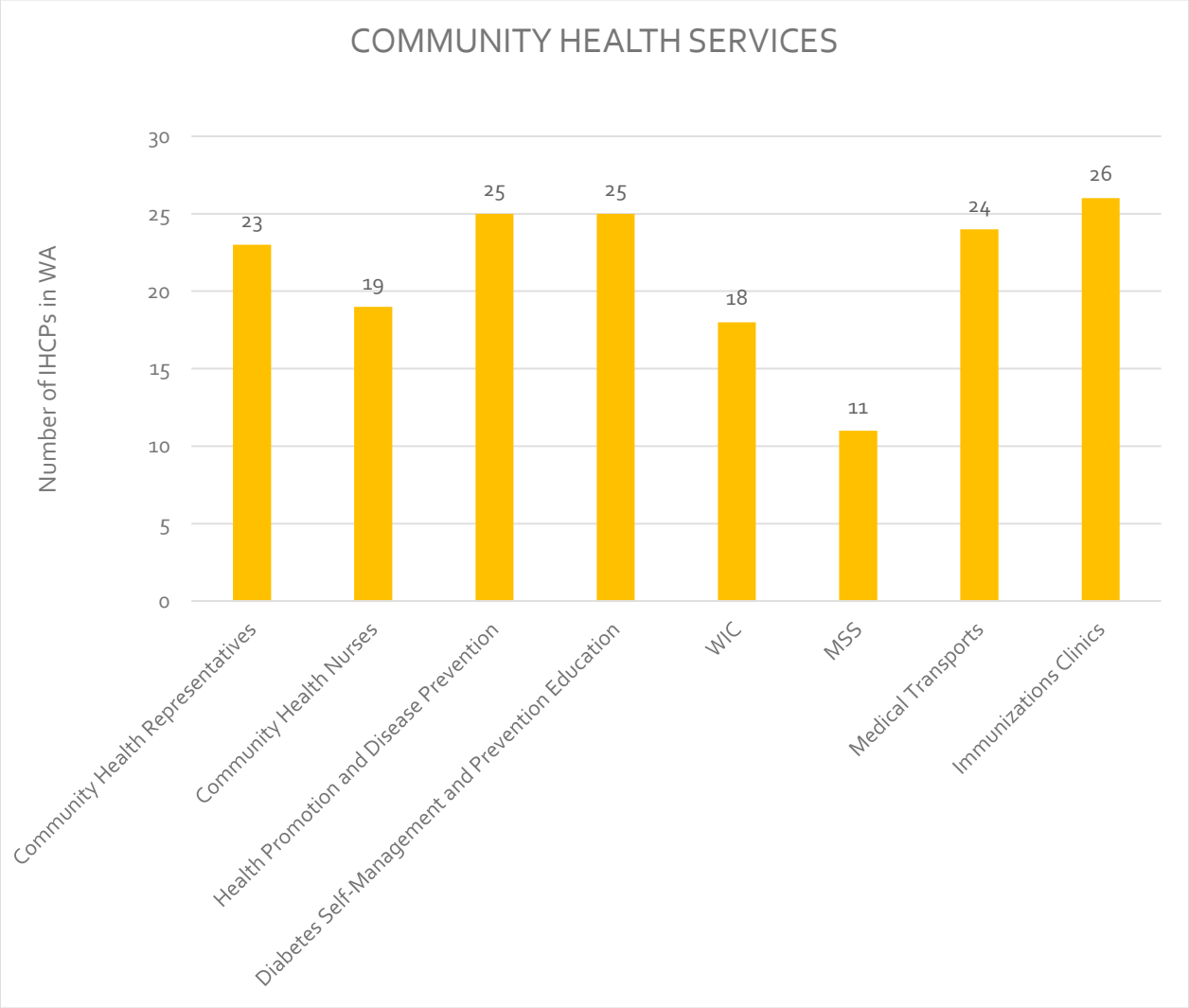
Most (28 of 32) IHCPs in Washington provide outpatient behavioral health services and are at the forefront of integrating these with physical health care. This level of existing capacity and expertise place IHCPs in a forefront position to achieve maximum integration of care and measurably improve population health.

A dangerous gap in Washington is the lack of culturally effective inpatient behavioral health services. Long waits for the availability of a bed are the norm. This is a life-threatening situation for individuals in need of the highest level of care. Medicaid Transformation provides a unique opportunity for IHCP in Washington State to develop and implement a collaborative solution to a problem unsolvable by any one entity.



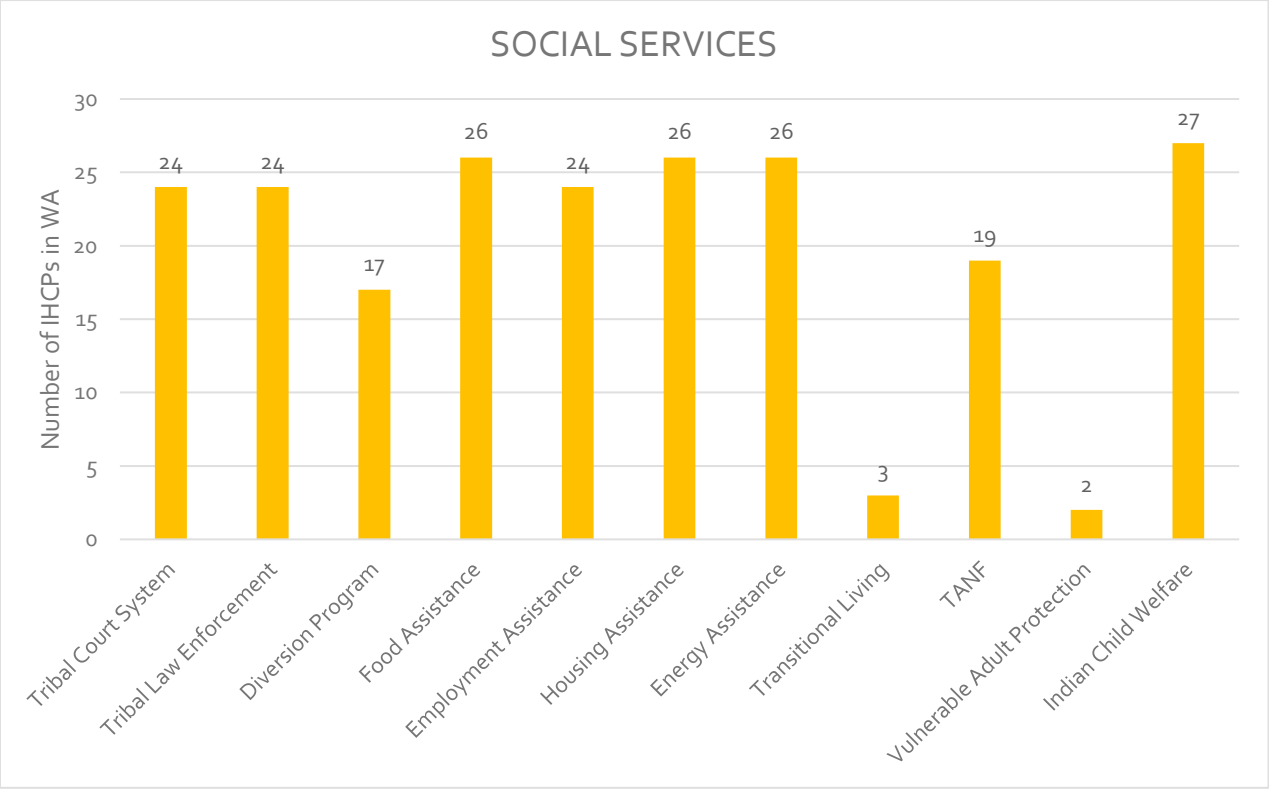
Community Health Services

Based on millennia of tradition, community-based services are an area of great expertise among IHCPs, despite inadequate funding. Most IHCPs provide a broad range of services that support clinical care, delivered within the context of family and community. The focus on community further injects culture into the system of care and provides the inherent incentive of taking actions for the greater good of one's relations. The existing capacity and cultural basis for community health services represent yet another area where IHCPs are well positioned to successfully accomplish Medicaid transformation.



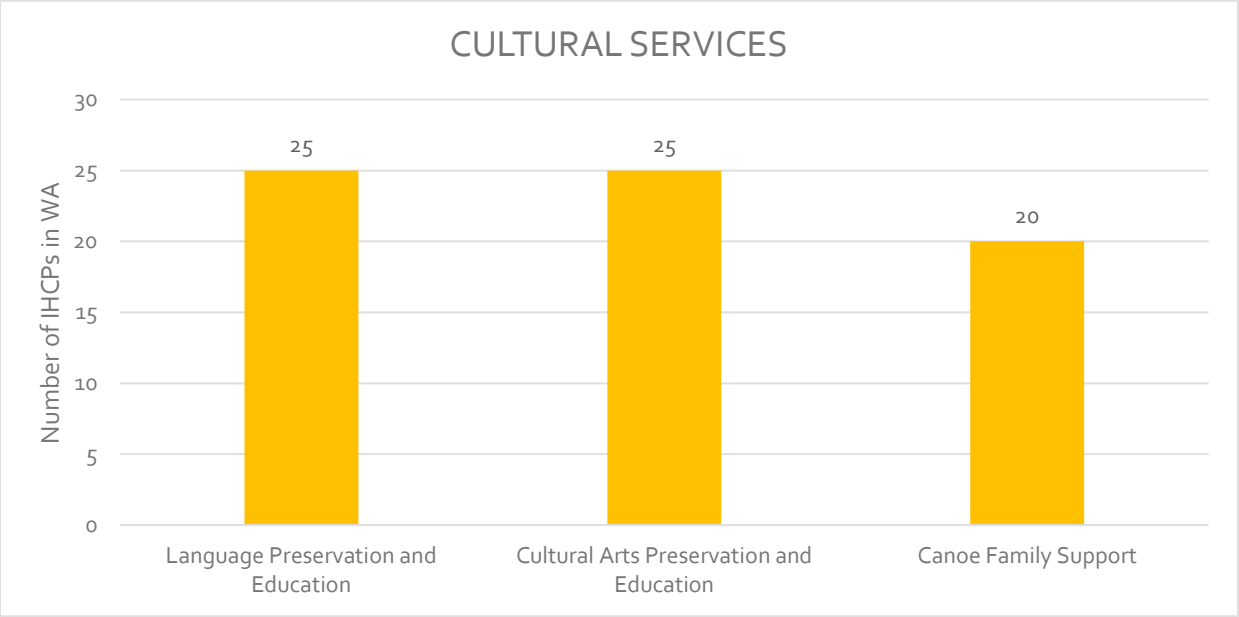
Social Services

Tribes have long understood that services viewed by non-Indian health care systems as separate and distinct from health care are integral for achievement of whole person health. As a result of cultural traditions and the necessities created by underfunding, most IHCPs manage a broad array of social services that – at minimum – coordinate with health care, and in many cases, operate with a high level of integration.



Cultural Services

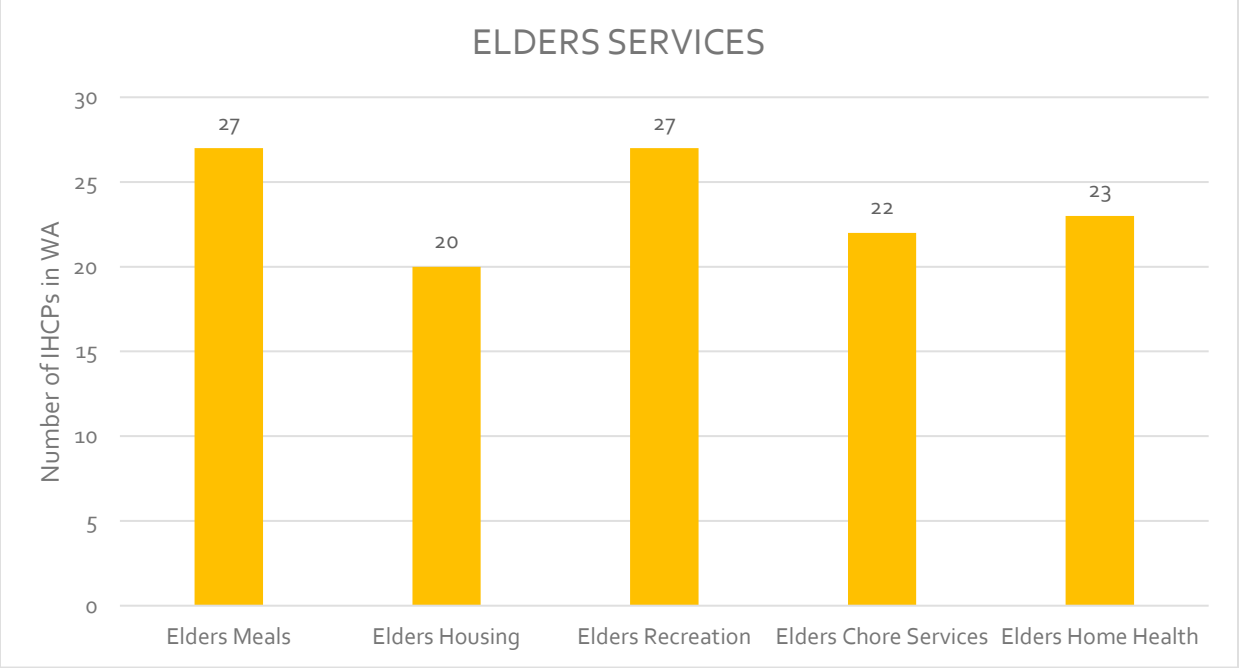
Most IHCPs operate with the assumption that culture is the foundation for strength and wellness. The majority of IHCPs include culture, not as an ancillary service, but as an indivisible component of a whole system. Restorative justice, traditional healing practices and the recognition of mind-body-spirit oneness are evidenced throughout Washington IHCPs' systems of care delivery.



