

2022-23 BIENNIAL REPORT



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Governor's Indian Health Advisory Council



2022-23 Biennial report

GOVERNOR'S INDIAN HEALTH ADVISORY COUNCIL

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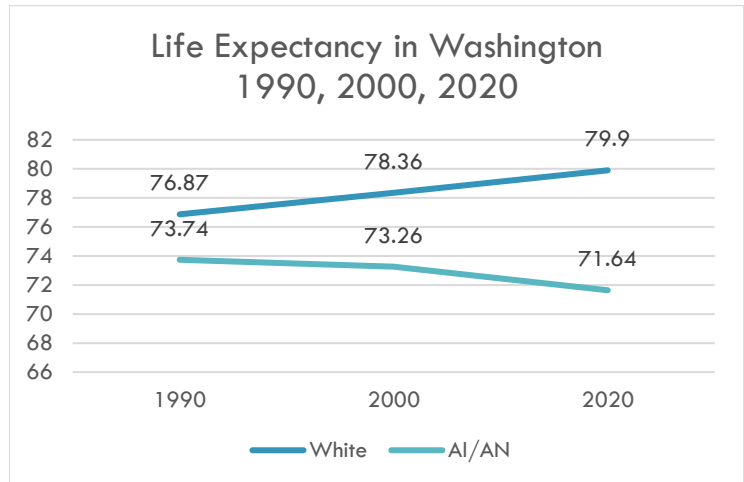
Acknowledgements

Our gratitude goes out to the Tribes, Urban Indian health Programs, Tribal organizations and epicenters in Washington State for their tireless work to improve the health status of American Indians and Alaska Natives in this state.

AIHC would like to thank the state agency staff from the Department of Health, the Washington State Health Care Authority and the Office of Financial Management who assisted in accessing data for this report.

Section 1: Introduction and Purpose

In Washington State, American Indians and Alaska Natives (AI/AN) experience a higher burden of chronic disease, mortality and other health disparities than the State's non-AI/AN population. These disparities are the direct result of historical trauma related to colonization, federal and state policies continually prioritizing land and resource acquisition over the lives of Indigenous populations, limited fulfillment of treaty rights including chronic underfunding of health care and public health services for AI/AN, discrimination and racism, limited understanding of Tribal sovereignty and ongoing institutional barriers. Health disparities and life expectancy for AI/AN for in Washington have only worsened in the last 20 years even with the initiation of the Affordable Care Act and similar progressive policies. The Tribal Nations and AI/AN populations of Washington are the first stewards of our beautiful state. Washington Tribes and Native values on current and future state populations are a state treasure. However, the health status as indicated by gap in life expectancy for AI/AN compared to the white population continues to widen. Action must be taken to address the alarming, widening gap in health inequities for the AI/AN population in Washington.



Health Equity starts with Tribal self-determination. Tribes should control the policies, metrics, plans, and goals intended to achieve health equity for their own people. Tribes know best their people, communities, social and historical context, needs, and strengths. Tribes are the experts in charting a path to health equity for their citizens.¹ Self-government is critical to American Indian and Alaska Native well-being. After more than a century and a half of federal experimentation, we've learned that recognizing and supporting Tribal self-determination, self-government, and self-reliance is what changes Indian life for the better.²

The Washington Indian Health Improvement Act (SB 5415) was enacted in 2019 to address health inequities and improve the health status of all AI/AN in Washington State by investing in the capacity and infrastructure needed to implement programs, increase access to care, strengthen continuity of care, and improve population health in a manner consistent with Tribal sovereignty and self-determination. The law created the Governor's Indian Health Advisory Council to direct this work (see Appendix A).

¹ Health Equity in Indian Country, National Indian Health Board, 2022

² Kalt, 1996.

One of the responsibilities of the Governor's Indian Health Advisory Council (GIHAC) is the Biennial Indian Health Improvement Advisory Plan. According to RCW 43.71B.030, the Washington State Health Care Authority, the American Indian Health Commission for Washington State, and other member entities of the GIHAC shall prepare and amend from time to time a biennial Indian health improvement advisory plan to:

- (a) Develop programs directed at **raising the health status of American Indians and Alaska Natives and reducing the health inequities** that these communities experience; and/or
- (b) Help the State, the Indian Health Service, Tribes, and urban Indian organizations, statewide or in regions, **improve delivery systems for American Indians and Alaska Natives** by increasing access to care, simplifying the administrative burden of health care delivery, strengthening continuity of care, and improving population health through investments in Tribal Public Health capacity and infrastructure.

