



Disparities and Challenges Facing American Indians and Alaska Natives: How Clinicians Can Help Reduce Inequities

Washington Medical Commission
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Vicki Lowe, Executive Director
American Indian Health
Commission for Washington State

Heather Erb, PLLC
Attorney at Law
www.erbflawfirm.com



American Indian Health Commission for Washington State

About Us

Pulling Together for Wellness

We are a Tribally-driven, non-profit organization providing a forum for the twenty-nine tribal governments and two urban Indian health programs in Washington State to work together to improve health outcomes for American Indians and Alaska Natives.



PRESENTATION OVERVIEW

How Clinicians Can Help Reduce Inequities for American Indians and Alaska Natives

- PART I: Being familiar with the Indian Health System and Tribal Sovereignty**
- PART II: Understanding Historical Trauma and Resiliency**
- PART III: Coordinating Care with the Indian Health Care Provider**
- PART IV: Supporting Policies and Laws that Work for AI/AN Patients**



**PART I: Being familiar with
the Indian Health System
and Tribal Sovereignty**



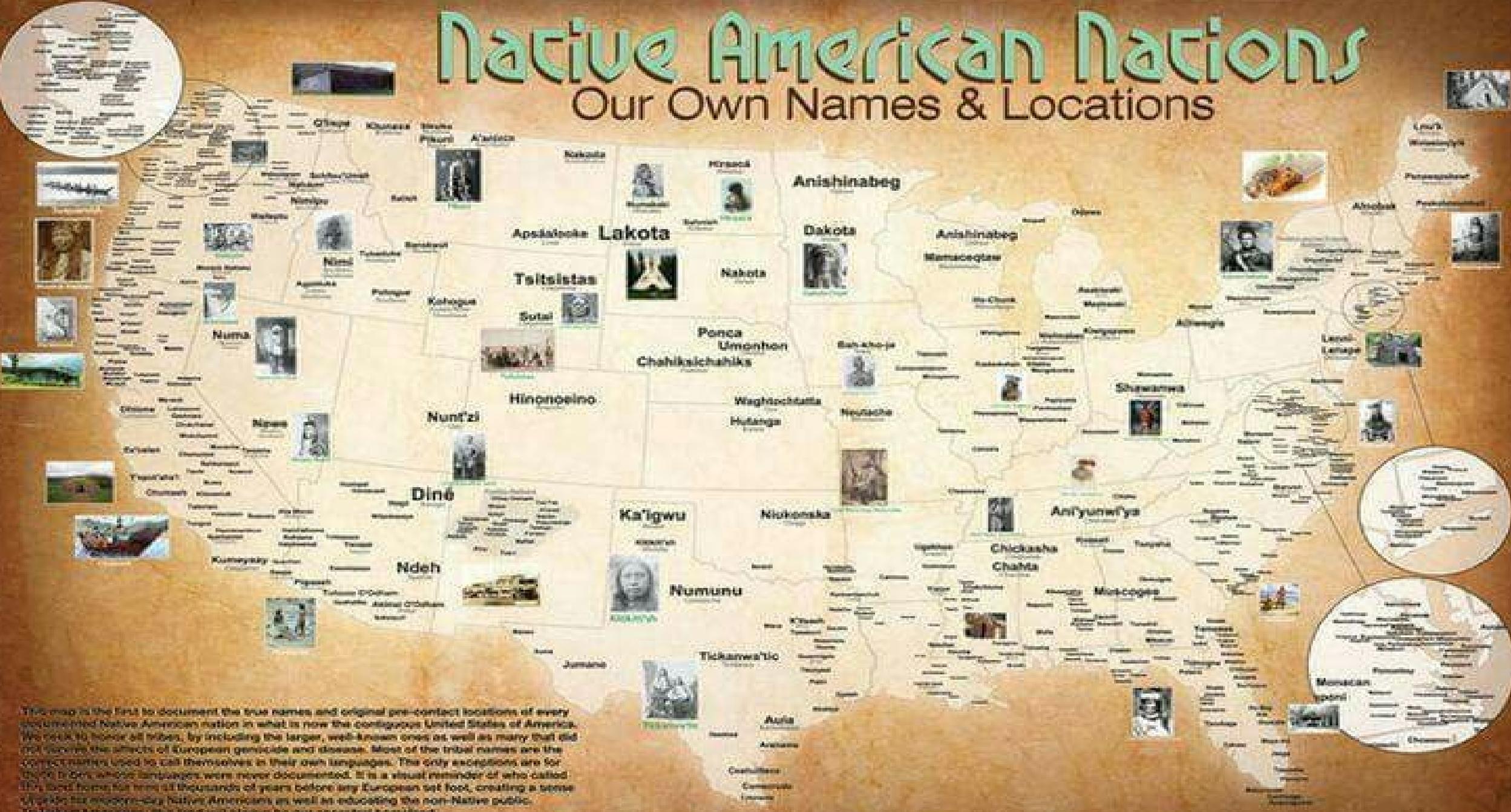
Understanding and respecting Indian law and policy can bring about great improvements for tribal nations and American Indian and Alaska Native people AND benefit the citizens of the state of Washington.



LEGAL AND HISTORICAL FOUNDATIONS OF THE INDIAN HEALTH SYSTEM

Native American Nations

Our Own Names & Locations



This map is the first to document the true names and original pre-contact locations of every documented Native American nation in what is now the contiguous United States of America. We seek to honor all tribes, by including the larger, well-known ones as well as many that did not survive the effects of European genocide and disease. Most of the tribal names are the correct names used to call themselves in their own languages. The only exceptions are for those Diné, whose languages were never documented. It is a visual reminder of who called this land home for tens of thousands of years before any European set foot, creating a sense of pride for modern-day Native Americans as well as educating the non-Native public. To Native Americans, this land will always be our ancestral homeland.

© 2008 Native American Nations. All rights reserved. This map is a copyrighted work of art. No part of this map may be reproduced without the written permission of the author.

At first, the United States government used treaty making to encourage stable relationships and trade with the Tribes.

Treaty making was a method used to take Indian Land.

370 Indian Treaties were made with the U.S. Government and Indian Tribes from 1789 to 1871.

Changes in administrations and westward expansion changed what was negotiated in treaties.

Under Andrew Jackson, federal policy for treaty making with Tribes changed from alliance to open Indian land for settlement by non-Indians.

TREATY MAKING

1854-56: TREATIES WITH TRIBES IN WASHINGTON TERRITORY

EIGHT TREATIES WERE “NEGOTIATED” DURING THESE TWO YEARS

Treaty of Medicine Creek (1854)	Nisqually, Puyallup, Squaxin Island, Steilacoom, S'Homamish, Stehchass, others Reservation, fishing, hunting, pasturing (stallions for breeding only), health care	Treaty of Point Elliott (1855)	Lummi, Suquamish, Tulalip (Snohomish, Skykomish, others), Swinomish, Snoqualmie, Skagit, Duwamish, others Reservations, fishing, hunting, health care
Treaty of Point No Point (1855)	Jamestown S'Klallam, Port Gamble S'Klallam, Lower Elwha Klallam, Skokomish, others Reservation, fishing, hunting, health care	Treaty of Neah Bay (1855)	Makah Reservation, fishing, whaling, sealing, hunting, health care
Treaty with the Yakama (1855)	Yakama, Palouse, Piquouse, Wenatshapam, Klikatat, Klinquit, Kow-was-say-ee, others Reservation with schools and fishery, fishing, hunting, pasturing, health care	Treaty of Walla Walla (1855)	Umatilla, Walla Walla, Cayuses Reservation, fishing, hunting, pasturing, health care
Treaty with the Nez Perce (1856)	Nez Perce Reservation with schools, fishing, hunting, pasturing, health care	Quinault Treaty (1856)	Quinault, Quileute Reservation, fishing, hunting, pasturing horses (stallions for breeding), health care

29 Washington State Federally Recognized Tribes

- Chehalis Confederated Tribes
- Confederated Tribes of the Colville Reservation
- Cowlitz Indian Tribe
- Hoh Tribe
- Jamestown S’Klallam Tribe
- Kalispel Tribe
- Lower Elwha Klallam Tribe
- Lummi Nation
- Makah Tribe
- Muckleshoot Tribe
- Nisqually Tribe
- Nooksack Tribe
- Port Gamble S’Klallam Tribe
- Puyallup Tribe
- Quileute Tribe
- Quinault Nation
- Samish Indian Nation
- Sauk-Suiattle Tribe
- Shoalwater Bay Tribe
- Skokomish Tribe
- Snoqualmie Tribe
- Spokane Tribe
- Squaxin Island Tribe
- Suquamish Tribe
- Stillaguamish Tribe
- Swinomish Tribe
- Tulalip Tribes
- Upper Skagit Tribe
- Yakama Nation