Elders Services

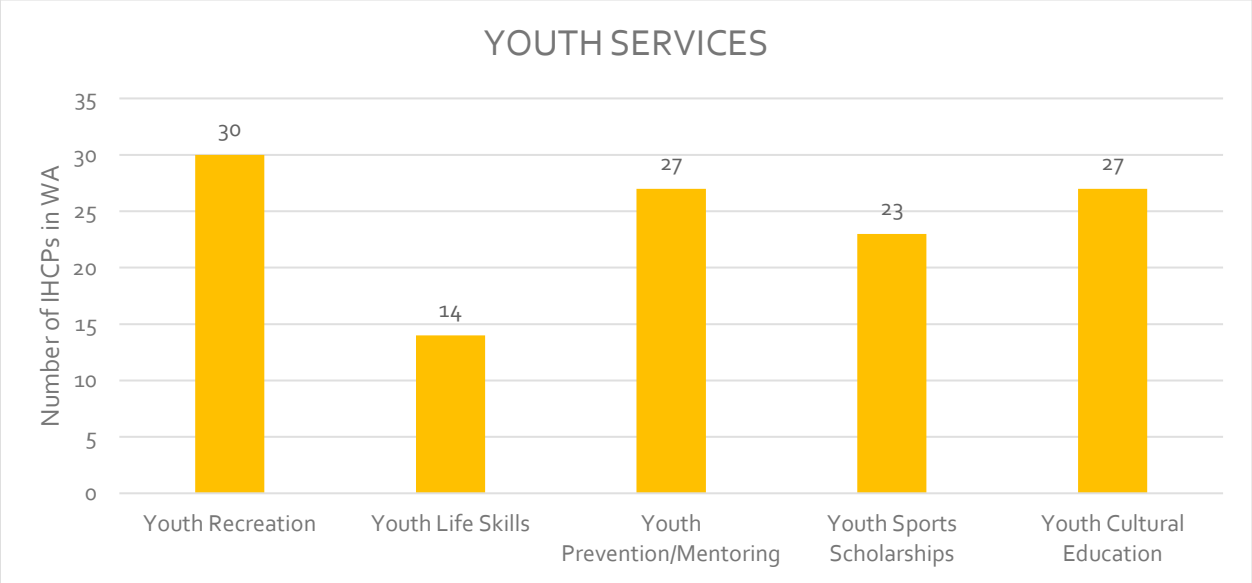
The cultural ways of respecting, honoring and including elders in the fabric of community life underlies the large number of well-established health care and social services for elders among Washington's IHCPs. In contrast to many non-Indian systems, the contribution and engagement of immediate and extended family in the care of elders allows IHCPs to offer a broad range of services to improve and protect elders' health status.

The tradition of caring for elders includes family caregiving even as elders require higher levels of care, avoiding the need for costly skilled nursing. Increases in the amount and flexibility of funding available to IHCPs is needed to assure the stability and sustainability of these important services that contain the cost of care and preserve health status.



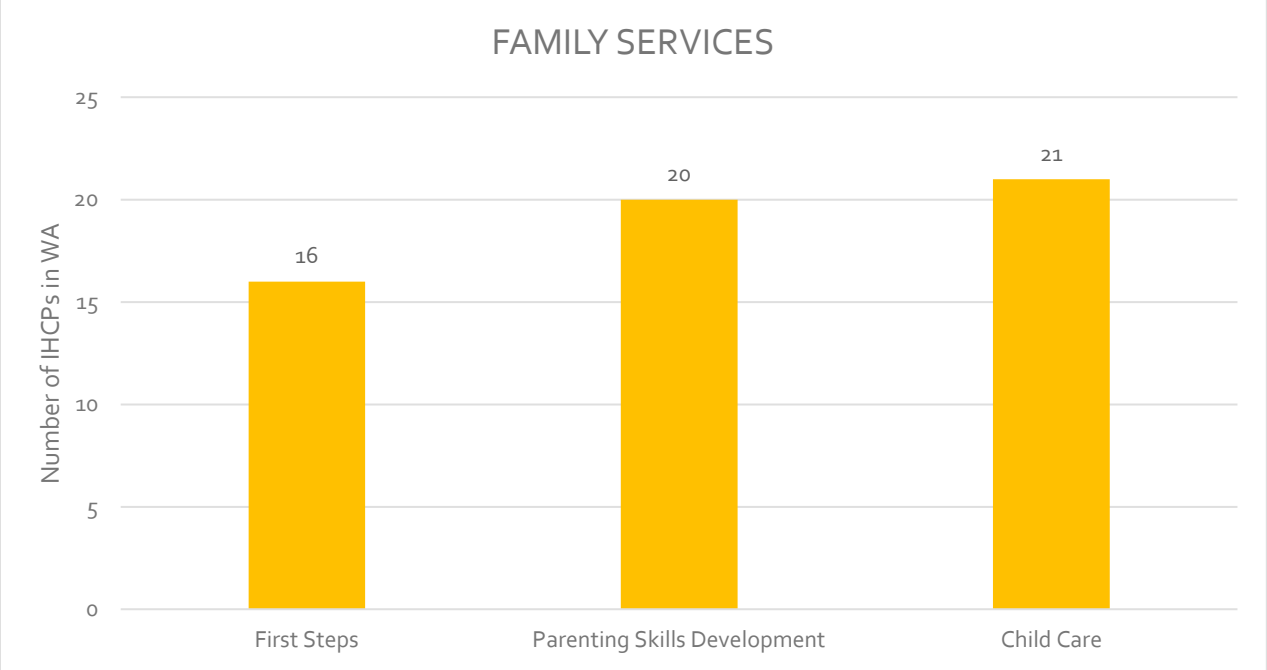
Youth Services

Ingrained in Tribal cultures is the knowledge that significant investments in community members early in life help assure the future of the community. Most IHCPs (30 of 32) include services for youth as substantive components of the overall system of care. These programs support the development of leadership skills, knowledge of Tribal culture and an understanding of the importance of individual and community wellness to survival. Operating these programs within the broader umbrella of the health care delivery system helps support the goals of improved health outcomes.



Family Services

Culturally, family is the bedrock of life for AI/AN. Many of Washington's Tribal communities use an expanded definition of family which is inclusive of all community members. IHCPs include services to families as part of the health care delivery system. These services are important to address the intergenerational/historical trauma suffered by families where children were completely removed from their Tribal community and raised without an understanding of traditional ways. Family services help keep these families together and support the use of traditions and culture to begin healing the cycle of trauma. IHCPs encourage family members to participate in care plans and to serve as advocates for their relations, when appropriate.

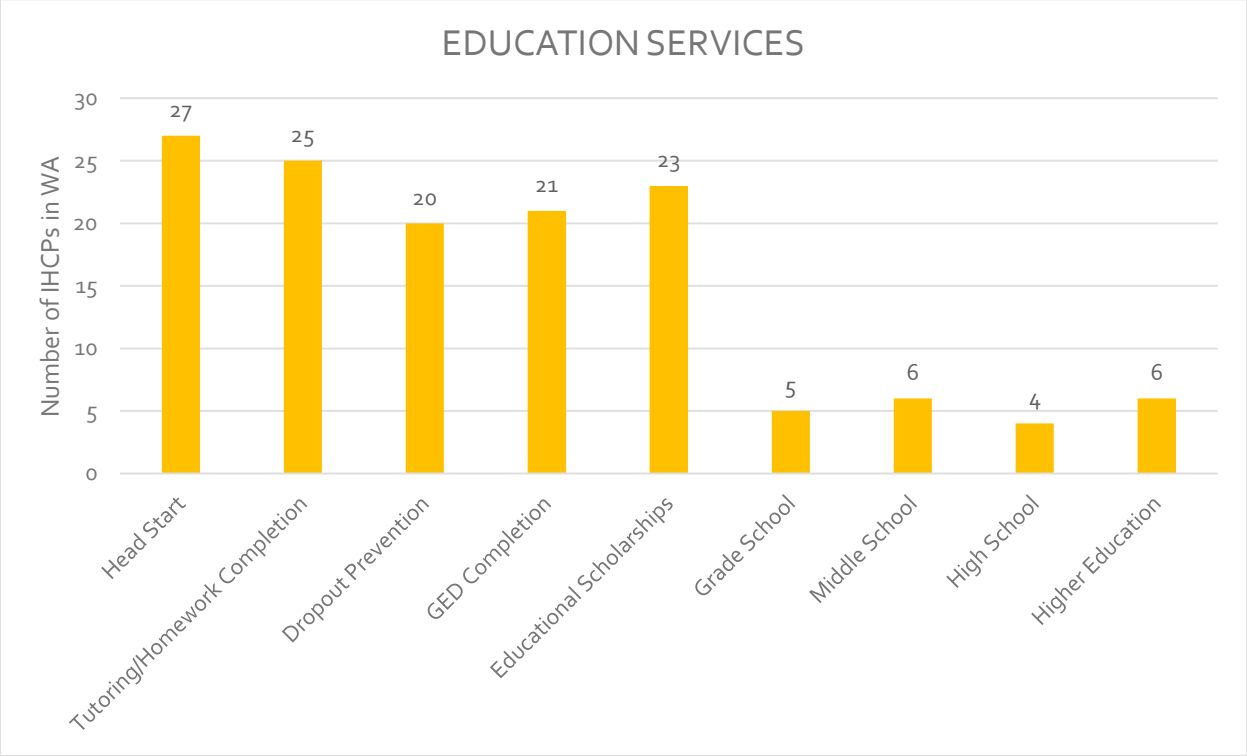


Education Services

Educational attainment is recognized to play a key role in health status. In general, individuals who have completed more education live longer, healthier lives, and their children also experience better health outcomes.[xi] In the public education system, less than 50% of AI/AN residing in Washington State have more than a high school education. Also, AI/AN are underrepresented as providers in healthcare fields.

Most (27 of 29) Tribes manage a Head Start program. Although only a few Tribes administer their own primary, secondary and higher education programs, Tribes and UIHPs have developed and implemented a broad array of services to support educational attainment and workforce development. These services provide an important culturally effective supplement to the public health system for AI/AN children and adults.

In the work to transform Medicaid, linking the system of care with education services and promoting educational achievement will help achieve the desired population health outcomes. Through Medicaid transformation efforts, IHCPs will leverage their existing capacity and community specific expertise to increase educational attainment, meet healthcare workforce needs and strengthen the efficacy of investments in Medicaid transformation. These efforts will include support for Community Health Aid Training Programs to increase the number of Native providers in Native communities.



C. Inventory: Data, Health Information and Population Health Systems at IHCPs

Tribes and UIHPs are uniquely qualified to understand the health needs of their communities and implement programs with cultural efficacy. To inform health care policy, environment and systems decisions, Tribal governments and UIHPs must have timely access to quality data.