To raise the health status of AI/AN and improve the Indian health delivery system in Washington, two overarching structural issues must be addressed: (1) institutional barriers to health improvement; and (2) the critical limitations on AI/AN data and Tribal data. Addressing the data limitations will allow the GIHAC to accurately define areas of need to design targeted programs and interventions and to evaluate over time, the efficacy of these strategies. More importantly, resolving the institutional barriers that prevent improvement in the health of AI/AN population will allow these interventions to be implemented effectively and in culturally competent ways.

This report is the first edition of the Biennial Indian Health Improvement Advisory Plan.

Section 2: What Are Healthy Tribal Communities?

To raise the health status of American Indians and Alaska Natives (AI/AN) and improve the Indian health delivery system in Washington, state partners must understand how Tribal nations define a healthy community. The American Indian Health Commission (AIHC) has facilitated the development of a Tribes/Urban Indian-driven healthy communities framework referred to as Pulling Together for Wellness (PTW). This framework focuses on a comprehensive prevention strategy that integrates Native and western knowledge to reduce risk factors for chronic disease among AI/AN in Washington State. Pulling Together for Wellness utilizes a Policy, Environment, Systems change approach and incorporates culturally appropriate strategies designed for Tribal and urban



Indian communities. This approach is intended to shift from “sick care” to systems and services based on wellness and prevention.

Tribal and Urban Indian health leaders determined the following definition as part of the Pulling Together for Wellness Framework: "A healthy Tribal and Urban Indian community is a safe and nurturing environment, where American Indian and Alaska Native people can experience emotional, spiritual, physical, and social health. Healthy communities provide the resources and infrastructure needed to empower people to make healthy choices and to ensure health equity."

A critical component to successful Policy, Environment, Systems change is developing cross-sector partnerships beyond the traditional health care system. Those partnerships are necessary to build community capacity and environments that empower people to make healthy choices. Successful partnerships require non-Indian partners to understand and respect Tribal sovereignty and self-determination and learn the history of the Tribes and Indian communities in the region.

The development of the Pulling Together for Wellness framework included significant discussion and review of research and evidence-based practices, practice-based evidence, promising practices, best practices, and cultural adaptations. The framework acknowledges that the work of improving the health status of AI/AN requires utilizing the best knowledge available, but the terminology used must resonate with the Tribal and urban Indian communities being served.

In sum, to assure effective strategies to improve the health status of American Indians and Alaska Natives and build self-governed systems, services and environments that support health and wellness, Tribal and urban Indian health leaders and subject matter experts must be included at every step of the design and development, and culture must be at the center.

Indigenous Quality of Life Measures

A comprehensive ability to monitor and prioritize health indicators that also include quality of life measures is essential to the health outcomes of Tribal and Urban Indian communities across Washington. Tribes and Urban programs must be able to prioritize activities that have meaning and impact for their community members.

A common understanding of well-being, or Indigenous Quality of Life Measures (IQOLM) rooted in Indigenous values, is missing from health care and policy and decision making.

Quality of life measures extend beyond physical and mental health wellness and include the factors that make life enjoyable and feel worthwhile. Indigenous communities include quality of life factors based on core values that can be different than mainstream western factors. Some factors are the same or similar to western ones, but Native communities may put more emphasis or priority on their outcomes than would be seen in a more typical western model. Understanding there is more than one

way to achieve the desired outcome means, for Indigenous populations, the process is not the focus as much as relationships and impacts.

Background:

Addressing health equity in Indian Country requires an understanding of the historical injustices and longstanding structural inequities that have led to the health inequities now experienced by American Indians and Alaska Native living both at their Tribes or as Urban Indians. The systemic issues which give rise to AI/AN health inequities are rooted in the long history of harmful federal and state Indian policies: genocide; uprooting AI/ANs from homelands and Tribal community structures; bans on cultural practices and language; forced relocation to both reservations and urban centers; abusive boarding schools; and other destructive policies. The consequences of such longstanding structural discrimination are many, including but not limited to:

- ◆ Undercutting of Tribal sovereignty and disempowering of Tribal governments;
- ◆ Structural racism and the conceptualization of AI/AN as a “race” and not citizenship;
- ◆ Disconnection of AI/ANs from community, identity, and culture;
- ◆ Distrust and broken relationships between Tribal nations and federal and state governments;
- ◆ Erasure of AI/AN peoples, identities, culture and histories;
- ◆ Disparities in opportunities, like education, jobs, and health care; and
- ◆ Devaluing of Indigenous ways of knowing³
- ◆ Appropriation and commodification of cultural and spiritual practices⁴

In order to change directions and ultimately eliminate the gap in health outcomes for the first peoples of Washington, the need exists to return to Indigenous values that recognize the impact of colonization, misdirected state policies, development and missteps in health delivery systems on the health and wellness of American Indians/Alaska Natives living in Washington.

The development and guidance of IQOLMs will serve to address and repair our systems, policies, and environments as an outcome of our value and protect our future generations, those that follow, and the land around them.

³ NIH Health Equity in Indian Country, 2022

⁴ Glasker, Angela, et al. Borrowed Meanings: The Appropriation And Commodification Of Native American Culture, The John Wesley Powell Student Research Conference -April 2005

Quality of life measures extend beyond physical and mental health wellness and include the factors that make life enjoyable and feel worthwhile. Native communities may put more emphasis or priority on outcomes such as social conditions in which families grow, live, and age often have a greater impact on health than behaviors, genetics, or health careⁱ.

Early childhood experiences, discriminatory bias, social inequality and social exclusion, security of access to healthy food and water, epi-genetics related to intergenerational trauma, history of colonialism or genocide, safe housing free of violence, safe and trusted healthcare that honors traditional healing, and the ability to find sustained income are among the social characteristics that have been shown to affect health outcomes for individuals and communities worldwide, but some of these social determinants of health may be missed if Indigenous communities are not at the table when designing state wide measures.

In 2012, the World Health Organization (WHO) defined Quality of Life as “... an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns”. The WHO developed a set of quality-of-life measures to acknowledge that traditional health measures alone, such as morbidity and mortality: ⁵

1. Do not measure the perceived, social, or spiritual impact of health and are not strength based. They do not tell the health story of an individual or community.
2. Were developed without Indigenous representation, resulting in translation of the western model of health measures being consuming and unsatisfactory at the Tribal/Village level.
3. The western model of medicine, concerned only with eradication of disease and symptoms, misses the importance of the quality of the human-to-human transaction where the patient’s well-being is the primary aim.

The IQOLM concept is based on experience and recognition that there has been an absence of Indigenous wisdom and understanding in the state health decision making infrastructure. This has created an absence of Indigenous values and voice when developing structures and policies influencing health and well-being of Washington residents. These same decisions and health structures can benefit from the acknowledgement of accepted frameworks for Indigenous Wellness that have been created under the guidance of Tribal and Urban Indian Leaders in this state, including in the Pulling Together for Wellness (PTW) and Traditional Ecological Knowledge (TEK) that integrate value-based and environmental impacts on wellness. For example, the health of the salmon runs and shellfish in our

⁵ World Health Organization, [WHOQOL Manual](#), 2022

state are directly linked to environmental toxins, water quality, and climate events that also impact human health.

“[The health of the salmon are] the foundation of our long-term culture and identity, and they are indicators of the overall health of everyone and everything that lives here...Our health and our treaty rights depend on our food being safe to eat.” Billy Frank Jr.

Like other areas in need of consistent and comprehensive measuring, quality of life measures can be found throughout a variety of community assessments and health surveys given to a variety of populations and collected by a variety of entities. The World Health Organization defines quality of life as “a state of physical, mental and social well-being, not merely the absence of disease and infirmity.”

Mainstream western culture bases quality of life on job status and income levels. “Low income” status is based on income that is reportable to the Internal Revenue Services (IRS). A person can be low income but still have all their needs met. Many Tribal families do subsistence hunting and fishing. If they live on a reservation, they might not own the land they live on, just the house, and receive income from a treaty right that is not reportable to the IRS. Not only is the desired outcome different, but the process to achieve the outcome is different. Their quality of life is much more complex than job status or income level would indicate.

A comprehensive ability to monitor and prioritize well-being measures that also includes quality of life measures is essential to the health outcomes of Tribal and Urban Indian communities across Washington. Tribes and Urban programs must be able to prioritize activities that mean the most to their community members. Forcing Indigenous people to measure success by using mainstream western priorities is assimilation.