TWO IMPORTANT THEMES FOR INDIAN LAW

THEME 1 → Sovereignty

TRIBES = Independent entities with
inherent power of self-government

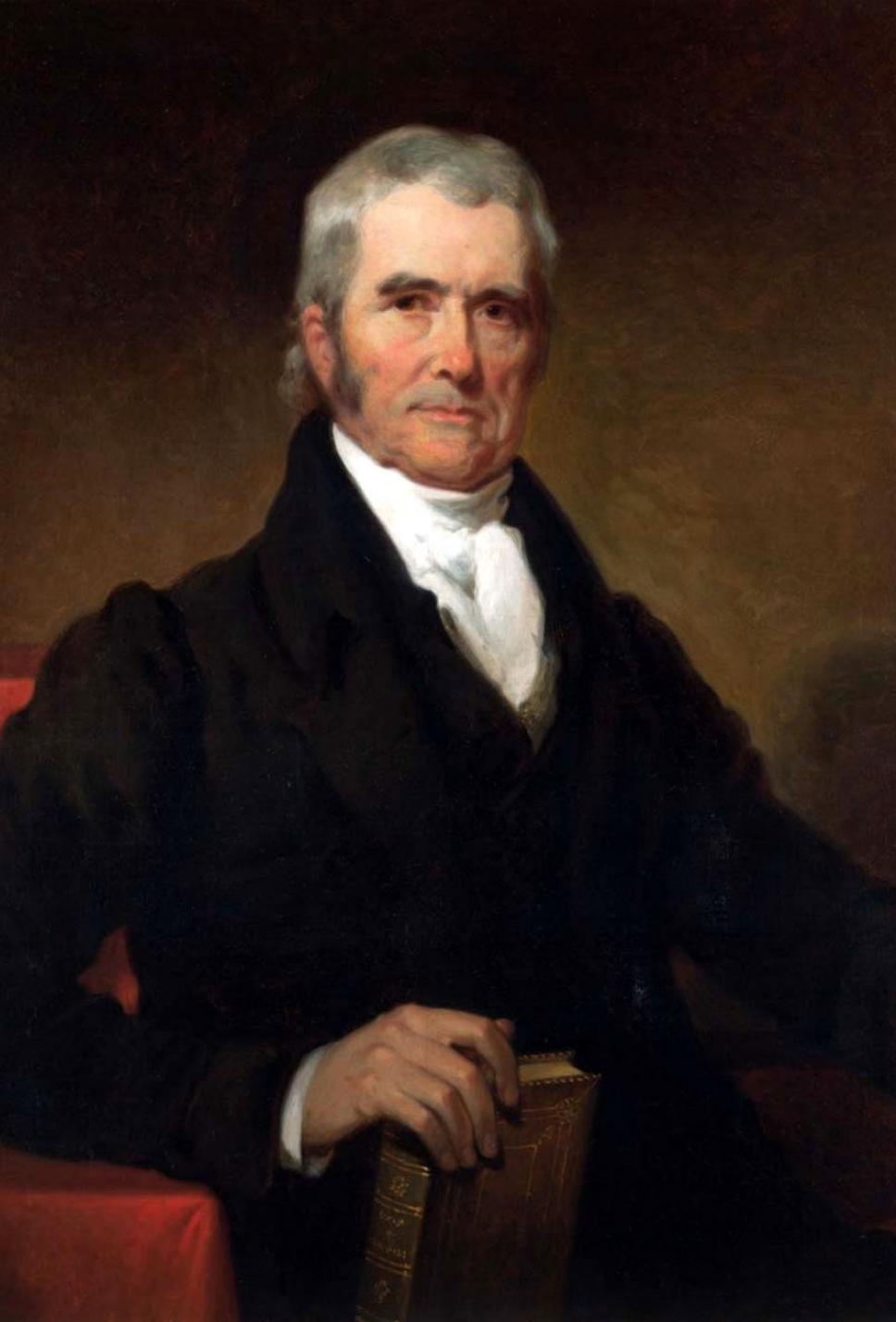
See American Indian Law in a Nutshell, William Canby, Jr., 6th Edition

TRIBAL SOVEREIGNTY

Tribal Sovereignty predates the formation of the United States government.

Prior to contact, Tribal governments had complete sovereignty.

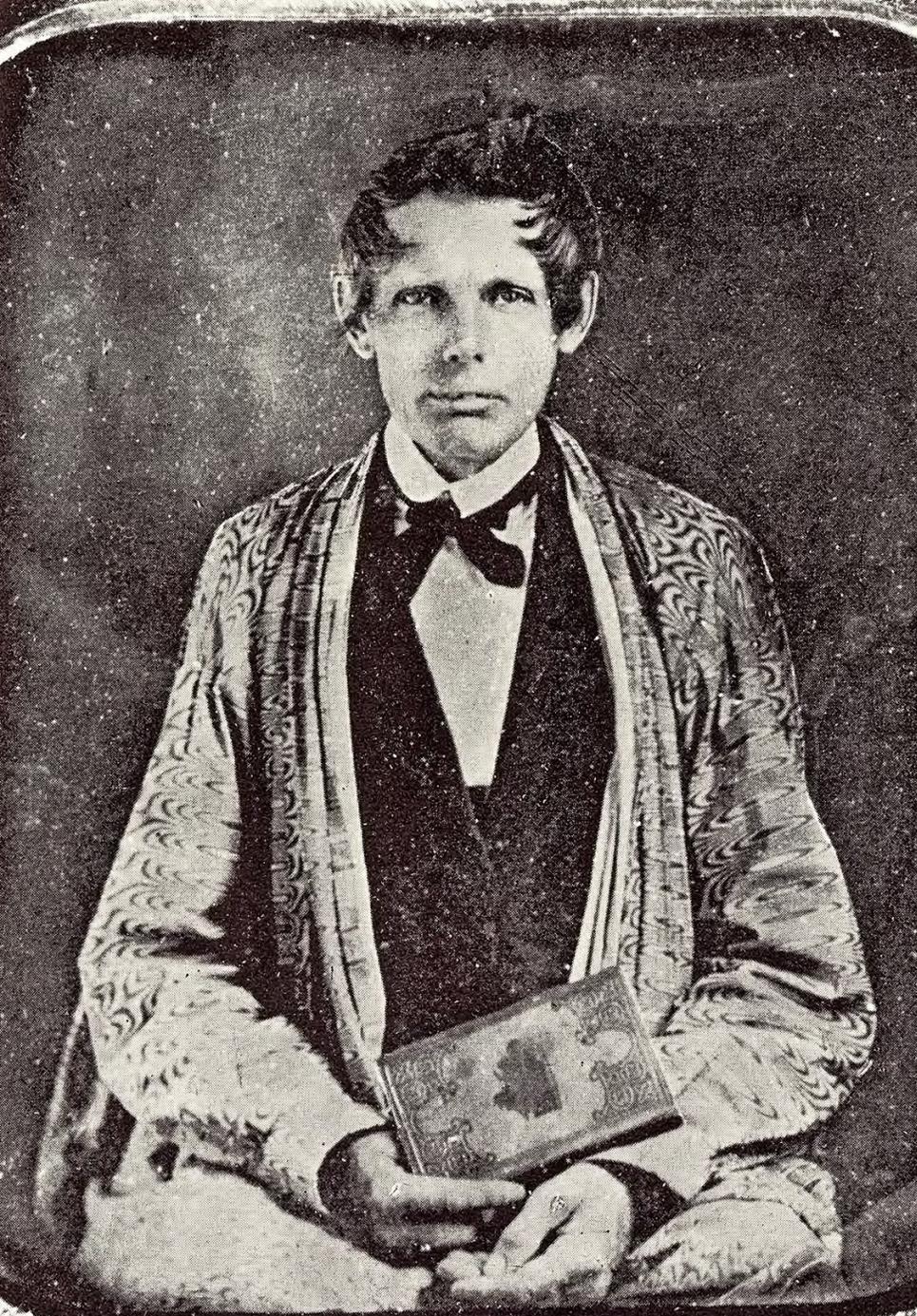




THE MARSHALL TRILOGY

- Johnson v. M'Intosh (1823) ruling used the Discovery Doctrine to establish the nature of Indian title. Upon "discovery" the Indians had lost "their rights to complete sovereignty, as independent nations," only retaining a "right of occupancy" in their lands.
- Cherokee Nation v. Georgia (1831) held that the tribe was not a foreign nation, rather a "domestic dependent nation" subject to the sovereignty of the United States federal government.
- Worcester v. Georgia (1832) ruled that tribal sovereign powers were not relinquished when Indian tribes exchanged land for peace and protection.