Data currently available for AI/AN in Washington State have significant limitations in accuracy and timeliness. Most available data come from state registries and third-party sources; for example, the state cancer registry, Medicaid claims data, etc. Although these sources of data are useful, they lack the precision and timeliness that data collected and managed by Tribes and UIHPs can offer. Problems include misclassification of individuals as non-Native and the lack of data on individuals who receive care exclusively at I/T/U facilities. These data limitations result in undercounts and produce an incomplete or inaccurate picture of the populations' needs.

Health information management capacity is essential to integrating care, coordinating services from diverse providers and measuring the efficacy of services provided. IHCPs lack the resources to acquire hardware and software to support current and future health care delivery needs and recruit and retain a qualified workforce to manage, analyze and use their populations' data. Most IHCPs (18 of 32) still utilize RPMS, the Indian Health Service's antiquated health information management system, to document primary care.

IHCPs in Washington need population health management software with robust interfaces to electronic health record systems and other health information databases to easily report and analyze population health data. Without these, the capacity to design population health improvement strategies that address each community's unique set of health issues, resources and risk factors and track the efficacy of programs implemented is out of reach. At present, none of the IHCPs currently have population health management software.

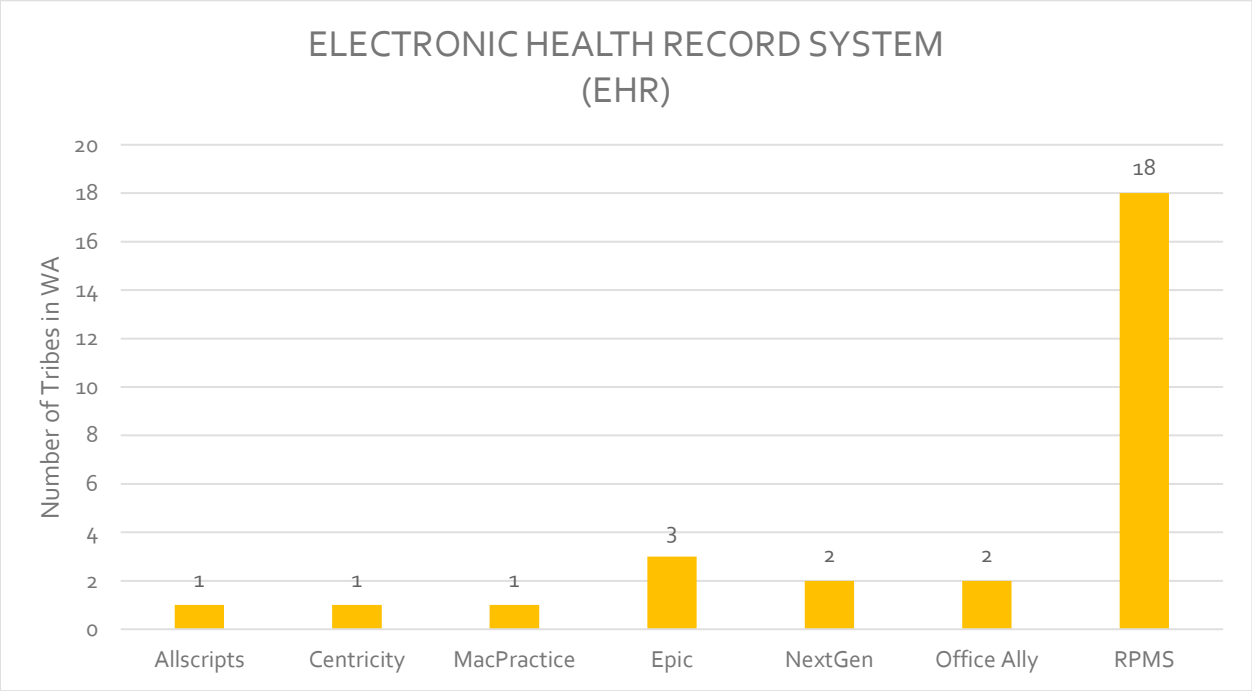
In addition to hardware and software needs, IHCPs lack the workforce to support current and future health information technology (HIT) needs. Funding is needed to hire additional staff and train existing staff to:

- Manage individual and population health data
- Support the exchange of health information
- Meet the challenges of Medicaid transformation.

Recruiting and retention of HIT staff has been especially difficult in rural settings and in attracting talent to support an obsolete system like RPMS.

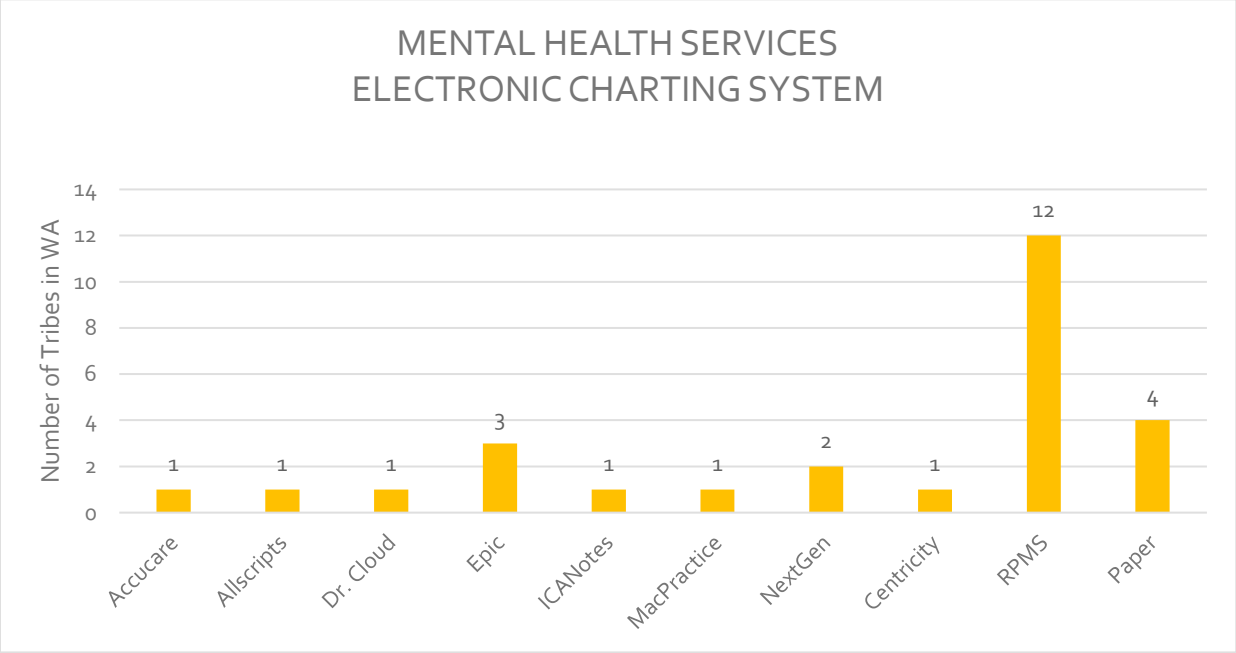
Electronic Health Record Systems

In Washington State, 18 of the 32 IHCPs utilize IHS' RPMS system. Although functional, RPMS is an antiquated system that lacks the technology to support key Medicaid transformation strategies, including but not limited to: practice transformation, value-based purchasing, care coordination, population health management and reporting requirements. RPMS' lack of interoperability prevents IHCPs from easily sharing health information with providers outside their facility, including other IHCPs and non-Indian providers. Unlike commercial electronic health record software, RPMS does not include a billing module specifically designed to maximize third party revenue. Furthermore, it is unclear how much longer the RPMS system will be supported by IHS.



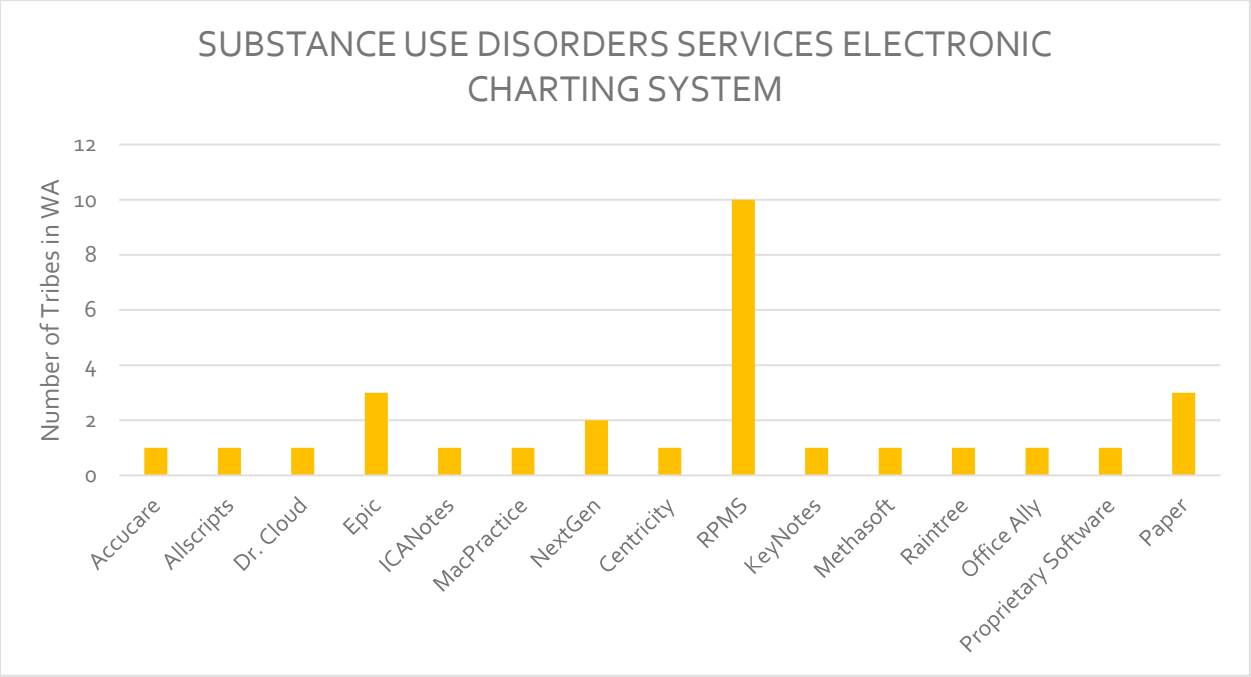
Mental Health Services Electronic Charting Systems

In Washington, most IHCPs have adopted electronic charting systems for mental health services. Only 4 of the existing programs continue to use paper charts. As with primary care patient data, RPMS is the system used by most IHCPs in Washington.



Substance Use Disorders Treatment Electronic Charting Systems

Although RPMS is the most commonly used system for substance use disorders services charting, there are many systems being utilized. IHCPs using the most robust HIT systems (for example, EPIC and NextGen) are using the same system to chart primary care and behavioral health services. This approach naturally supports whole-person integrated care and care coordination. Unfortunately, most IHCPs have not had the resources to acquire such systems.



D. Inventory: Evidence-Based and Promising Practices at IHCPs

Statement on Evidence-Based Practices

With the severe health inequities in Indian country nationwide and in Washington State as described above, the need for effective health care practices for the AI/AN population is high. Unfortunately, "[t]here are limited evidence-based practices, promising practices or research based practices that have been tested in tribal communities."[xii] Recognition that there is a lack of practices which have been studied outside the Indian Health Care Delivery System is critical, particularly for behavioral health care practices and all provider-client interactions. Cultural and socioeconomic contexts mediate the relationship between the behavioral health treatment or the provider's statements and actions and how that treatment or those statements and actions are received by the patient.[xiii] As a result, from the clinical perspective, excessive reliance on evidence-based practice is problematic.

> Guidelines that are inflexible can harm by leaving insufficient room for clinicians to tailor care to patients' personal circumstances and medical history. What is best for patients overall, as recommended in guidelines, may be inappropriate for individuals; blanket recommendations, rather than a menu of options or recommendations for shared decision making, ignore patients' preferences.[xiv]

Furthermore, even if evidence-based practices were to exist for AI/AN communities, they present a host of additional challenges.

> The range of Washington's tribal communities—urban, rural and frontier—adds another level of complexity to finding EBPs that have been adequately normed for tribal communities. What is known is that a "cut and paste" approach to services does not work. EBPs are expensive to implement and maintain. For any EBP to be effective there has to be ongoing fidelity monitoring and technical assistance—this is an additional cost to the actual service provision. For those practices that may exist, other barriers come into play and that includes conflicts with the primary funding streams Tribes use for behavioral health services, including; Indian Health Services, Medicaid, Tribal and State.[xv]

As a result, Tribes and other Indian health care providers in Washington State consistently ask for any policies – including Medicaid Transformation Project policies – that promote or require evidence-based practices to respect both the limitations of the evidence for those practices and the need for flexibility to support cultural adaptation of those evidence-based practices and culturally-appropriate promising practices, including traditional healing practices.