Purpose:

The purpose of the Indigenous Quality of Life Measures (IQOLM) project is to establish a set of operational statewide measures of quality of life based on an Indigenous vision of health rooted in the cultural beliefs and values. IQOLM will be utilized to address American Indian/Alaska Native (AI/AN) health disparities in our state and evaluate barriers created by state agency systems, policies, regulations, and programs.

These measures will be informed by Tribal and Urban Indian leaders in Washington State. IQOLM will guide state actions with engagement from acknowledgement to awareness, to actionable initiatives and efforts, building a deeper understanding of the importance of cultural values and sustainability from an Indigenous lens.ⁱⁱ

This project stems from a legacy of efforts by Washington Tribal Leaders speaking for the need to include measures that align with the values and needs of Tribes and American Indian/Alaska Native communities. The inclusion of IQOLM and understanding of Indigenous cultural values in

the state system prior to determining strategies, tactics, and use evidence-based programs that may not be relevant to Indigenous people will enable the development of specific Tribal/Community-driven direction to achieve better health outcomes. The Governor's Indian Health Advisory Council provides a new avenue of inclusion in decision making and a forum to begin to address historical inequities and the resulting health disparities and to begin to restore the health of our families and communities.

Like other areas in need of consistent and comprehensive measuring, quality of life measures can be found throughout a variety of community assessments and health surveys given to a variety of populations and collected by a variety of entities. The Pulling Together for Wellness values, the [North Sound Native Transformations Project](#), and the [Swinomish Indigenous Health Indicators](#) are all excellent examples of integrating Indigenous values into metrics for Health and Well-Being.

The Pulling Together for Wellness framework is used as a facilitator for discussion with Washington Tribes and Urban Indian Organizations, the GIHAC and State Agencies. The PTW framework is a well-established and trusted Washington promising practice, informed by Traditional Public Health Practice. The Framework was designed through the guidance of Tribal Leaders. It has been vetted at the local Tribal level, through meetings with Tribal Councils, engagement including Tribal Youth Councils, The Evergreen State College's Native MPA model. The framework has also been presented within the state structure, regionally and nationally in Tribal and non-Tribal conventions. The PTW framework is an Indigenous-based tool that would benefit all populations in Washington.

For the purposes of inventorying Washington State agencies self-assessed barriers and challenges, the following 7 indicators, based on the Swinomish Indigenous Health Indicators, and modified based on the PTW framework, provide a structure for outlining each agencies inventory of challenges. These measures, similar to an impact review, should be considered in all State policies, funding, decision making and program development.

DRAFT Indigenous Quality of Life Measures for WA- Crosswalk with Pulling Together for Wellness Visions										
										IQOL Measure
										Health and wellness
										Self Determination/Sovereignty
										Community Connection
										Education / Teachings
										Generational Clarity
										Cultural Sovereignty
										Resource Security
Pulling Together for Wellness Vision										
Our babies are born healthy; our mothers and fathers are supported.										
Our tribal youth and adults are strong in mind, body, and spirit.										
Our elders live long healthy lives (100+).										
Our families have access to healthy nutritious food and know how to hunt, catch, gather, grow, harvest and preserve it.										
Our families play and learn together in safe and nurturing environments.										
Our people are self-sufficient and have opportunities for employment and life-long learning.										
Our people have safe affordable housing.										
Our people have self-responsibility.										
Our people are happy, kind, and have good humor.										
Our communities nurture our children and respect our elders.										
Our communities embrace traditional values about respect and honor of all people of all ages.										
Our communities have food sovereignty.										
Our communities practice and hand down traditions from generation-to-generation in ceremony, language, and living.										
Our communities respect and are connected to our natural environment.										
Our environments are safe and provide all people with culturally appropriate choices to be healthy.										
Our environments are free of alcohol, commercial tobacco, and other drugs.										
Our systems, policies, & environments are trusted, empower our people, are culturally competent, & promote health equity.										



Draft Framework for Indigenous Quality of Life Measures

1. Tribal Sovereignty, Self-Governance

- Sample question: Does this program/policy/funding acknowledge and reinforce Tribal self-governance?

2. Community Connections

- Sample question: Does this program/policy/funding support and acknowledge and reinforce existing community connections at Tribes and Urban Indian communities?