"The Indian nations had always been considered as distinct, independent, political communities, retaining their original natural rights, as the undisputed possessors of the soil, from time immemorial..." Worcester v. Georgia, 31 U.S. 515, 559 (1832)



U.S. RECOGNITION OF TRIBAL SOVEREIGNTY

Indian nations within the United States possess the inherent power to govern.

“The Indian nations had always been considered as distinct, independent, political communities, retaining their original natural rights, as the undisputed possessors of the soil, from time immemorial...”

Worcester v. Georgia, 31 U.S. (6 Pet.) 515, 559 (1832)

SOVEREIGNTY IS AN INHERENT POWER

In contrast to a city, who derives certain powers to enact regulations from the State, a tribe's power is inherent and the tribe needs no authority from the federal government.

Iron Crow v. Oglala Sioux Tribe, 231 F.2d 89 (8th Cir. 1956); Merrion v. Jicarilla Apache Tribe, 455 U.S. 130, 149 (1982).

TRIBAL SOVEREIGNTY IN PRACTICE

AUTHORITY TO GOVERN

Sovereignty ensures control over the future of the tribes and encourages preservation of tribal culture, religions, and traditional practices.

Tribes have the authority to, among other things, govern their people and their land; define their own tribal membership criteria; create tribal legislation, law enforcement and court systems; and to impose taxes in certain situations.

Building Bridges for the New Millennium: Government to Government Implementation Guidelines, May 18, 2000



THEME 2 → TRUST RESPONSIBILITY

Trust responsibility is a legally enforceable obligation of the United States to protect tribal self-determination, tribal lands, assets, resources, and treaty rights, as well as carry out the directions of federal statutes and court cases.



Building Bridges for the New Millennium: Government-to-Government
Implementation Guidelines, State-Tribal Workgroup, May 18, 2000

FEDERAL TRUST TREATY RESPONSIBILITY TO PROVIDE HEALTH CARE TO AI/AN

“And the United States finally agree to employ a physician to reside at the said central agency, who shall furnish medicine and advice to their sick, and shall vaccinate them; the expenses of ...medical attendance to be defrayed by the United States, and not deducted from the annuities.”

Treaty of Point Elliot, 1855, Article 14

FEDERAL TRUST STATUTORY RESPONSIBILITY TO PROVIDE HEALTH CARE TO AI/AN

Under the Indian Health Care Improvement Act (IHCA), “[f]ederal health services to maintain and improve the health of the Indians are ... required by the Federal Government’s historical and unique relationship with, and resulting responsibility to, the American Indian people.”

25 U.S.C. § 1601(a)

Five Important Federal Indian Health Care Statutes

Snyder Act of 1921

Indian Self-Determination and Education Act of 1975

Indian Health Care Improvement Act of 1976

Patient Protection and Affordable Care Act of 2010

Indian Health Care Improvement Act Reauthorization and Extension Act

INDIAN HEALTH CARE DELIVERY SYSTEM

INDIAN HEALTH CARE PROVIDER DEFINED → WAC 284-170(16)

(16) "Indian health care provider" means:

(a) The **Indian Health Service**, an agency operated by the U.S. Department of Health and Human Services established by the Indian Health Care Improvement Act, Section 601, 25 U.S.C. Sec. 1661;

(b) **An Indian tribe**, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. Sec. 1603(14), that operates a health program under a **contract or compact** to carry out programs of the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. Sec. 450 et seq.;

(c) **A tribal organization**, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. Sec. 1603(26), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the ISDEAA, 25 U.S.C. Sec. 450 et seq.;

(d) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. Sec. 1603(14), or tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. Sec. 1603(26), that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. Sec. 47 (commonly known as the Buy Indian Act); or

(e) **An urban Indian organization** that operates a health program with funds in whole or part provided by Indian Health Service under a grant or contract awarded pursuant to Title V of the Indian Health Care Improvement Act, Section 4(29), 25 U.S.C. Sec. 1603(29).

Indian Health Care Providers (IHCPs)

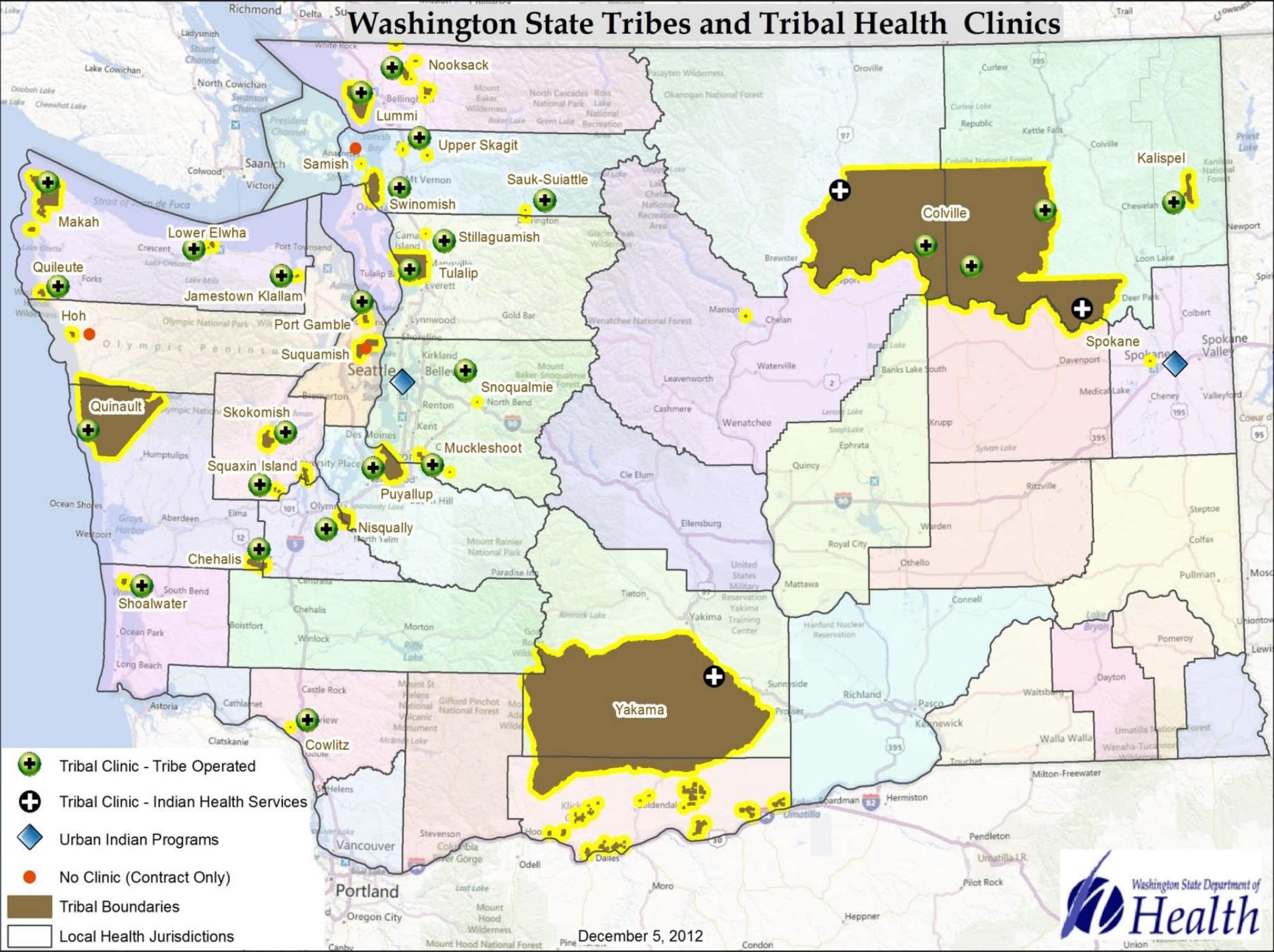
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graph TD; A[Indian Health Care Providers (IHCPs)] --- B[IHS Facility (Direct Site)  
25 USC § 1661]; A --- C[Tribal Compact/Contract Tribes  
25 USC § 450 et. seq.]; A --- D[Urban Indian Health Care Providers  
25 USC 1603 § (29)];
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IHS Facility (Direct Site)
25 USC § 1661

Tribal Compact/Contract
Tribes
25 USC § 450 et. seq.