> There needs to be an explicit acknowledgement that each Tribe knows what works best in a tribal community and that a pilot project or study that works in one tribal community

> may not necessarily be easily replicated in another. Each Tribe in Washington has its own rich and unique history, culture and traditions. It is essential that the development of culturally appropriate and responsive providers for behavioral health services includes interaction with the Tribes directly.[xvi]

In this report, these culturally adapted evidence-based practices and culturally-appropriate promising practices together are called "Culturally Appropriate Practices" or "CAPs".

Principle of Community-Driven Care Models

The following inventory of CAPs offers a menu of options; it is a foundational principle of this plan that Tribes and UIHP need to be given the ability to develop their own, community-driven care models. This concept of allowing Tribes the flexibility to develop or tailor programs to meet their needs flows throughout the National Tribal Behavior Health Agenda (December 2016).[xvii] Yet, the national Medicaid program has historically not funded Tribes or UIHP in a manner that supports community-driven care models. Rather, the national Medicaid program has typically been driven by the individual partner-states, with specific federal requirements for how states treat AI/ANs or Tribes, but with no focus on supporting Tribes' and UIHPs' diverse yet holistic models of care. With Medicaid Transformation Projects, the Tribes and UIHP will seek to transform Indian health care at the level of the individual Tribe and UIHP.

Framework: National Behavior Health Agenda

The Tribal Behavioral Health Agenda (NTBHA) was developed in response to recommendations from the Tribal Technical Advisory Committee of the Substance Abuse and Mental Health Services Administration (SAMHSA). The NTBHA:

- Provides a clear national statement about the extent and need to prioritize behavioral health and related problems, their impact on the well-being of tribal communities, and a set of strategies based on direct input from tribal leaders and representatives,
- Identifies foundational elements that should be considered and integrated into both existing and potential programmatic and policy efforts,
- Elevates priorities for action that could or are likely to contribute to meaningful progress in tackling persistent behavioral health problems for Native youth, families, and communities,
- Creates a platform to allow Tribal and Federal collaborators to routinely examine funding, program, and policy priorities that best support opportunities to improve communication, align efforts, and make real and measurable improvements in behavioral health for American Indians and Alaska Natives

Below is the NTBHA as a framework for this inventory.

Figure X: Framework Adapted from National Tribal Behavior Health Agenda (4 of the 5 domains)

1. Historical and Intergenerational Trauma

A key consideration for Tribes and Indian health care providers is the developing literature on historical trauma (also known as intergenerational trauma) and the development of clinical practices and other services informed by that trauma and other types of trauma (such as adverse childhood experiences). More recently, researchers have found evidence of epigenetic inheritance, where gene expression is altered through DNA methylation in a parent preconception and then passed on to offspring.[xviii]

The following Culturally Appropriate Practices have been used successfully in Tribal communities to increase wellbeing and break cycles of intergenerational trauma.

a. Support Systems

i. **Clinical Tools**
- *Description:* Use of clinical models and tools to identify and address historical trauma and mitigate related symptoms in AI/AN clients, such as the Historical Loss Scale and the Historical Loss Associated Symptom Scale.[xix]
- *Providers:* Clinical staff and other medical professionals.
- *Patients/Participants:* All patients seen by practice.

ii. **Analytical Tools**[xx]
- *Description:* Multi-level framework for understanding the impacts of historical trauma on individuals, families, and communities.
- *Providers:* Clinical staff, other medical professional and other Tribal and UIHP staff.
- *Patients/Participants:* All patients seen by practice and their families and communities.

b. Community Connectedness

i. **Elder Gardening**
- *Description*. Program for elders to participate in gardening – growing healthy foods, fostering social relationships, and including physical activity.
- *Providers*: Community programs working with elders.
- *Patients/Participants*: All ages with a special focus on elders.

c. Breaking the Cycle

i. **Native Students Together Against Negative Decisions (Native STAND)**

- *Description*. A comprehensive curriculum for training peer educators that promotes healthy decision making for Native youth. Adapted from STAND—Students Together Against Negative Decisions—a peer educator curriculum developed for youth in rural Georgia.
- *Providers:* Youth programs and trained peer educators.
  Patients/Participants: Community members

ii. **Working with Horses, including 4-H Clubs, Relay Race Groups, Community Rides**

- *Description*. Equine therapy provider works with participants on topics including self-esteem, leadership development, and social skills, etc., through horse care and riding related activities. In some cases, youth have entered some of their projects into the local County fairs and were awarded ribbons for their efforts.
- *Providers*: Youth programs and community programs such as 4 -H, youth group leaders, horse trainers and riding instructors.
- *Patients/Participants*: Community members with an interest in working with horses.

iii. **Resilience Trumps Aces**

- *Description:* Mobilizing the community through dialogue to radically reduce the number of adverse childhood experiences while building resilience and a more effective service delivery system.
- *Providers: All IHCP and Tribal Staff*
- *Patients:* Community members affected by Adverse Childhood Experiences

2. Socio-Cultural-Ecological Approach

Prior to colonization, Native peoples had self-sufficient and sustainable food systems and plant medicine and spiritual practices related to land and nature. Over time, removal from traditional homelands, limited access to traditional food and natural resources, and transitions to cash economies, among other things, weakened tribal socio-cultural-ecological systems. Today, many Native communities and households are food insecure, dependent on outside food sources, and maintain a diet of Western food stuffs that are often linked to negative and deteriorating health, community and economics. Recognizing that the loss of self-sufficient food, plant medicine and cultural/spiritual systems is a contributing factor to the many issues Native communities face today.

a. Traditional Foods, Medicines, and Cultural Practices

i. **Elder Gardening**
   - *See* "1. Historical and Intergenerational Trauma, b. Community Connectedness" for more information.

ii. **Food Gathering, Hunting, Fishing, Shellfish Harvesting (Food Sovereignty)**
   - *Description*: Learning and practicing methods of gathering traditional foods, including gathering roots, berries and other edibles, hunting and fishing and shellfish harvesting.
   - *Providers:* The role differs across tribal communities. Traditional leaders and other tribal community members with significant experience.
   - *Patients/Participants:* All ages, depending on cultural appropriateness of the activity and age range.

iii. **Traditional Medicines**
   - *Description*. Gathering of flora, roots, etc., for traditional teas and medicines.
   - *Providers*: Traditional leaders and highly trained ethnobotanists.
   - *Patients/Participants*: Potentially all ages depending on the cultural appropriateness of the activity and age range.

iv. **Traditional Gathering of Materials for Cultural Practices**
   - *Description*. Bark, reed, and root gathering for basket weaving and making of hats, headbands, and mats for traditional ceremonies. Gathering of cedar and sage for cleansing practices.
   - *Providers*: Traditional leaders
   - *Patients/Participants*: All ages depending on the cultural appropriateness of the activity.

b. Housing

i. **Safe House**

- *Description*. The Tulalip Tribes' Legacy of Healing Advocacy Center & Safe House[xxi] offers emergency housing, crisis intervention, transitional housing services, community-based education and support programs. Safe House beds are provided for women and their children, as well as food, counseling, support groups and advocacy. Emergency shelter days are between 30-90 days. It is a place of hope and healing.
- *Providers*: Tribal program and community resource programs.
- *Patients/Participants*: Tulalip Community and Native American women living in Snohomish County who are victims of domestic violence, sexual assault, dating violence and stalking

c. Healthy Families and Kinship

i. **Family Spirit**

- *Description:* Culturally tailored home visiting intervention for American Indian teenage mothers designed to increase parenting competence and promote healthy infant and toddler emotional and social adjustment.
- *Providers:* Health educators trained in the 63 lessons.
- *Patients/Participants:* Native teen mothers, from pregnancy through 36 months postpartum.

v. **Positive Indian Parenting**

- *Description*. This program prepares tribal and non-tribal child welfare personnel to train American Indian and Alaska Native parents using a culturally specific approach. The materials presented during this two- or three-day training draw on the strengths of historic Indian child-rearing practices and blend traditional values with contemporary skills. Storytelling, cradleboards, harmony, lessons of nature, behavior management, and the use of praise are discussed.
- *Providers*: Trained child welfare personnel.
- *Patients/Participants*: Families with children.

vi. **Native American Fatherhood and Families**

- *Description*. This organization offers two programs:
    i. *Fatherhood is Sacred & Motherhood is Sacred*, a foundational facilitator certification curriculum focused on the importance of faith and belief, consequences of good and bad choices, importance of being teachable and truth, importance of wisdom and service, and the importance of self-identity and relationships.

ii. *Linking Generations by Strengthening Relationships*, a second level facilitator certification curriculum focused on learning as sacred, link of problems to self-worth, improving relationships, identifying personal characteristics that are damaging to a relationship, accepting and showing love, learning traditional values of marriage, dating, and courtship.

- *Providers:* NAFFA certified facilitator
- *Patients/Participants:* Parents and family members

d. Chronic Disease Management

i. **Wisdom Warriors (includes the Stanford Chronic Disease Self-Management Model)**

- *Description.* Provides Elders the education, support and tools to make healthy choices resulting in lifestyles that promote self-care, good choices and longevity. The Elders are rewarded with the Program medicine bag, beads, charms, and most important, more active control of their own health and wellbeing.
- *Providers:* A tribal coordinator trained in the program
- *Patients/Participants:* Elders

ii. **Special Diabetes Program for Indians**

- *Description:* In response to the diabetes epidemic among American Indians and Alaska Natives, Congress established the SDPI grant programs in 1997. This $150 million annual grant program, coordinated by I.H.S. division of Diabetes with guidance from the Tribal Leaders Diabetes Committee for diabetes treatment and prevention to IHS, Tribal, and UIHP across the United States has had an impact on the health of AI/AN nationwide. Programs are designed to address local community priorities. Sixty-six SDPI Demonstration Projects successfully completed a six-year program translating the results of diabetes prevention and cardiovascular disease risk reduction research into diverse, real world Indian health settings. Toolkits have been developed in partnership with these sites which will help disseminate their positive results, best practices, and lessons learned throughout Indian Country.
- *Providers:* Clinical staff, providers, community health staff, health educators
- *Patients/Participants:* All patients seen by practice and their families and communities.

3. Prevention and Recovery Support

AIAN communities are strong and resilient. Recognizing the negative consequences of substance use disorders (SUD) and suicides in our communities is important. Equally important is the recognition that Tribes and UIHPs have the knowledge and practices to prevent and successfully intervene using community-based and culturally grounded approaches.

The following Culturally Appropriate Practices have been used successfully in Tribal communities to prevent and intervene in SUD and suicides and increase wellness and a sense of hope and belonging.

a. Substance Use Disorder Prevention and Recovery

i. **Healing of the Canoe**
- *Description.* The Healing of the Canoe partnership; a community based, culturally grounded prevention and intervention life skills curriculum for tribal youth that builds on the strengths and resources in the community. The Culturally Grounded Life Skills for Youth Curriculum uses the Canoe Journey as a metaphor, providing youth the skills needed to navigate their journey through life without being pulled off course by alcohol or drugs – with tribal culture, tradition and values as compass to guide them, and anchor to ground them.
- *Providers*: Tribal leaders and youth programs
- *Patients/Participants*: Youth

ii. **White Bison Medicine Wheel and 12 Steps**
- *Description*. This program provides a culturally appropriate 12 Step-program for AI/ANs based on the teachings of the medicine wheel, the cycle of life, and the four laws of change. This program incorporates the context of intergenerational trauma.
- *Providers*: White Bison trainers
- *Patients/Participants*: Community members interested in sobriety and wellbriety

b. Suicide Prevention

i. **THRIVE**
- *Description:* THRIVE (Tribal Health: Reaching out InVolves Everyone) works to reduce suicide rates among AI/AN by increasing tribal capacity to prevent

suicide and improving regional collaborations. Program includes technical assistance, suicide prevention trainings and resources.