3. Indigenous Ways of Knowing/Traditional Ecological Knowledge⁶

⁶ [Guidance for Federal Departments and Agencies on Traditional Knowledge](#), White House Briefing Paper, November 2022.

- a. Sample question: Have supporting evidence for the program/policy/etc. included Traditional Ecological Knowledge?

4. Health and Wellness

- a. Sample questions: Will this program/policy/funding support existing Tribal programs that have the support of the community to address a specific health issue? Is it community-driven?

5. Culture Sovereignty, Culture is prevention.

- a. Sample questions: Does this program/policy/funding recognize the importance of a culture in promoting a healthy community. Does it support a culturally tailored intervention?

6. Generational Clarity - policies and initiatives acknowledge historical trauma of past generations while also looking forward to how decisions made today will impact those in future generations

- a. Sample question: Are State staff and decision makers trained in intergenerational trauma and historical state policies that have impacted the resources and members of WA Tribes?

7. Resource Security (Natural Resource and Human Resource)

- a. Sample question: Does this state policy/program support traditional foods and the health of the land base needed for toxin-free and plentiful hunting and gathering?

Health and wellness	Self Determination/ Tribal Sovereignty	Community Connection	Traditional Knowledge	Generational Clarity	Cultural Sovereignty	Resource Security
Improving Health and Wellness for AI/AN						
Action: Programing that effectively supports cultrally appropriate prevention and addresses health disparities for AI/AN						
Support, Understanding and Respect of Self Determination and Tribal Sovereignty						
Action: Staff training and Policy Consultation that upholds and Tribal Soviegnity and Self Determination						
Support, Understanding of Strengths and Reliency Factors of Indigenous Community Connections						
Action: Policy and resources that acknowledge and strengthen Community Building						
Support Traditional Knowledge and Teachings						
Action: Utilize Traditional Ecological Knowledge (knowledge of Elders) for traditional/ healthy ways of living						
Recogizing and Supporting Generational Clarity: Culture is Prevention						
Action: Policy, staffing and programming that has understanding of impact of intergenerational trauma as well as Indigenous Resiliency						
Support and Recognitionof Cultural Soveignty						
Action: Policy and resources that priooritze community/Tribal driven intervention and support Traditional Ways						
Recognition of Importance of Resource Security						
Action: Protections for traditional food gathering,consideration of impact on habitat, water and air on all practices						



<<<<. AI/AN Data Inclusion and Tribal Data Ownership. >>>>

<<<<Tribal Inclusion from Beginning. >>>>

Indigenous Resiliency Factors

Indigenous resiliency factors are important in quality of life, cultural identity, and community wellness indicators. Tribes and Urban programs need support for measuring, implementing, supporting, and evaluating activities that strengthen Indigenous resiliency factors.

To build resilience, general protective factors⁷ can include:

- Cultural/Social factors: Presence of mentors and support for development of skills and interests; opportunities for engagement within school and community; opportunities to contribute to community; positive norms; clear expectations for behavior; physical and psychological safety;
- Social/Ecological factors: Access to traditional land; use of lands and water; health and abundance of traditionally relied on plant foods and medicines, animals, and seafood; control of land and water, especially limiting pollutants; retention and reclamation of sacred sites;
- Family & personal factors: Family provides continuity of traditional teachings through family history through stories passed down generational. Families provide structure, limits, rules, monitoring, and predictability; supportive relationships with family members; clear expectations for behavior and values, positive physical development, academic achievement/intellectual development, high self-esteem, emotional self-regulation, good coping skills and problem-solving skills; engagement and connections in two or more of the following contexts: school, with peers, in athletics, employment, religion, culture.

Examples of tracking and measuring resiliency factors in Indigenous communities can include:

- Participation in cultural practices that include traditional food, language, music and customs;
- Frequency and ability to participate in traditional ceremonies, including having or being able to access the resources needed to participate;
- Community protective factors: opportunities for prosocial involvement;
- Knowledge of family lineage and history of relationship to and ancestral villages.
- Ability to talk to neighborhood adults;
- Availability and access to activity, service, and culture clubs;
- Availability and access to sports teams and recreational opportunities;
- Impacts of COVID Protocols on cultural/traditional practices for gathering. Recognizing different ways to address through social media and virtual platforms. The support structures of the community were really needed, could not ignore the grief and need; had to adapt.