Urban Indian Health Care
Providers
25 USC 1603 § (29)

Washington State Tribes and Tribal Health Clinics



Indian Health Services (IHS)

- An agency in the Department of Health and Human Services.
- Provides health care for approximately 2.2 million eligible AI/AN through a system of programs and facilities located on or near Indian reservations, and through contractors in certain urban areas.
- IHS defines eligible individuals as persons who are of Indian descent and are members of their community. 42 C.F.R. § 136.12 (a)(1)



IHS FACILITY - DIRECT SERVICES TRIBES



Source: GAO | www.gao.gov

Direct Service Tribes (DST) receive primary health care services from the Indian Health Service.

These services include: direct patient care such as internal medicine, pediatrics, women's health, and dental and optometry services.

Service Units on the Colville, Spokane, and Yakama reservations



TRIBAL COMPACT AND CONTRACT TRIBES

Titles I and V of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended), provide Tribes the option of exercising their right to self-determination by assuming control and management of programs previously administered by the federal government.

Since 1992, the IHS has entered into agreements with tribes and tribal organizations to plan, conduct, and administer programs authorized under Section 102 of the Act.

Today, over half of the IHS appropriation is administered by Tribes, primarily through self-determination contracts or self-governance compacts.

27 Tribes administer IHS funds to provide health care services in WA. These tribes provides both direct care and contracted care.

PURCHASED AND REFERRED CARE PAYING FOR CARE REFERRED OUTSIDE THE INDIAN HEALTH CARE SYSTEM

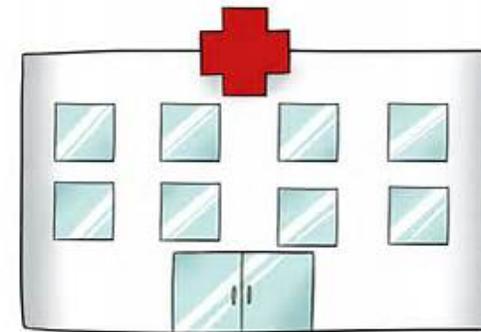
Indian Health Care Provider



- Health Care
- Mental Health
- Substance Use
- Dental

*Referral &
Coordination*

Non-Indian Health Care Provider



- Specialty Care
- Inpatient Care

URBAN INDIAN HEALTH PROGRAMS

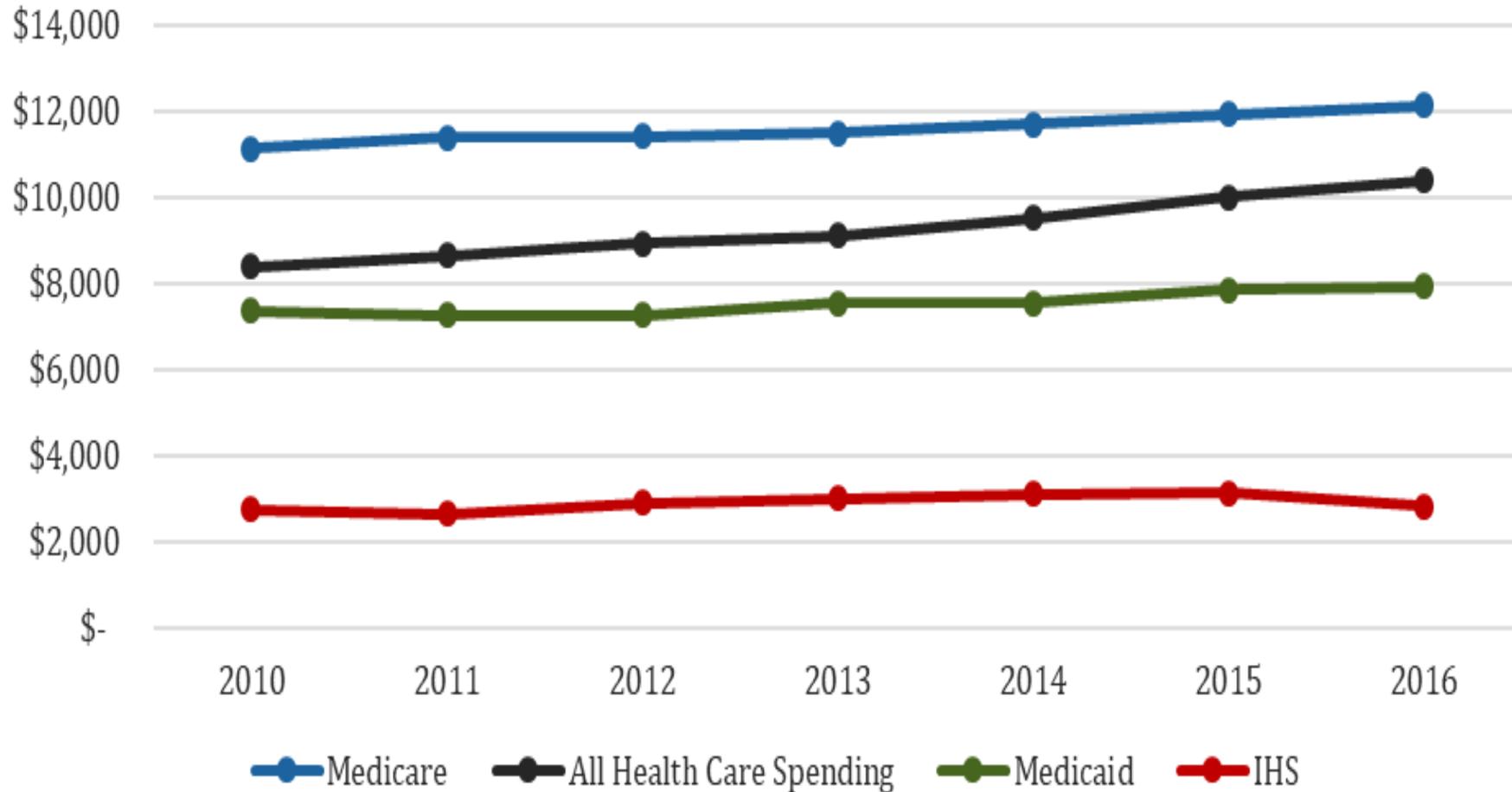
Title VI of the IHCA authorizes the IHS to fund urban Indian organizations to provide health care and referral services to the urban Indian populations. 25 U.S.C. 1651-1660d.

As of 2014, IHS provides contracts and grants to 33 urban-centered, nonprofit urban Indian organizations providing health care services at 57 locations throughout the U.S.

2 UIHPs: Seattle Indian Health Board and NATIVE Project of Spokane



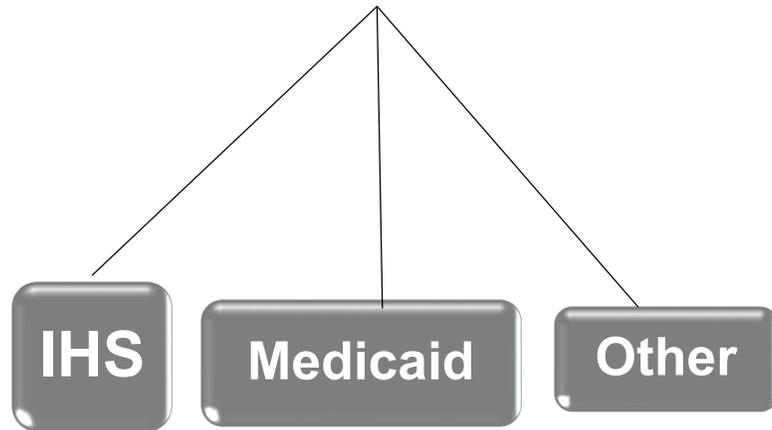
Chart 6: National Health Care Spending per Capita, 2010-2016



Source: Jessie Dean – National Health Expenditure Accounts (NHEA) Table 1 for All Health Care Spending per capita and Table 21 for Medicare and Medicaid Spending per enrollee; National Congress of American Indians Fiscal Year Indian Country Budget Requests: Healthcare for IHS Spending per user