- *Providers:* Depends on model being used, see website for more.
- *Patients/Participants:* Depends on model being used, see website for more.

ii. **Adolescent Suicide Prevention Program**

- *Description*: A suicide prevention program that emphasizes community, school, outreach, surveillance, innovative behavioral health programs, ongoing program evaluation and sustainability.
- *Providers*: Multiple services and coordinators
- *Patients/ Participants*: Youth and the broader tribal community

iii. **Assessing and Managing Suicide Risk**

- *Description*: A database of multiple effective suicide prevention programs and interventions. Include an assessment to filter resources and narrow in on the most useful ones.
- *Providers*: varies based on approach
- *Patients/Participants*: varies based on approach

4. Integrated Health Care

For both economic and traditional reasons, integrated care has already been happening within the Indian Health Care Delivery System. Whole person care, "grow your own workforce", home visiting programs can be found within many Tribal and UIHP in our state. Trusted community members providing trauma informed care within their own community will be support by the strategies list below:

a. Workforce Redevelopment

i. **Community Health Aide Program**

- *Description*: The Community Health Aide Program (CHAP) is a system of education and certification and a network of tribally based providers. CHAP includes Tribal Community Health Providers, Tribal Behavioral Health Providers, and Tribal Dental Health Providers. The CHAP works in tandem with the existing health system to create an accessible rung on the health providers profession ladder and to wrap around the existing health infrastructure work better for tribal communities by training tribal members to provide health services to their communities. CHAP providers are first responders and primary tribal health providers and can be providers involved in many of the other programs described in this Inventory. The providers work at the community level in interdisciplinary teams.
- *Providers:*
    - *Tribal Community Health Providers* - Community Health Aides are primary health care providers. There are 5 levels of Community Health Aides that build upon each other.
        - Community Health Aid level 1-4 (CHA I, CHA II, CHA III, CHA IV) and the top level, Community Health Practitioner (CHP) the scope of practice for each provider is different and encompasses all of the scope of practice for the levels below the highest level of training reached by the individual.
    - *Tribal Behavioral Health Providers* - The Behavioral Health Aide (BHA) Program is designed to promote behavioral health and wellness in Alaska Native individuals, families and communities through culturally relevant training and education for village-based counselors. There are 4 levels of Behavioral Health Aides that build upon each other.
        - Behavioral Health Aide level 1-3 (BHA I, BHA II, BHA III) and the top level, Behavioral Health Practitioner (BHP).

- *Tribal Oral Health Providers* - Dental Health Aides are primary oral health care professionals. They provide basic clinical dental treatment and preventive services. They are multidisciplinary team members and advocate for the needs of patients. There are 5 levels of Dental Health Aides that build upon each other.
    - Primary Dental Health Aide level 1-2 (PDHA I, PDHA II), Expanded Function Dental Health Aide level 1-2 (EFDHA I, EFDHA II) and the top level, Dental Health Aide Therapist (DHAT). The scope of practice for each provider is different and encompasses all of the scope of practice for the levels below the highest level of training reached by the provider.

b. Integrated Care Models

i. **American Indian Medical Home**

- *Description*. Between 2008 and 2014, the Indian Health Service provided technical assistance to Service Units and tribal health programs in the IHS Care Model, which blends patient-centered medical home concepts with traditional and cultural healing practices.
- *Providers*: IHCP
- *Patients/Participants*: All patients

ii. **Integrating Behavioral Health within the Structure of Health Services**

- *Description*. While one of the key evidence-based practices supported by the Medicaid Transformation Project is clinical integration of primary care and behavioral health care, Tribes have had a head start on that work – limited primarily by lack of funding.
- *Providers*: IHCP
- *Patients/Participants:* All patients

iv. **Native American-focused Pediatric Integrated Care Collaborative**

- *Description:* Providing trauma-informed pediatric integrated care, while encouraging adaptive practices and customization based on the needs of unique communities, environments, and organizational structures. Integrating behavioral and physical health services targeting traumatic stress exposure and

recovery to promote sustainable integration through a Breakthrough Series, Learning Collaborative, and a Training and Resource Toolkit.

- *Providers:* All
- *Patients:* Children who have suffered trauma.

v. **Traditional Healing as part of Integrated Health Care**

- *Description.* Long before the birth and development of the American health care system, traditional healing practices have been part of the lifeways of the twenty-nine tribal nations and members of other Tribes who reside in Washington State. From the tribal perspective, traditional healing practices are a fundamental element of Indian health care that helps patients achieve wellness and healing for various physical and mental illnesses and to restore the patient's relationship with his or her family, community, and environment.

  In 1978, with the passage of the American Indian Religious Freedom Act, the Indian Health Service (IHS) policy issued at that time required the Service Units to comply with requests by patients seeking the services of native practitioners, to provide a private space to accommodate the services and required the staff to be respectful of a persons' religious and native beliefs. In 1994, IHS updated the policy indicating that IHS would facilitate access to traditional medicine practices recognizing that traditional health care practices for many of the patients served contribute to the healing process and help patients maintain their health and wellness. The Indian Health Care Improvement Act (U.S. Code Title 25 Chapter 18) contains several sections noting the acceptance and respect for these practices and specifically incorporating them into various preventative service categories, including behavioral health services and treatment.

- *Traditional Healing in Behavioral Health.* Tribes have practitioners of various traditional healing practices, both indigenous to the specific Tribe and shared from another tribal nation (Navajo Nation traditional healing practitioners being the most common), offering their services in the Tribes' behavioral health programs. Blending traditional healing practices with Western treatment has been found to offer more effective healing of historical trauma.[xxii]
- *Other examples* of traditional healing practices include:
  - Sweat lodges
  - Smudging/purification
  - Talking circles
  - Songs and drumming
  - Red Road teachings
  - Native crafts

- Storytelling
- Cultural presentations
- Drum making
- Carving
- Berry picking (traditional food gathering)
- Beading
- Drum circles

c. Culturally Appropriate Health Care Practices

i. **Gathering of Wisdom**[xxiii]

- *Description*. This is a culturally and spiritually informed substance use disorder counseling model, developed by the Swinomish Indian Tribal Community. Native American mental health workers, Tribal elders, a psychologist, a psychiatrist & a community mental health center administrator combined traditional Indian & modern mental health knowledge into a unique Indian cultural perspective.
- *Providers:* IHCPs
- *Patients:* All patients, their families and community members

ii. **Native Water Dancing**

- *Description.* Native Water Dancing combines physical therapy with a culturally appropriate activity that would allow the Elders and vulnerable adults to have a good time doing something that they may have lost hope of ever being able to do again due to illness, injury, or pain issues.
- *Provider(s)*. Team of traditional practitioner of songs and drumming and physical therapist.
- *Patient(s)*. Many of Natives loved to dance in their youth but are unable to now due to the debilitating effects of diabetes, strokes, arthritis, TBI's, cardiac issues, etc. Finding an activity for them that would allow them to interact with others and be able to do the things they thought they never would be able to do again, would enhance their overall mental, physical, and psychosocial well-being immensely. Additionally, having caregiver with them in the pool would allow them to "bond" over a cultural activity that is sacred to them. Following the dancing, the elders could meet for lunch in the deli of the gym for a lunch and possibly get some education on healthy eating tips from our dietician.

iii. **Equine Therapy: Healing with Horses Program**

- *Description*. The use of horses within the therapy setting, is an effective and fun therapy model provided in a safe environment. This approach can be used to

address emotional roadblocks, address past trauma and provide emotional healing, and increase self-esteem.

- *Provider(s).* Equine Assisted Therapy is a modality of treatment: Licensed mental health professionals are providing the treatment, have been trained in both the Eagala model for equine therapy and mental health counseling as part of a treatment with horses, which can be individual, family or group sessions. The providers are certified and receive continuing education.
- *Patients.* Anyone coming in for mental health counseling is asked if they are interested in getting counseling with horses present. People are referred internally from the Muckleshoot Behavioral Health and any patient is potentially able to be seen in the Healing with Horses program. This modality is appropriate for patients experiencing:
    i. Grief and Loss
    ii. Depression
    iii. Anxiety
    iv. Anger management
    v. Almost any behavioral health disorder
    vi. Trauma/Multigenerational Trauma

ii. **Wisdom Warriors (Stanford Chronic Disease Self-Management Model)**

- See above for more information; the Wisdom Warriors program ties in with clinical treatment plans.

d. Behavioral Health Practices

- Internal Family Systems Therapy (Developed by Dr. Richard Schwartz)
- Eye Movement Desensitizing Reprocessing Therapy (Developed by Francine Shapiro)
- Cognitive Behavior Therapy (CBT)
- Trauma Focused CBT
- Dialectical Behavior Therapy (Developed by Marsha Linehan)
- ACT (Acceptance and Commitment Therapy)
- Mindfulness approaches
- Art Therapy

e. Alternative Providers/Services

- Massage
- Chiropractic
- Acupuncture
- Naturopathy (already Medicaid covered)
- Osteopathic Body Manipulation (already Medicaid covered)

E. Inventory: Barriers to Implementing Culturally Appropriate Practices

Despite treaty obligations and federal law to provide health care to AI/ANs, the Indian Health Care Delivery System receives from discretionary IHS Congressional appropriations less than one-third of the overall funding it needs to provide care to AI/AN. Perhaps due to this consistently chronic underfunding,[xxiv] Congress and CMS have enacted and promulgated numerous Medicaid requirements – including requirements that IHS is the payer of last resort.[xxv] While Medicaid requirements protect the ability of Medicaid-enrolled AI/ANs to receive care at IHCPs, the need for IHCPs to seek reimbursement from Medicaid and other third party payers creates administrative complexity, as IHCPs must manage client eligibility and coverage along with referrals and payments. Coupled with the excessive dependence on federal grant funding for various initiatives, this underfunding and complexity undermine the ability of IHCPs to offer and maintain holistic models of care.

1. Barriers: Indian Health Service

In addition to the grossly inadequate discretionary Congressional appropriations, and perhaps because of it, the Indian Health Service does not provide clear or timely guidance to Tribes – even when the guidance sought is related to federal laws administered by IHS. For example, when Congress authorized Tribes to receive reimbursement from Medicaid and other third party payers, Congress required Tribes to use Medicaid and Medicare funds received through reimbursement to provide additional health care services, for improvements in health care facilities and Tribal health programs, or for any health care-related purpose of the health program or any health care-related purpose.[xxvi] However, the requirements are not clear, and the Indian Health Service does not provide clear or timely guidance on whether such funds can be used for wellness activities, cultural practices, and traditional healing practices, and what the requirements are to do so, such as whether Tribes must include these activities in their Annual Funding Agreements with IHS in order to use these excess funds on these activities.

Likewise, the information technology and data solutions provided by the Indian Health Service are obsolete and interfere with the Tribes' ability to manage the health of their people and to send and receive electronic health records using meaningful use standards. In addition, with the legacy of inappropriate and harmful research on American Indian populations, Tribal data needs present unique challenges as data can be held by state and federal agencies, impeding the Tribes' abilities to manage the health of their people as sovereign nations.[xxvii] In Washington State with an Indian Health Care Delivery System that lacks a hospital or specialty care, this means that Tribes and IHCPs have incomplete health data in the IHS or Tribal systems. Tribes and IHCPs need the capacity to hold and manage population health data. All of the IHCPs in WA have to work to meet the varied EHR needs for sending and receiving information with hospitals and

specialty care providers; this interferes with ability for IHCPs to coordinate patient information with hospitals and specialty care providers.

2. Barriers: Medicaid

The Medicaid program presents its own sets of obstacles to Tribes' and other IHCPs' offering and maintaining holistic models of care. As a state-federal partnership program, Medicaid does not support individualized plans of financing for Tribes or IHCPs. Instead, Medicaid is predicated on statewide requirements, applicable to Tribes and IHCPs except if federal laws or rules create an exception for AI/ANs or Tribes/IHCPs. Those exceptions, though, are not enough to support Tribal/IHCP models of care.

Under Washington State Medicaid, enrollees are covered under either the fee-for-service program or the managed care program. Under Medicaid fee-for-service rules, covered services must be available statewide and to all Medicaid enrollees, providers must meet state licensure requirements, and services are paid for per service according to HIPAA claim requirements. These requirements preclude Medicaid financial support for traditional healing services provided by Tribes and IHCPs. States are not appropriate licensing authorities for traditional healing practitioners, and fee-for-service reimbursement is not necessarily the most culturally appropriate means for supporting traditional healing services. Moreover, there is no existing federal taxonomy for traditional healers, as such practitioners do not fit the mold of traditional Western medical practices.