⁷ <https://youth.gov/youth-topics/youth-mental-health/risk-and-protective-factors-youth>

Section 3: Overview of Indian Health in Washington State

American Indians and Alaska Natives Population. According to Census 2020, in Washington 313,633 people identified as American Indian/Alaska Native (AI/AN) alone or in combination with another race. This number represents 4.1% of Washington State's population and indicates a growth of 57.5% in the last ten years.⁸

Tribes. Washington State encompasses the ancestral homelands of the Indigenous people who have lived here since time immemorial. There are currently 29 federally recognized sovereign Tribal nations within the borders of Washington State. Although not every Tribe has a reservation land base, each Tribe has the inherent sovereign authority to provide for the health of its people, wherever those individuals may reside.

Indian Health Care Providers. In Washington, most Tribes compact or contract with the federal government to operate their own primary medical care clinic. Three Tribes in eastern Washington have health clinics operated by the federal Indian Health Service (IHS) on their lands. One of those Tribes also operates a federally qualified health center (FQHC) and a convalescent center. Most specialty care for AI/AN in Washington is accessed from non-Tribal health care providers. Unlike other Indian Health Service Areas, in the Portland Indian Health Service Area, there are no hospitals operated by the Indian Health Service. As well, no Tribes, or other Indian organizations operate a hospital. One Tribe does operate an oncology center. Two Tribes do not have a health facility and provide primary care through Purchased and Referred Care (PRC). Services provided at each Tribe are unique to each Tribe.



Washington is the home of 29 federally recognized Tribes. 54% of American Indian and Alaska Native people, or a majority, live in rural and small-town areas on or near reservations. Nationally, 68%, live on or near their home reservations.⁹ Many AI/AN individuals living in urban areas receive primary health care services from one of two urban Indian health programs (UIHOs): the Seattle Indian Health Board; and The Native Project of Spokane. Washington Tribal clinics also are the health home for many AI/AN

⁸ Source: U.S. Census Bureau Race and Ethnicity in the United States: 2010 Census and 2020 Census Tableau

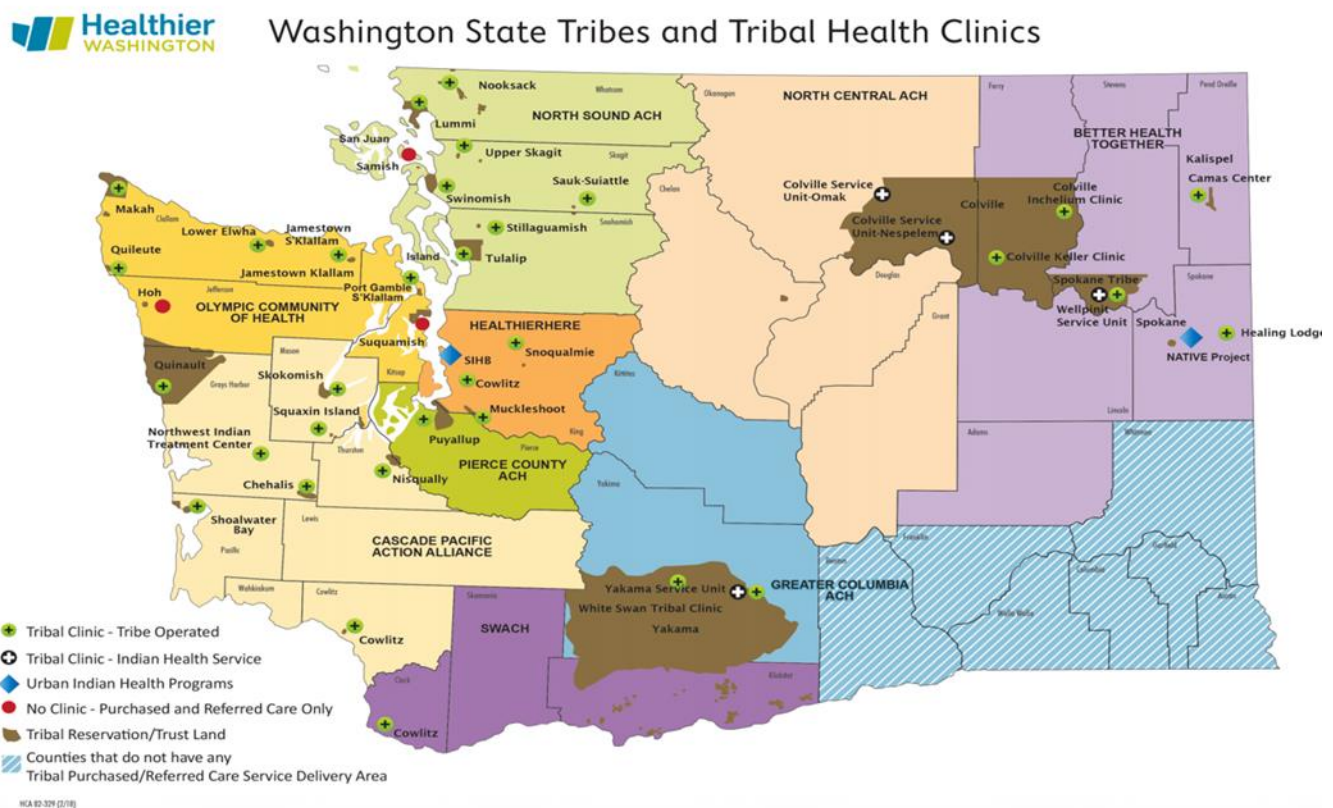
⁹ <https://www.firstnations.org/knowledge-center/publications/strengthening-tribal-community-institutions/#filtersnearly>