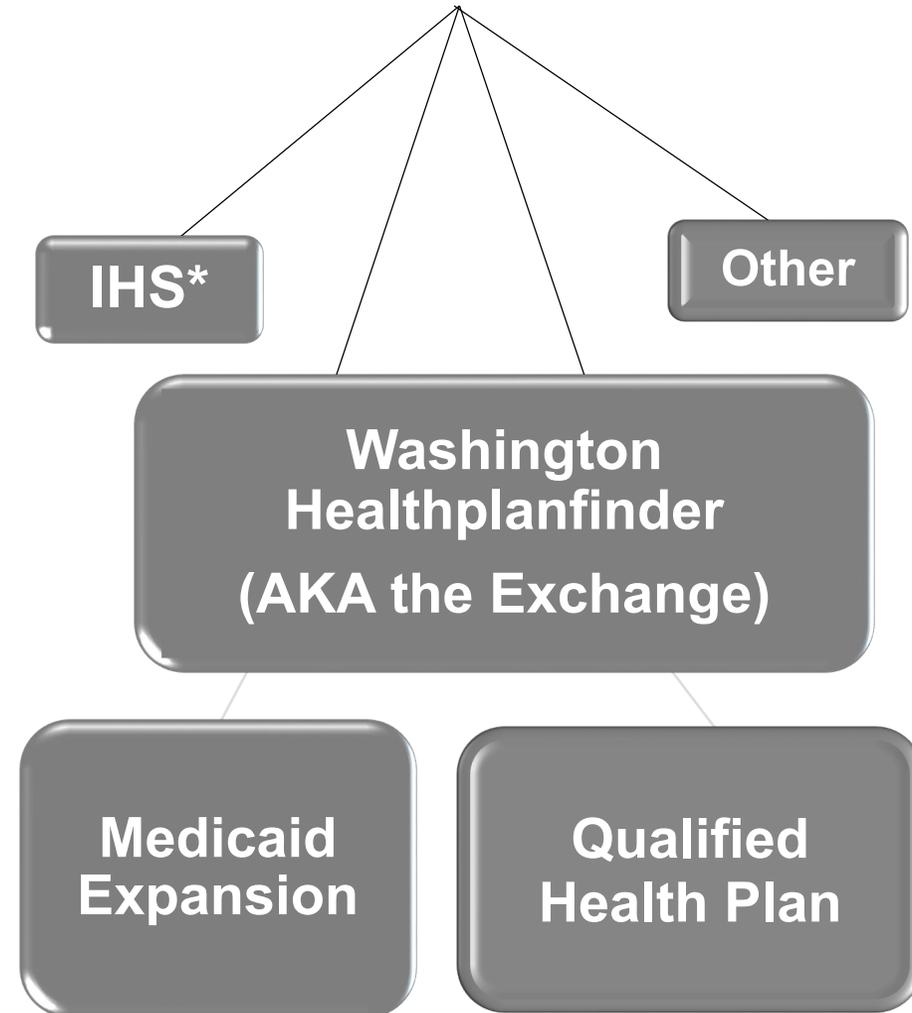
INDIAN HEALTH CARE COVERAGE OPTIONS

BEFORE ACA



*IHS is the payer of last resort

AFTER ACA



Washington State Uninsured Population

2012 to 2017 Comparison

Estimates based on the American Community Services Report from the U.S. Census Bureau

Summary Tables:

Washington

American Indian and Alaska Native Population 2012 and 2017	
2012	2017
194,178	214,406

American Indian and Alaska Native Uninsured 2012 and 2017	
2012	2017
42,017	20,971

Uninsured Rate 2012 and 2017	
2012	2017
22%	10%

Medicaid Enrollment 2012 and 2017	
2012	2017
55,956	84,065

Percent with Medicaid 2012 and 2017	
2012	2017
29%	39%



**PART II:
Understanding Historical
Trauma and Resiliency**

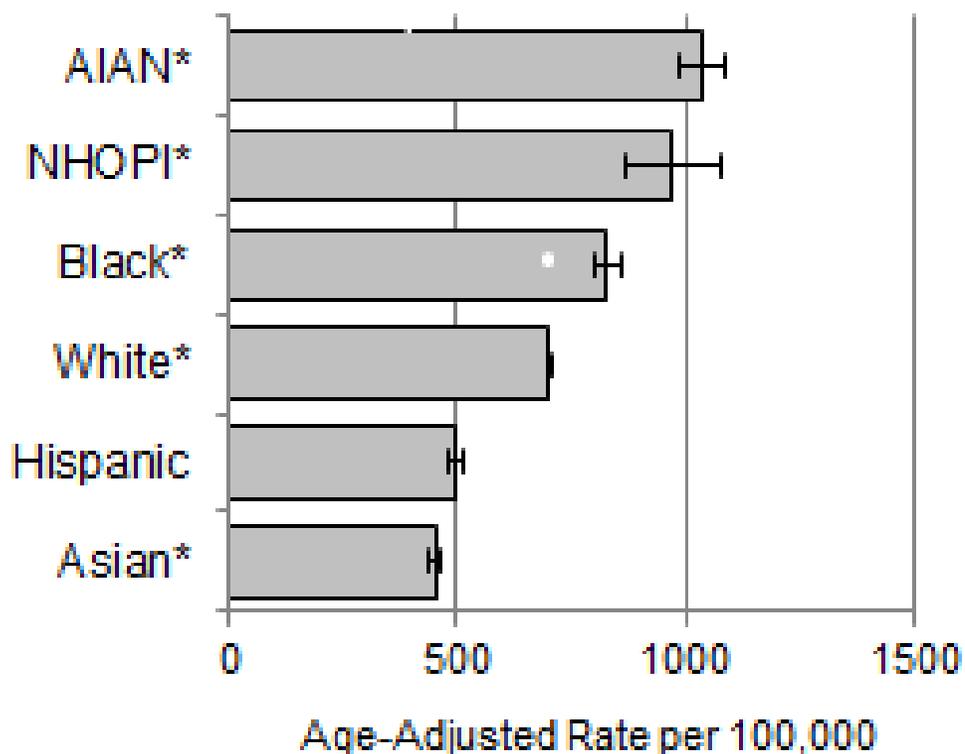


Adverse Childhood Effects and Historical and Intergenerational Trauma in AI/AN Communities

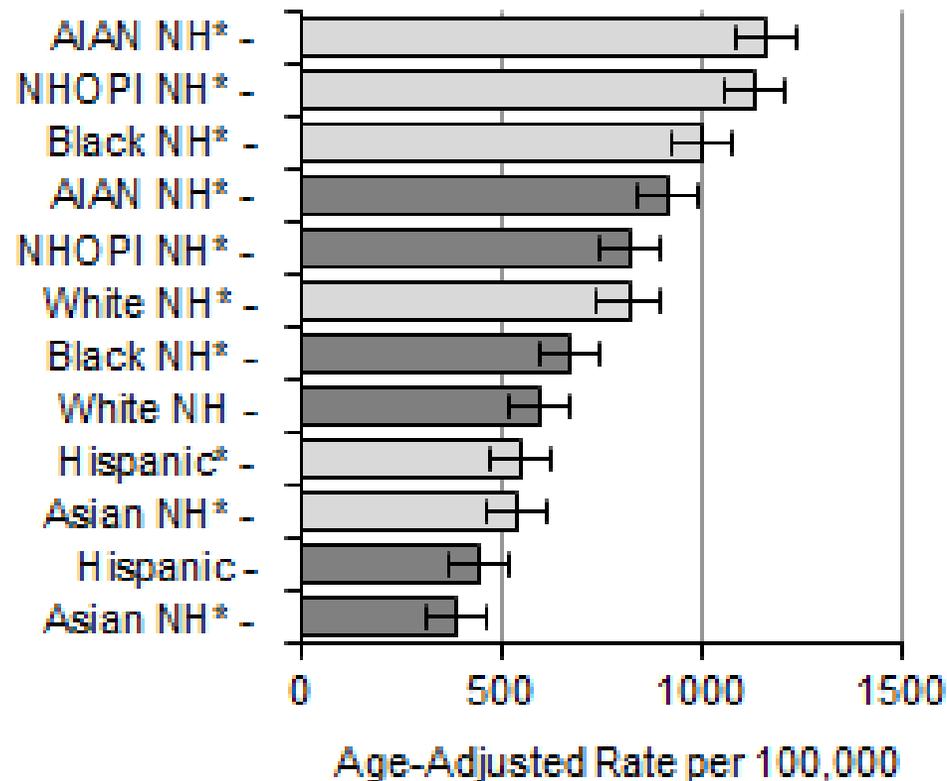
- In AI/AN communities, there exists disparately high rates of adverse childhood experiences which are a direct result of historical trauma.
- Historical trauma becomes intergenerational trauma through repeating cycles of ACEs over generations.
- Historical trauma refers to situations where a community experienced traumatic events, the events generated high levels of collective distress, and the events were perpetuated by outsiders with a destructive or genocidal intent.
- The effects of historical trauma, however, manifest in the everyday experience of AI/AN communities today.