In addition to the fee for service model, traditional Medicaid managed care also presents itself as a barrier for Tribes and other IHCPs who aim to offer culturally appropriate care. Numerous studies have shown that AI/AN populations suffer higher rates of chronic illness than the general population; thus, financing AI/AN healthcare delivery using standard, Western-based models fails to recognize these health disparities and leaves IHCP's unable to meet the needs of their local AI/AN population. Most, if not all, Medicaid managed care entities are rooted in Western-based care healthcare management practices. Therefore, just as with the fee for service system, managed care delivery systems often do not recognize or finance traditional healing services or other culturally appropriate health and wellness practices. In most cases, Tribes and IHCPs, not managed care entities, have the best understanding of their AI/AN population and what tribally appropriate care models, such as traditional healing services, may be most effective for their patients.

Moreover, the only Washington State Medicaid program that offers a "per member per month" payment to Tribes is the Primary Care Case Management (PCCM) program, which pays participating Tribes and other IHCPs $3.00 per month for coordinating care for enrolled patients. This amount is not sufficient to cover the expenses for coordinating care, let alone to support other types of services, such as traditional healing. In addition to PCCM, Washington State

Medicaid does offer the Health Homes Program, which reimburses Care Coordination organizations on a multi-tiered, encounter-based payment structure for providing care coordination services, developing a health action plan, and executing face-to-face visits with high-risk Medicaid patients with multiple chronic conditions. Tribes and Tribal organizations are eligible to become care coordination organization; however, the Health Home Program only provides reimbursement for treating the sickest subsection of the Medicaid population and, thus, ignores a large portion of the AI/AN Medicaid population. Furthermore, the Health Home Program does not directly provide financing specific to culturally appropriate care, such as traditional healing services.

As previously mentioned, Medicaid funding for Washington AI/AN culturally appropriate health and wellness activities is largely non-existent. With today's increasing investments in preventative healthcare and the promotion of wellness, more and more health insurance and managed care entities are incentivizing and/or providing resources for their patents to seek health and wellness activities. Such activities might include subsidizing healthy food choices, providing premium rebates for health activity commitments, and covering the costs of gym memberships, to name a few; however, AI/ANs enrolled in Medicaid continue to have little access to culturally appropriate, holistically-based health and wellness programs. This is largely to do with the fact that most culturally-based wellness programs are either underfunded or receive no financing whatsoever.

Alongside the lack of culturally appropriate care, attaining the appropriate amount of long-term services and supports (LTSS) can be a challenge for AI/AN patients. LTSS are not funded by IHS, through the 1115 Waiver, some services provided can be paid for, however the eligibility is very narrow.

As discussed within this document, AI/ANs patients have, often, experienced intergenerational trauma; however, existing functional assessment tools typically do not consider intergenerational trauma when allotting LTSS coverage. One specific example of this would be the Washington Department of Social and Health Service's (DSHS) Comprehensive Assessment Reporting Evaluation (CARE) tool. The CARE tool is used by case managers to document a client's functional ability, determine eligibility for long-term care services, evaluate what and how much assistance a client will receive, and develop a plan of care. Unfortunately, though, the CARE tool's logic does not take into consideration intergenerational trauma when determining a patient's hourly coverage, which, ultimately, may prevent an AI/AN patient from receiving the care they truly need. Furthermore, the tool captures any informal supports that a client may be receiving. For a Tribe providing unfunded, culturally appropriate care for a Tribal member, the CARE tool logic will reduce the available hours of care that can be paid on behalf of the patient. This case both limits the patients access to Medicaid coverage, as well as limits the amount of Medicaid financing available to providers attempting to provide culturally appropriate care.

As with IHCPs and other culturally appropriate providers, non-IHCPs often lack sustainable financing to treat AI/AN Medicaid patients. In Washington, 57% of AI/AN Medicaid patients are enrolled in the fee for service program; however, fee for service Medicaid is often the lowest payer for non-IHCPs in Washington. Thus, non-IHCPs are incentivized to treat other patient groups (commercial, Medicare, etc.) before treating AI/AN Medicaid fee for service patients. This is highly problematic, as IHCPs are often limited to providing more basic primary care outpatient services. Without access to specialty care services, many AI/AN Medicaid patients are unable to attain the specialty services they need. Furthermore, this lack of financing makes it particularly difficult for Tribes and their Medicaid membership to find culturally appropriate, trauma-informed specialty care. The combination of a lack of financing and a lack of culturally-informed care significantly limits the access to the specialty care Medicaid AI/ANs require.

Another barrier to implementing culturally appropriate care for Tribes and IHCPs are the many technical reporting requirements that existent within the Medicaid. In order to achieve reimbursement, Medicaid providers are required to properly document patient treatment and encounters in order to provide proof of proper treatment and validate billing practices. As Washington State Medicaid and CMS move more and more to fully-digital platform, technical challenges continue to arise for many safety net providers. For Tribes and IHCPs, such challenges are intensified, as Tribes and IHCPs often lack sustainable funding and/or are located in geographical areas with little cellular or internet coverage. This is particularly an issue for in-home care providers who, beginning in 2019, will be required to remotely log treatment hours while onsite. Many of the Tribal patients they service are located in areas without any cellphone or internet coverage, making it very difficult to log treatment within their client's home.

In summation, Tribes and IHCP's are best equipped to understand the unique needs of their populations and, thus, should be encouraged to develop unique, culturally appropriate practices. Within the current Medicaid reimbursement model, though, Tribes and IHCPs are often unable to financially sustain culturally relevant care without non-Medicaid subsidization. By limiting culturally sensitive innovation, Medicaid is stifling the opportunity to advance more effective, non-Western treatment techniques, which may achieve improved health outcomes for the AI/AN Medicaid population at an equal or lower overall cost to the Medicaid system.

II. PLAN FOR IMPROVEMENT OF AI/AN BEHAVIORAL HEALTH

A. Strategies to Build on Available Services and CAPs

Although there are many barriers for Tribes and IHCPs, there currently are some available, Medicaid reimbursable service models that can allow Tribes and IHCPs to either directly or indirectly provide culturally appropriate services. Furthermore, new, viable frameworks could be established to better allow Tribes and IHCPs to provide culturally appropriate practices in a

financially sustainable manner. By implementing sustainable CAP frameworks, Tribes and IHCPs can improve AI/AN medical and behavioral health outcomes and reduce the total cost of care.

As previously mentioned, traditional healing services have long been a pivotal part of Tribal healthcare, especially as it pertains to behavioral health; yet, conventional Medicaid reimbursement models fail to financially recognize that traditional healing can significantly improve AI/AN health outcomes. One recognized modality of reimbursing the costs associated with traditional healing is the Arizona Health Care Cost Containment System's (AHCCCS) pending AI/AN traditional healing services 1115 waiver application.[xxviii] This application supports reimbursement for Traditional Healing Services provided in, at, or through facilities operated by the Indian Health Service, a Tribe or Tribal organization, or an UIHP to Medicaid eligible AI/AN. As noted before, states are not appropriate licensing authorities for traditional healing practitioners; however, under the AHCCCS waiver, Tribes and IHCPs are given the ability qualify and endorse traditional healing practitioners to treat their eligible Medicaid AI/AN population underneath the patient's plan of care. Such an arrangement allows individual Tribes and IHCPs the ability to select and credential the most effective traditional healing practitioners for their Tribal members. Furthermore, this arrangement allows the IHCP to bill on behalf of the traditional healing practitioner, and 100 percent federal medical assistance rate (FMAP) would apply to the state's payment for the service. The AHCCCS pending waiver provided the following payment options are provided for consideration:

> **Option A. Per Encounter payment:** AHCCCS to reimburse the IHS, Tribal and Urban health facilities (through arrangements), at the IHS All Inclusive per encounter rate available for Medicaid inpatient and outpatient services.
>
> **Option B. Fee for Service payment:** Fee for Service reimbursement to be based on traditional healing services provided to an individual patient.
>
> **Option C. Member Benefit Allowance:** This would be provided as an added value benefit to an eligible AI/AN through AHCCCS. A traditional healer recommends a ceremony that the patient needs and they are eligible for a determined benefit allowance each year. The practitioner will be paid upon completion of the service.

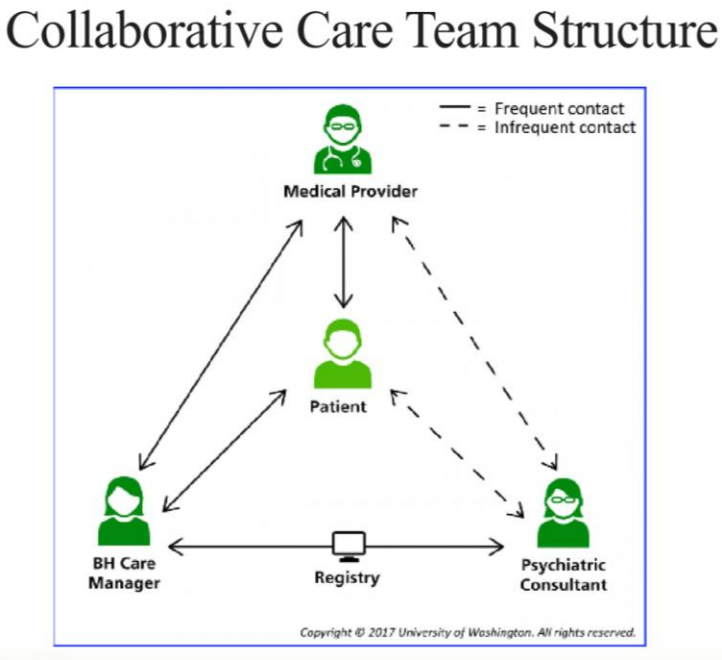
As discussed previously, fee-for-service payment and other existing reimbursement methodologies may not necessarily be the most culturally appropriate means for supporting traditional healing practitioners; however, there are costs associated with providing such services; thus distinguishing reimbursement methodologies can allow Tribes and IHCPs to provide financially sustainable traditional healing services for the AI/AN they serve. Therefore, it is important to explore existing and new, alternative reimbursement methodologies for AI/AN traditional healing services.

As discussed throughout this document, culturally appropriate care programs do not easily fit into the Medicaid fee for service system, nor are there codes available for IHCP's to bill for these services. Today, Tribes and IHCPs often do not possess the necessary healthcare funds to sustain care coordination, case management, and other culturally appropriate services, as many of these services are not eligible for fee for service reimbursement. A possible solution would be to implement a PMPM rate for all Medicaid AI/AN patients currently attributed to an IHCP. This would allow IHCPs to hire additional staff to address care coordination, case management, or other programs and services that are vitally needed to address the many elevated risk factors that exist with the AI/AN population. Washington's Health Homes program currently offers such a program, providing a monthly multi-tiered, encounter-based payment for providing care coordination services. This program is limited to only the sickest/highest risk patients in the clinics population. The program can add tremendous value for these high-risk patients, however, there are many other patients who would also benefit from these additional resources for care coordination as well as other services related to Wellness, Behavioral Health or Preventive Medicine programs, many which fall under the category of non-traditional/culturally appropriate programs. Additionally, as previously mentioned, Washington does provide the PCCM program for IHCPs; however, the $3.00 PMPM payment does not provide sufficient financing to cover the expenses for coordinating care, let alone to support other types of services, such as CAPs.

By providing the Tribe with a sufficient PMPM amount for all enrolled AI/AN Medicaid members, the Tribe could use these funds to expand services and oversight to the sickest patients in their clinics while also expanding services around many of the culturally appropriate programs highlighted in this document. If the Tribes were allotted the IHS encounter rate for all attributed patients, this would sufficiently fund the Tribe to develop meaningful programs designed to support all clinic patients who historically have a greater risk of developing chronic diseases that result in more intensive outpatient care and hospitalizations. A PMPM model would allow Tribes and IHCPs to expand culturally appropriate programs that improve the entire clinic populations health, reduce risk factors, and decrease overall spending within the Medicaid program.

As discussed throughout this document, collaboration of care between physical and behavioral healthcare is vital for Tribes and IHCPs when treating AI/ANs. In Washington, the Psychiatric Collaborative Care Services program will help to facilitate this necessary collaboration. The program is a model of behavioral integration that enhances standard primary care practices by adding two key services: Care management support and regular psychiatric inter-specialty consultation to the primary care team. The model facilitates the treatment of common mental health conditions and focuses on defined patient populations. The model requires weekly psychiatric consultation with special attention to patients not progressing. Patients are expected to stay in this model 4 to 6 months, while those remaining in the program for greater than 12 months will require prior authorization.

The following graphic provides a visual representation of the collaborative care team:



Programs like Psychiatric Collaborative Care Services will better allow Tribes and IHCPs to improve behavioral health outcomes; however, it is important to keep such models flexible in terms of CAP integration and financing. Such flexibility will allow Tribes and IHCPs to financially sustain effective integrated delivery models. Traditional Healers could be the Behavioral Health Manager in this model.

Another financing strategy Washington Tribes and IHCPs are looking to implement is an Indian Health Care Reinvestment Pool. Per federal regulation, all Medicaid eligible services provided to Medicaid AI/AN patients qualifies for 100 percent FMAP, meaning all AI/AN Medicaid expenses are passed through to the federal government. Because this is the case, and because Washington State Medicaid does not achieve 100 percent FMAP for non-AI/AN Medicaid patients, Washington State Medicaid realizes annual budget savings for care delivered to its AI/AN Medicaid population. Understanding this, Washington Tribes and IHCPs are working to implement new, state-based legislation that will reallocate these annual savings into an Indian Health Care Reinvestment Pool. The reinvestment pool is to be maintained by the Washington HCA, with Washington Tribes and UIHP providing oversight and determining the use of funds. Under such an arrangement, Tribes and UIHPs would have the opportunity to finance individualized Tribal/IHCP models of care aimed at improving AI/AN behavioral healthcare needs. Examples could include reinvestment pool grants for Tribes/IHCPs looking to address behavioral healthcare needs, investments into data and population health management infrastructure, construction of a clinical data repository, and resources for bolstering IHCP

integrated healthcare delivery, to name a few. However, such opportunities will not be available to Washington Tribes and IHCPs until legislation is finalized, passed by the state legislature, and executed by HCA.

For Tribes with a 638 compact or contract, there exists an opportunity to utilize their Tribal health center's Medicaid Federally Qualified Health Center (FQHC) status to attain additional finances to offset other healthcare costs. In January of 2017, CMS provided clarification of Tribal FQHC's billing capabilities via the Frequently-Asked Questions(FAQs) Federal Funding for Services 'Received Through' an IHS/Tribal Facility and Furnished to Medicaid Eligible American Indians and Alaska Natives (SHO #16-002) document.[xxix] In particular, the FAQ clarifies that Tribal FQHCs can implement a contract with a non-IHCP provider, bill the IHS encounter rate for the service provided by the outside provider to the AI/AN patient, and keep any additional revenue after paying the provider underneath their contracted arrangement. CMS provides the following example within the FAQ:

> "[I]f a Tribal FQHC contracts with a cardiologist whose practice is offsite, and if the cardiologist treats an AI/AN Medicaid beneficiary as a patient of the FQHC, the Tribal facility may bill the Medicaid program for the cardiologist's service at the facility rate, not at the Medicaid rate for that cardiologist's service, and 100 percent FMAP would apply to the state's payment for the service."

Therefore, if the Tribal FQHC can attain a positive margin underneath such an arrangement, the sponsoring Tribe now has access to additional funds that can be utilized to offset costs for other healthcare operations, such as CAPs. Furthermore, when non-IHCPs see Tribal FQHC Medicaid AI/AN patients under such an arrangement, 100% FMAP would apply to the state's payment for the service. This could enable Washington State Medicaid to better finance CAPs, facilitate more integrated healthcare delivery, and increase AI/AN access to specialty care. However, Tribes and IHCPs in Washington still require technical assistance as to how Tribal FQHCs will be able to set up and bill under said contracted arrangements, as well as whether or not Tribal FQHCs will have a more restricted set of outpatient services than current available to 638 facilities.

Traditional approaches are effective to the AI/AN population. A few examples of cultural appropriate services currently offered and models for the Tribes using them are:

- North Sound BHO has contracted with a local Tribe using SAMHSA block grant funding (sub-recipient) for traditional healing to be provided for their members (more than Medicaid eligible) who choose that type of service.
- Salish Cancer Center – although able to receive third party reimbursement for certain services, traditional healing is funded with Tribal dollars.

Ultimately, these identified strategies can better enable Tribes and IHCPs to deliver and expand CAPs; however, many of these strategies will require ongoing work with state and federal Medicaid administrations to implement new, financially sustainable alternative reimbursement methodologies that best allow Tribes and IHCPs to address the behavioral healthcare needs of their AI/AN patients.

B. Investments in Data, Health Information, Population Health Systems

Data Project: Improving the Quality of AI/AN Data and Strengthening Tribal Data Sovereignty

Purpose

Most data currently available for AI/AN in Washington State come from state registries and third-party sources; for example, the state cancer registry, Medicaid claims data, etc. They lack the precision and timeliness that data collected and managed by Tribes and UIHPs can offer. Tribal governments, UIHPs must have timely access to quality data to inform health care policy, environment and systems decisions to improve health status among AI/AN. At present, none of the IHCPs in Washington are utilizing a population health management system.

The Washington State AI/AN Data Quality and Data Sovereignty Project is designed to:

1) increase the timely availability of quality health data for AI/AN in Washington,
2) support data sovereignty, and
3) strengthen data capacity for Tribes and UIHPs.

Medicaid Transformation Investment Areas

The Data Project supports the following primary investment areas of Medicaid Transformation:

- Health Systems Capacity Building
- Care Delivery Redesign
- Prevention and Health Promotion

Project outcomes, by Medicaid Transformation Investment Area include:

<u>Health Systems and Capacity Building</u>

- Financial Sustainability
    - Value Based Payments
        - The project will provide Tribes and IHCPs the capacity to analyze and report population health outcomes by type of care received, whether it is a clinical intervention (e.g., metformin use, opioid use) or a non-clinical intervention (e.g., participation in cultural foods classes, participation in yoga classes, canoe journey), and/or by provider to compare cost of care in relation to efficacy

- Workforce Innovation
    - Integrating Emerging Professions into Healthcare Teams
        - The project will provide non-clinical staff the ability to document non-clinical health-related information (e.g., supportive housing, employment support) so that clinicians have access to the information, and a mechanism to efficiently and securely share information and coordinate care
        - The project will provide Tribes and IHCPs the capacity to analyze and report population health outcomes in relation to care provided by emerging professions
        - The project will strengthen community-based workforce capacity by training AI/AN community members on system administration and data management
- Population Health Management
    - Increased access to population health data
        - The project will provide Tribes and IHCPs the capacity to analyze and report community health assessment data to inform community-specific health needs inventories, develop community health improvement plans and track outcomes
        - The project will provide the capacity to aggregate data from the various Tribal and Urban IHCPs to develop a statewide understanding of the health of American Indians and Alaska Natives
        - The project will provide the capacity to analyze population health data from multiple domains of care (i.e., primary care, behavioral health, social services)
    - Syndromic Surveillance
        - The project will provide the capacity to conduct syndromic surveillance and support early detection of emerging public health threats and epidemics

<u>Care Delivery Redesign</u>

- Bi-Directional Integration of Primary Care and Behavioral Care
    - The project will provide the ability to share relevant PHI between primary care and behavioral care providers
    - Support standards of care for bi-directional integration through patient screening alerts
    - Support evidence-based approaches for patient-centered care (e.g., PCMH, IPC, Collaborative Care Model)
- Community-Based Care Coordination

    - Support Pathways Community Hub and similar models
    - Access to clinical measures in relation to participation in non-clinical services (e.g., Initiative 3 – supportive housing and employment)
    - Referral Manager Module
- Transitional Care
    - Support care transition models
- Diversion Interventions
    - Access to ED data

Prevention and Health Promotion

- Opioid Use Disorder Prevention and Treatment
- Maternal and Infant Health
    - Support integration of primary care and home visiting services
- Access to Oral Health
- Chronic Disease Prevention and Control
    - Access to clinical data in relation to participation in prevention programs

Project Health Information Technology (HIT) Solutions

The project includes two primary solutions:

1) a population health management information technology solution owned and managed by each Tribe/UIHP, and

2) a data aggregation hub operated by the Washington State Tribal Coordinating Entity.

Solution 1: Population Health Solution

- Owned and operated by each Tribe and each UIHP that chooses to participate
- Allows each Tribe and UIHP access to meaningful information from its electronic health record, as well as other data sets for the public health/community health programs they manage and social determinants of health
- Provides each Tribal government and UIHP leadership with actionable data regarding their population's health status
- Provides access to accurate data extracted directly from the original sources (EHR and other community data sets)
- Provides the ability to measure the efficacy of specific interventions (e.g., a specific type of inhaler, traditional foods class) for a specific population

- Facilitates coordination of services between clinical and non-clinical programs
- Provides the ability to view costs and health status information together
- Includes a highly-customizable reporting function that is being used by several Tribes in California to improve patient care, report User Population to the IHS National Data Warehouse, generate GPRA reports and Meaningful Use Provider Incentive reports, etc.
- Serves as a tool to increase data capacity for each Tribe and UIHP
- Provides Tribes and UIHPs the capacity to determine very specifically what information they choose to share
- Supports data sovereignty by providing full ownership and control of a community's data

Solution 2: Data Aggregation Hub

- Operated by the Tribal Coordinating Entity
- Receives and aggregates the clinical and non-clinical data that Tribes and UIHPs choose to share
- Produces statewide aggregated, de-identified health information for Tribal and UIHP populations
- Model used by Kaiser Permanente in California to manage population health data for its many sites

Project Activities

- Training and technical support for IHCP staff to install, deploy and maintain HIT solutions and interfaces
- Training for IHCP staff on utilizing HIT to support delivery of care using evidence-based standards for substance use disorders treatment, maternal and child health, preventive care, and chronic disease management
- Training for IHCP staff on utilizing HIT to meet reporting standards, including:
    - State Common Measures
    - GPRA
    - IHS Diabetes Audit
    - UDS
    - HEDIS
    - Syndromic Surveillance
    - NCQA Patient Centered Medical Home
    - IHS IPC

- Training for IHCP staff on utilizing HIT to support Bi-Directional Integration of physical and behavioral health care
- Training for IHCP staff on utilizing HIT to support Community-Based Care Coordination and Pathways-like models
- Training for IHCP staff on utilizing HIT to support Transitional Care
- Training for IHCP staff on utilizing HIT to support Value-Based Payments, combining clinical and payment data, using comparative ROI, and measuring outcomes of clinical and non-clinical interventions (including culturally-based programs)
- Training for IHCP staff on utilizing HIT to support integration of emerging professions into the healthcare team
- Training for IHCP staff on utilizing HIT to support community assessments and community health needs inventories
- Training for IHCP staff on utilizing HIT to support data sovereignty and data sharing
- Training for IHCP staff on utilizing HIT to support linkage and coordination with Data Aggregation Hub

Modernization of Electronic Health Record Technology for IHCPs

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 set interoperability and meaningful use standards for health information management systems. These standards require healthcare providers to not only adopt, but also make "meaningful use" of health information technology. Systems are certified by the Office of the National Coordinator for Health Information Technology (ONC), based on their ability to meet interoperability and meaningful use standards. Although RPMS achieved certification in 2014, the system has significant deficiencies in the areas of interoperability, support for meaningful use, business office management, care coordination and population health management. Also, it is unclear how much longer RPMS will be supported, after the Veterans Administration's decision to retire VISTA, RPMS' "sister" system.

Eighteen of the 32 IHCPs in Washington State have not been able to acquire commercial electronic health record software to migrate away from RPMS. Of the 14 IHCPs that have migrated to commercial systems, some are using somewhat rudimentary systems that limit innovation and implementation of patient centered models and evidence-based standards.

Tribes and UIHPs lack the resources to purchase: hardware, software, implementation support, training, and technical assistance. Resources are also needed for IHCPs to invest in community-based workforce development that results in sufficient AI/AN HIT professionals to staff the system.

C. How Strategies and Investments will Achieve MTP Objectives

The overarching objectives of the Medicaid Transformation Projects include health and community systems capacity building, care delivery redesign, increasing access to prevention and health promotion, and expanding the workforce to meet the needs of communities. For Tribal communities in Washington, expanding access to culturally appropriate and traditional healing practices, integrating care models, creating a statewide, compatible data system, increasing access to alternative providers and services, and developing health, oral health, and behavioral health teams that include CHAP providers are necessary strategies to address the staggering health disparities in Tribal and other underserved communities and will be a first step toward making the health delivery system more efficient and effective for everyone who utilizes health care in Washington.