IMPACTS OF HISTORICAL AND INTERGENERATIONAL TRAUMA

**Deaths from All Causes
Race and Hispanic Origin
Washington State
Death Certificates, 2012–2014**



**Deaths from All Causes
Gender and Race or Hispanic Origin
Washington State
Death Certificates, 2012–2014**



* Non-Hispanic, single race only
AIAN: American Indian/Alaska Native
NHOPI: Native Hawaiian/Other Pacific Islander

* Non-Hispanic, single race only
AIAN: American Indian/Alaska Native
NHOPI: Native Hawaiian/Other Pacific Islander

WA STATE - LIFE EXPECTANCY AT BIRTH

Patterns in life expectancy data by race indicate that American Indian and Alaska Native, and Native Hawaiian and Other Pacific Islanders have the shortest life expectancy: 73 and 75 years, respectively. Hispanics and Asians have the longest life expectancy: 86 years.

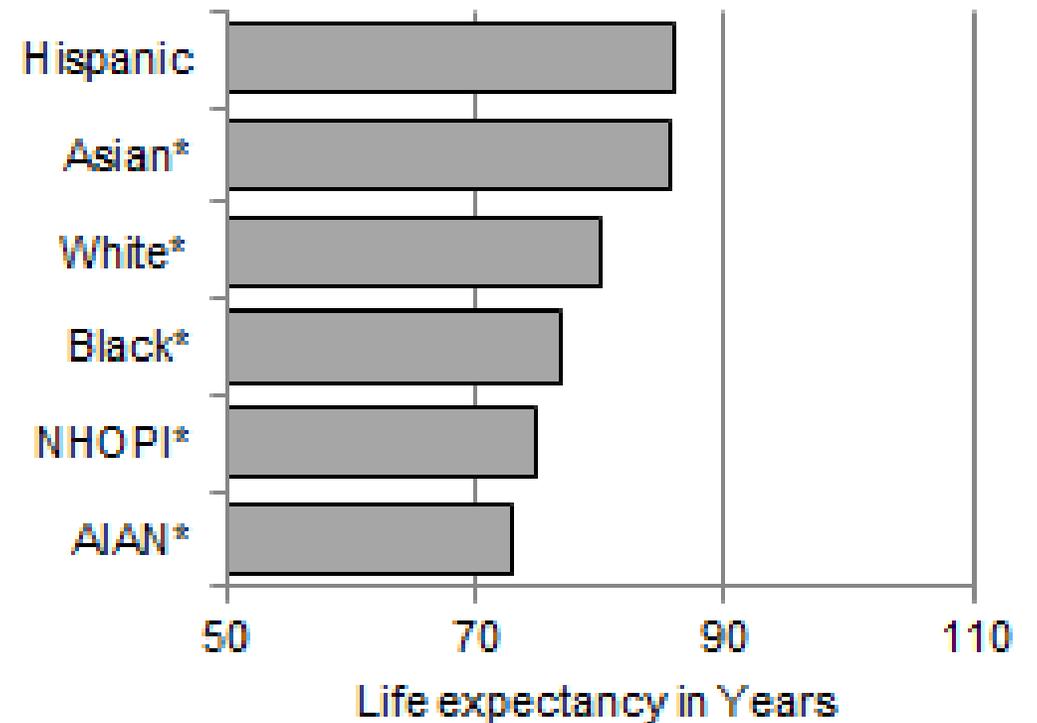
Data Sources

Washington State Death Certificate data: Washington State Department of Health, Vital Registration System Annual Statistical Files, Deaths 1980–2014, released September 2015.

Washington State Population counts: 2000 and 2010 U.S. Census and 2001–2009 intercensal and 2011–2014 post-censal data. Washington State Department of Health

SOURCE: Health of Washington State chapter on Mortality and Life Expectancy published in 2013 and update 2015.

Life Expectancy at Birth
by Race or Hispanic Origin
Washington State
Death Certificates, 2012–2014

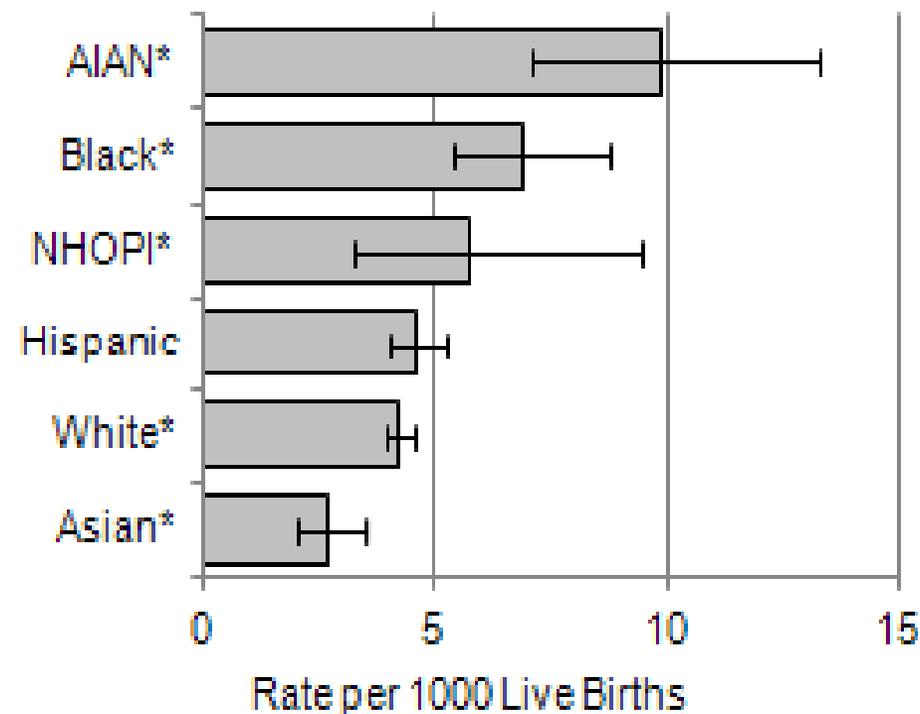


*Non-Hispanic, single race only

WA State – Infant Mortality

SOURCE: “Health of Washington State,” Washington State Department of Health, published 2012. Infant Mortality, Updated 2015

Infant Mortality
Race and Hispanic Origin
Linked Birth Infant Death File, 2009–2011

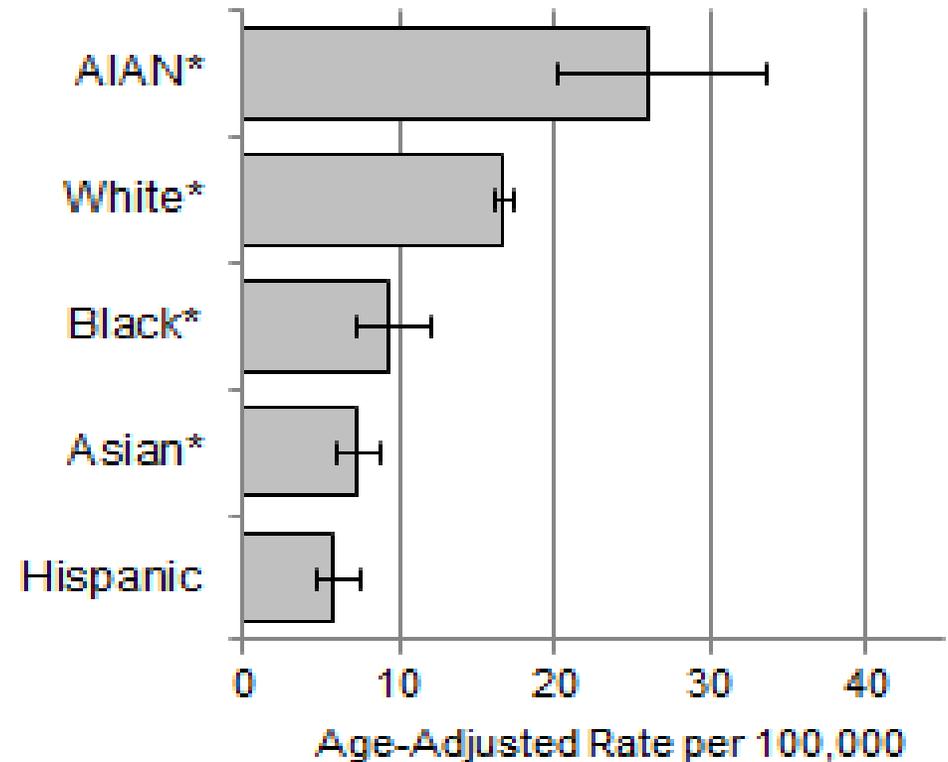


* Non-Hispanic
AIAN: American Indian/Alaska Native
NHOPI: Native Hawaiian/Other Pacific Islander