There is a real lack of recognition and understanding of Intergenerational/Historical Trauma in health care settings and a clear need to retrain existing workforce. There are also significant costs associated with acquiring the tools to incorporate culturally appropriate and traditional healing practices and trauma informed care into every interaction. Other challenges to reaching our goals for transforming the Tribal health delivery system include the need for ongoing resources and coordination support.

The strategies and investments in coordinating data between tribal health programs, expanding and scaling up culturally appropriate and traditional health practices, and implementing a CHAP program will provide a strong statewide framework for transforming the Tribal Health Delivery System. Utilizing community based resources and creating an accessible training model for Tribal communities supports the needs and priorities of Tribal communities throughout Washington.

These projects will support the needs and priorities of Tribal communities throughout Washington by:

- Improving the quality, availability, and reliability of data from Tribal communities;
- Creating an integrated data system to allow for improved tracking and follow up as patients move around the state;
- Improving care, tracking, and follow up;
- Providing trauma informed care with every interaction which will lead to better health care and better outcomes;
- Increasing access to healthy, traditional foods, increase physical activity, social and emotional connectivity, emotional awareness and regulation;
- Improving health and wellbeing of community members, especially in breaking cycles of trauma when able to mitigate or prevent Adverse Childhood Experiences;

- Implementing sustainable CAP frameworks so that Tribes and IHCPs can improve AI/AN medical and behavioral health outcomes and reduce the total cost of care;
- Building a framework for the Certification of CHAP providers including CHA/P, BHA/P, and DHAT
- Supporting the infrastructure in the early years of a CHAP Certification Board until it can be self sufficient
- Building a framework education programs based in Tribal colleges in the state.
- Supporting the development and implementation of CHAP training programs in the state.
- Increasing capacity at Tribal clinics
- Expanding access to consistent, routine, high quality traditional, primary health, oral health, and behavioral health care in tribal communities;
- Growing the number of AI/AN health, oral health, and behavioral health care providers available to Tribal communities;
- Increasing access to culturally competent care into Tribal communities;
- Creating a more efficient and effective health, oral health, and behavioral health teams that can meet the needs of the Tribal communities;
- Establishing cost effective solutions to the health, oral health, and behavioral health challenges into Tribal communities;
- Bringing care where it is needed most;
- Increase health prevention and management of chronic diseases;
- Increasing intergenerational transmission of healthy behaviors.

III. INSTRUCTIONS FOR PAYMENT OF IHCP PLANNING FUNDS

The Tribes and UIHPs have agreed that decisions regarding payment of earned IHCP Planning Funds will be made by majority vote of Tribes and UIHPs, with each having one vote to be held by the Tribe's or UIHP's delegate to the American Indian Health Commission for Washington State (AIHC) unless the Tribe or UIHP directs that vote to be held by someone else. If the IHCP Planning Funds are earned before the Tribes and UIHPs agree on how to allocate the funds, the state will not allocate the earned funds until the Tribes and UIHPs instruct the state on whom will receive the funds and in what amounts.

On December 14, 2017, the Tribes and UIHPs passed the following resolution:

> RESOLVED that, subject to the award of the Indian Health Care Provider (IHCP) Planning Funds in the anticipated amount of $5.4 million upon delivery of the IHCP Planning Funds Plan to Health Care Authority (HCA) no later than December

31, 2017, a majority of the Tribes and UIHP during the December 14, 2017 meeting of the delegates of the American Indian Health Commission for Washington State hereby instructs HCA to deliver $1,240,000.00 of the IHCP Planning Funds in the following amounts and to the following recipients in accordance with each recipient's delivery instructions:

Confederated Tribes of the Chehalis Reservation	$40,000.00
Confederated Tribes of the Colville Reservation	$40,000.00
Cowlitz Indian Tribe	$40,000.00
Hoh Indian Tribe	$40,000.00
Jamestown S'Klallam Tribe	$40,000.00
Kalispel Tribe of Indians	$40,000.00
Lower Elwha Klallam Tribe	$40,000.00
Lummi Nation	$40,000.00
Makah Tribe	$40,000.00
Muckleshoot Indian Tribe	$40,000.00
Nisqually Indian Tribe	$40,000.00
Nooksack Indian Tribe	$40,000.00
Port Gamble S'Klallam Tribe	$40,000.00
Puyallup Tribe	$40,000.00
Quileute Tribe	$40,000.00
Quinault Indian Nation	$40,000.00
Samish Indian Nation	$40,000.00
Sauk-Suiattle Indian Tribe	$40,000.00
Shoalwater Bay Indian Tribe	$40,000.00
Skokomish Indian Tribe	$40,000.00
Snoqualmie Indian Tribe	$40,000.00
Spokane Tribe of Indians	$40,000.00
Squaxin Island Tribe	$40,000.00
Stillaguamish Tribe of Indians	$40,000.00
Suquamish Tribe	$40,000.00
Swinomish Indian Tribal Community	$40,000.00
Tulalip Tribes	$40,000.00
Upper Skagit Indian Tribe	$40,000.00
Confederated Tribes and Bands of the Yakama Nation	$40,000.00
Seattle Indian Health Board	$40,000.00
NATIVE Project of Spokane	$40,000.00

The rest of the funds distribution will be determined by March 31, 2018 as agreed in the Tribal Protocols.

[i] Washington Health Alliance. Disparities in Care Report, 2014.
[ii] Data from Personal Communication from V. Warren-Mears, Director NWTEC. Analysis performed 12/2017 by the IDEA-NW project for this report.
[iii] Northwest Portland Area Indian Health Board. American Indian & Alaska Native Community Health Profile – Washington. Portland, OR; Northwest Epidemiology Center, 2014 (WA State death certificates, 2006-2012, corrected for misclassified AI/AN race).
[iv] Northwest Portland Area Indian Health Board. American Indian & Alaska Native Community Health Profile – Washington. Portland, OR; Northwest Epidemiology Center, 2014 (WA State death certificates, 2006-2012, corrected for misclassified AI/AN race).
[v] Data Source: Northwest Portland Area Indian Health Board. American Indian & Alaska Native Community Health Profile – Washington. Portland, OR; Northwest Epidemiology Center, 2014 (WA State death certificates, 2006-2012, corrected for misclassified AI/AN race).

[vi] Phipps KR, Ricks, TL. The oral health of American Indian and Alaska Native Children Aged 1-5 Years: Results of the 2014 IHS Oral Health Survey. Indian Health Service data brief. Rockville, MD: Indian Health Service. 2015.
[vii] Phipps KR, Ricks TL. The oral health of American Indian and Alaska Native adult dental patients: results of the 2015 IHS oral health survey. Indian Health Service data brief. Rockville, MD: Indian Health Service. 2016.
[viii] Excerpt from Report: American Indian Health Care Delivery Plan 2010-2013: Opportunities for Change- Improving the Health of American Indians and Alaska Natives in Washington State, "What Does It Take to Eliminate Disparities AI/AN Health Disparities?
[ix] https://www.doh.wa.gov/YouandYourFamily/OralHealth
[x]https://www.ihs.gov/DOH/documents/IHS_Data_Brief_March_2016_Oral_Health%20Survey_35_plus.pdf
[xi] https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf403347
[xii] Quotation from Report to the Legislature: Tribal Centric Behavioral Health, 2SSB 5732, Section 7 Chapter 388 Laws of 2013 (November 30, 2013), page 21. See also, e.g., Whaley, A.L., and Davis, K.E. (2007). Cultural competence and evidence-based practice in mental health services: A complementary perspective. *American Psychologist*, 62(6), 563-574; Castro, F.G., Barrera, M., Jr., and Steiker, L.K.H. (2010). Issues and challenges in the design of culturally adapted evidence-based interventions. *Annual Review of Clinical Psychology*, 6:213-239; Chu, J., Leino, A., Pflum, S., and Sue, S. (2016). Psychotherapy with racial/ethnic minority groups: Theory and practice. *Comprehensive Textbook of Psychotherapy: Theory and Practice*, 346. For some examples of research focused on AI/ANs, see Steinka-Fry, K.T., Tanner-Smith, E.E., Dakof, G.A., and Henderson, C. (2017). *Journal of Substance Abuse Treatment*, 75,
[xiii] Green, L.W., and Glasgow, R.E. (2006). Evaluating the relevance, generalization, and applicability of research: Issues in external validity and translation methodology. *Evaluation and the Health Professions*, 29, 126-153.
[xiv] Woolf, S.H., Grol, R., Hutchinson, A., Eccles, M., and Grimshaw, J. (1999). Potential benefits, limitations, and harms of clinical guidelines. BMJ 318(7182), 527-530.
[xv] Woolf, S.H., Grol, R., Hutchinson, A., Eccles, M., and Grimshaw, J. (1999). Potential benefits, limitations, and harms of clinical guidelines. BMJ 318(7182), 527-530.
[xvi] *Id*.
[xvii] See, e.g., HIT1.3: Allow tribes, within existing programs and new funding streams, the flexibility to develop, tailor, and/ or implement support mechanisms that best address their local and specific

manifestations of trauma; PR1.1: Create and support culturally and spiritually based programming and healing that aligns with the diversity and needs of the local Tribal population and engages communities in the development of diversion and reentry programs; BH3.3: Support tribally driven assessments and implementation of strengths-based, Tribal best practices; and NA2.1: Establish a national behavioral health communications campaign, in collaboration with tribes,…[that could be] tailored by tribes for local use…

[xviii] Harper, L. (2005). Epigenetic inheritance and the intergenerational transfer of experience. *Psychological Bulletin*, 131(3), 340-360; Yehuda, R., Daskalakis, N.P., Bierer, L.M., Bader, H.N., Klengel, T., Holsboer, F., and Binder, E.B. (2016). Holocaust exposure induced effects on FKBP5 methylation. *Biological Psychiatry*, 80(5), 372-380; Yehuda, R., and Bierer, L.M. (2009). The relevance of epigenetics to PTSD: Implications for the DSM-V. *Journal of Traumatic Stress*, 22(5), 427-434.

[xix] Armenta, B.E., Whitbeck, L.B., and Habecker, P.N. (2016). The Historical Loss Scale: Longitudinal measurement equivalence and prospective links to anxiety among North American indigenous adolescents. *Cultural Diversity and Ethnic Minority Psychology*, 22(1), 1-10; Whitebeck, L.B., Adams, G.W., Hoyt, D.R., and Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. American Journal of Community Psychology, 33(3-4), 119-130.

[xx] Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska Communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence*, 23(3), 316-338.

[xxi] https://www.tulaliptribes-nsn.gov/Home/Government/Departments/LegacyofHealingAdvocacyCenterSafeHouse.aspx

[xxii] Marsh, T.N. (April 26, 2016). Exploring how indigenous healing practices and a western treatment model "seeking safety" can co-exist in assisting indigenous peoples to heal from trauma and addiction. (Doctoral thesis retrieved from https://zone.biblio.laurentian.ca/handle/10219/2560).

[xxii] *See* Clarke, J.F., Eds. (1991). A Gathering of Wisdom: Tribal Mental Health, A Cultural Perspective.

[xxiii] *See* Clarke, J.F., Eds. (1991). A Gathering of Wisdom: Tribal Mental Health, A Cultural Perspective. Swinomish Indian Tribal Community: Swinomish, Washington

[xxiv] NIHB National Tribal Budget Formulation Workgroup (full funding at $32 billion)

[xxv] See 42 C.F.R. § 136.61

[xxvi] See 25 U.S. Code § 1641(d)(2)(A).

[xxvii] See, for example, Kelley, A., Belcourt-Dittloff, A., Belcourt, C., & Belcourt, G. (2013). Research ethics and indigenous communities. *American Journal of Public Health*, 103(12), 2146-2152; Yuan, N.P., Bartgis, J., and Demers, D. (2014). Promoting Ethical Research with American Indian and Alaska Native People Living in Urban Areas. *American Journal of Public Health,* 104(11), 2085–2091.

[xxviii] https://azahcccs.gov/AmericanIndians/Downloads/Consultations/Meetings/2016/TraditionalHealingWaiverLanguage.pdf

[xxix] United States, Department of Health and Human Services (HHS), The Centers for Medicare and Medicaid Services(CMS). "Frequently-Asked Questions(FAQs) Federal Funding for Services 'Received Through' an IHS/Tribal Facility and Furnished to Medicaid Eligible American Indians and Alaska Natives (SHO #16-002).", CMS, 18 Jan. 2017. www.medicaid.gov/federal-policy-guidance/downloads/faq11817.pdf