WA State - Suicide

SOURCE: "Health of Washington State," Washington State Department of Health, published 2012. Suicide, updated 2015

**Suicide Rates by
Race and Hispanic Origin
Washington State
Death Certificates, 2012–2014**

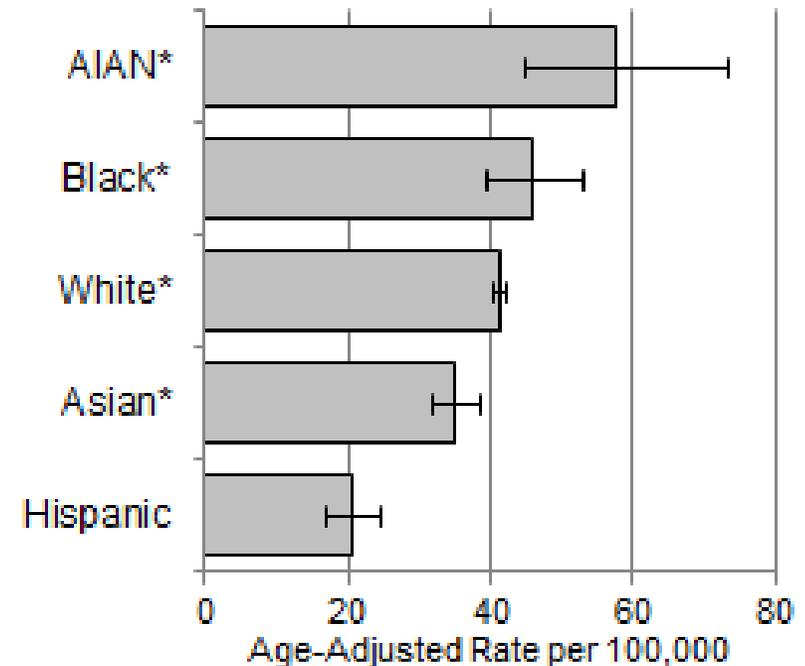


* Non-Hispanic, single race only
AIAN: American Indian/Alaska Native
Native Hawaiian/Other Pacific Islander not included due to unreliable rates due to small numbers.

WA State – Colorectal Cancer

SOURCE: “Health of Washington State,” Washington State Department of Health, published 2012. Colorectal Cancer

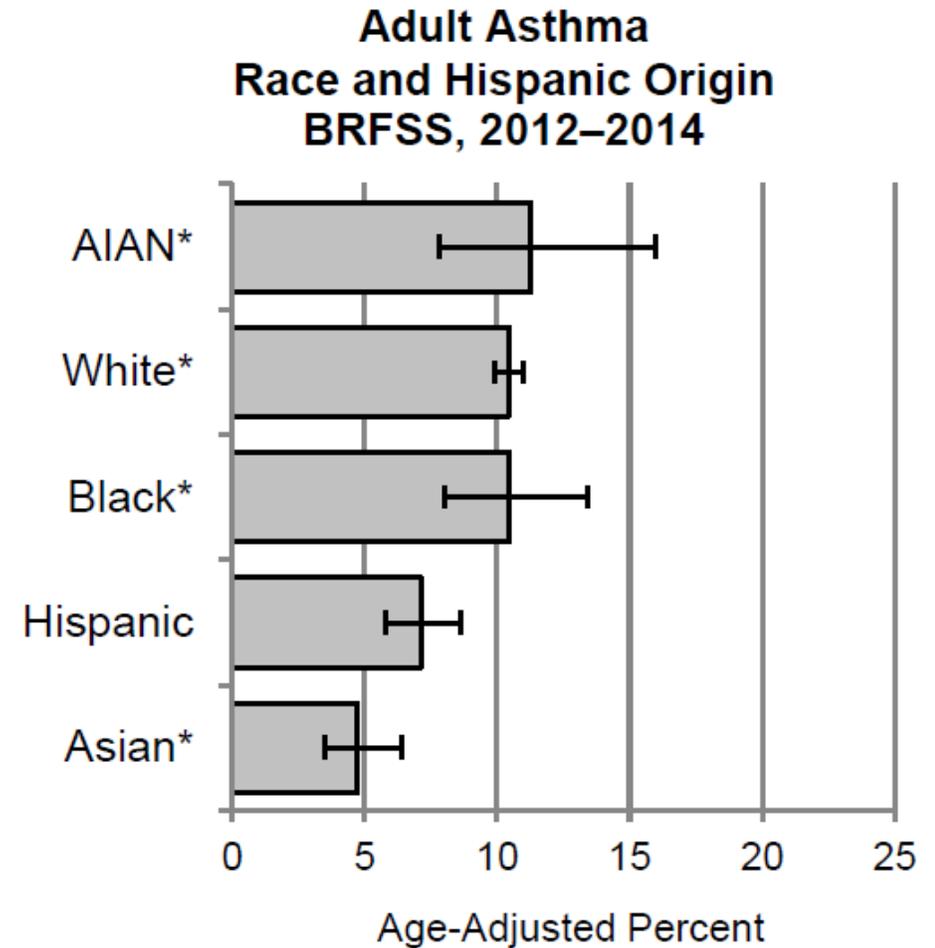
Colorectal Cancer Incidence
Race and Hispanic Origin
Washington State
Cancer Registry, 2008–2010



* Non-Hispanic, single race only
AIAN: American Indian/Alaska Native
Native Hawaiian/Other Pacific Islander not shown due to small numbers.

WA STATE - Asthma

SOURCE: "Health of Washington State," Washington State Department of Health, published 2012. Asthma, Updated 2015



* Non-Hispanic

AIAN: American Indian/Alaska Native

Compared to the Washington population as a whole, AI/ANs experience higher risks

- 34% of adults currently smoke
- 34% of adults are physically inactive
- 19% of 10th graders smoke
- 31% of 10th graders use marijuana
- Almost half of 10th graders do not get enough physical activity

Additionally:

- 39% of adults are obese
- 50% of adults have experienced 3 or more ACEs
- More adults have asthma, diabetes and have had heart disease
- or a stroke

Data Source: Washington State Healthy Youth Survey 2012 and
WA State Behavioral Risk Factor Surveillance System 2011-2013

Impacts of Historical Trauma: Toxic Stressors

Normal Life Stressors

- New job, lack of job
- Children, family-birth of a baby, loss
- paying the bills
- marriage, divorce, home management

Toxic stress-prolonged exposure creates:

- Health problems
- Depression, anxiety,
- tobacco, disability, obesity and disease substance use/abuse
- Domestic violence
- Lack of education/job/work

Resiliency and Protective Factors

- Attachment and Belonging: relationships with caring, competent people
- Community, Culture and Spirituality: Foster thriving communities
- Community Capacity Development: Leadership Expansion, Coming Together, Shared Learning, Results-Oriented Decisions

Resources for more information:

*Sanctuary Model: Dr. Sandra Bloom, 4 interrelated dimensions for safety

Physical – Psychological – Social - Moral safety

*The Scientist in the Crib: Patricia Kuhl, Ph.D.

Protective Factors in Tribal and Urban Communities

- The tribe as a large extended family, with responsibility to take care of each other
- Respect for the elders, grandmas and grandpas as teachers, responsible for sharing their wisdom and watching out for generations to come
- Aunties and uncles as disciplinarians, reinforcing proper behavior in a clear but loving ways, through human and animal stories



Protective Factors in Native Ways of Thinking

- Generosity as a symbol of wealth, assuring that contributing members of the community are honoring and caring for each other, or Wealth is determined by what you give, not by what you receive or acquire.
- The importance of striving to live in balance so all our needs get the attention they deserve.
- Our relationships and recognition we are connected to each other and all things.



PART III

Coordinating Care with the Indian Health Care Provider



Preserving the American Indian/Alaska Native Medical Home

An AI/AN patient seeking care from their IHCP can

- be comfortable sharing concerns with the primary care team
- ask questions with the primary care team
- develop a close communication with the primary care team
- have access to primary care case management, diabetes education, and care coordination
- be familiar with the staff who are often fellow community members
- seek culturally competent care

TRIBAL EXPERTISE IN HEALTH CARE

Community Health Programs

- Tribal health programs have utilized Community Health Nurses (CHNs) and Community Health Representatives (CHRs) for decades
- Home visiting, transportation to medical appointments, follow-up care from hospitalizations, prevention education, diabetes programs, walking and exercise programs help AI/ANs outside the clinical setting



TRIBAL EXPERTISE IN HEALTH CARE

Providing care within a maze
of federal and state rules

- IHS funding is subject federal regulations agreements, which differ between programs and between tribes
- Each Tribe or UIHP has their own rules for eligibility, referrals and billing
- Tribal and Urban billing staff can educate non-Indian providers experts on how the different regulations apply.



PAYOR OF LAST RESORT RULE

By regulation, the Indian Health Service is the payor of last resort (42 C.F.R.136.61), and therefore, the tribe's purchase and referred care program must ensure that all alternate resources that are available and accessible such as Medicare, Medicaid, SCHIP, private insurance, etc. are used before PRC funds can be expended.

IHS and Tribal facilities are also considered an alternate resource; therefore, PRC funds may not be expended for services reasonably accessible and available at IHS or tribal facilities.





**Part IV: Supporting
Policies and Laws that
Work for AI/AN Patients**

RECENT WASHINGTON STATE LEGISLATION



KEY LEGISLATION AND RULEMAKING

FEDERAL AND STATE LAWS HAVE HELPED TO IMPROVE THE HEALTH STATUS AMERICAN INDIANS AND ALASKA NATIVES IN WASHINGTON STATE

- Indian Health Improvement Act
- Washington Indian Health Improvement Act
- RCW 43.376
- SB 5432
- WAC 284-170

DENTAL HEALTH AIDE THERAPY BILL

SB 5079

On Feb. 21, Gov. Jay Inslee (D-WA) signed the first bill of the regular session into law—SB 5079.

The new law allows federally recognized tribes to use federal funding for dental health aide therapists (DHATs) who provide preventative care and procedures such as cleanings, fillings and oral exams.





**WASHINGTON INDIAN HEALTH IMPROVEMENT ACT
SB 5415**

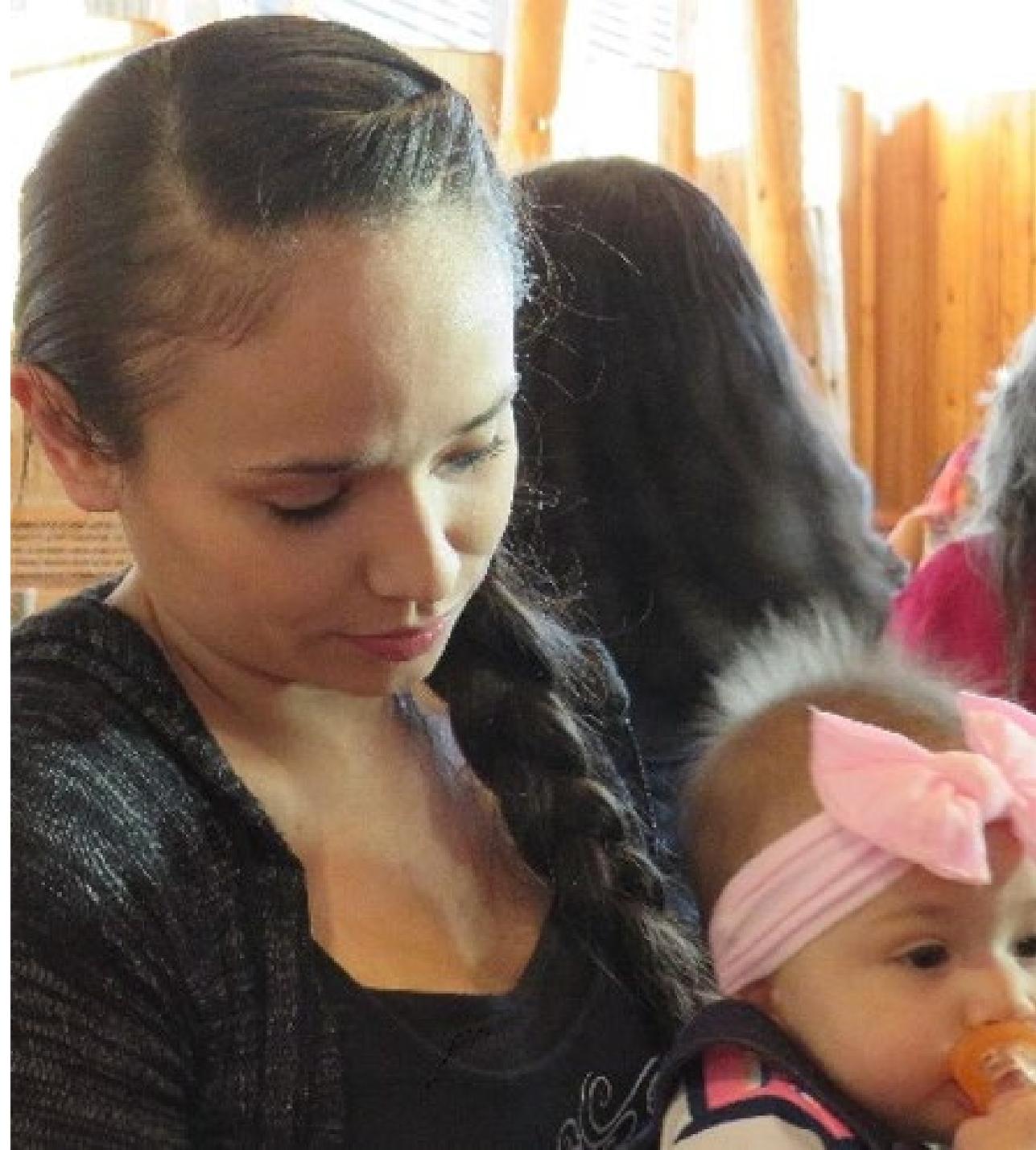
WASHINGTON INDIAN HEALTH IMPROVEMENT ACT

SB 5415

The Washington Indian Health Improvement Act was introduced in the 2019 legislative session by Senator John McCoy (D-38) and Representative Steve Tharinger (D-24). The bill was approved unanimously by the Washington State legislature in April.

AIHC took a lead role in the development and legislative advocacy for the bill.

SB 5415 will help the state of Washington, Tribes, and Urban Indian Health Programs increase access to care, strengthen continuity of care, improve population health, and strengthen cultural effective practices.



Washington Indian Health Improvement Act

Reinvests any new Medicaid savings from 100% Federal Medical Assistance Percentage (FMAP) encounters through Indian Health Care Providers back into the IHS Direct, Tribal 638, and Urban Indian Health Program system of care

Establishes the Governor's Indian Health Council, the Tribal Health Reinvestment Account and the Indian Health Improvement Account Advisory Committee.

Permanently authorizes the Governor's Indian Health Advisory Council and mandates the first Indian Health Improvement Advisory Plan. The Governor's Indian Health Advisory Council consists of representatives from all 29 federally recognized Tribes in Washington, CEOs of two Urban Indian Health Programs, four legislative members representing the majority and minority caucuses in the House and Senate, and one member representing the

CHALLENGES IN THE INDIAN HEALTH SYSTEM

- **Funding Needed to Address:**
 - Historical intergeneration trauma, ongoing discrimination, and ACEs
 - Prevention and public health work
 - Disparities in maternal and infant health
 - Disparities in morbidity and mortality rates
 - Disparities in social determinates of health
 - Affects of climate change on access to traditional ways of life (foods, land, sea level, housing, whole villages, etc.)
 - Culturally appropriate research to establish evidence-based strategies in Indian country





THANKYOU

www.aihc-wa.com