who may not be enrolled in that specific Tribe but live within the “service area” of the Tribal Clinic. Of notable mention is the Puyallup Tribe serving AI/AN living within the Tacoma metro area. Other Tribal Clinics are the only health care provider in the rural area. For example, the Kalispel Tribe of Indians operates the Camas Center for Community Wellness and the Shoalwater Tribal Health Center provide health and social needs for both their citizens and the larger non-native rural community.

Tribes and UIHOs as Community Partners

Tribal governments vaccinate teachers and first responders, open community centers to neighbors, fund off-reservation schools, maintain public safety, and collaborate with state and local governments on everything from salmon habitat restoration to childhood education.¹⁰ Tribes provided direct employment (including healthcare benefits) to 37,371 (1 in 86) Washington residents in 2022.

Most Tribes and both UIHOs provide outpatient behavioral health services. The Squaxin Island Tribe operates the Northwest Indian Treatment Center, an adult inpatient treatment facility. A consortium of seven Tribes operates the Healing Lodge of the Seven Nations, providing inpatient treatment for individuals ages thirteen through seventeen. The following map shows the location of Tribal clinics, IHS service units, and UIHOs.



¹⁰ [The Economic & Community Benefits of Tribes in Washington](#), WIGA, May 2022.

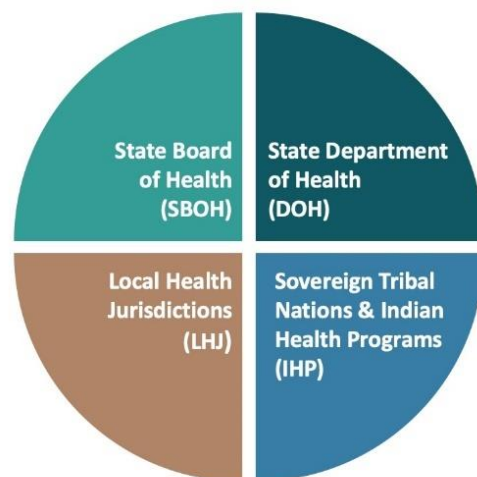
Tribal Public Health Services. Tribal nations and Indian health programs are one of the four components of Washington State’s public health system as defined under RCW 43.70.512.(1).

Tribes are sovereign nations. In contrast to the other three components of the State’s public health system, which derive certain authority from the State, Tribal nations’ power to establish and enforce their own laws is inherent.¹¹ This sovereign authority includes the power to provide and coordinate emergency health and medical services within their jurisdiction in response to emergencies or disasters of natural or manmade origin.

Tribes have a direct relationship with the federal government. A Tribe’s inherent sovereign authority means that neither the state nor local public health officers have jurisdiction on Tribal lands.

Tribal Health jurisdictions need to have access to the same resources as other parts of the governmental public health system. This includes the same access to data within state systems as local health jurisdictions (LHJ). This did not happen at the beginning of the pandemic. However, Tribes were allowed read only access for positive COVID tests and stood up a Tribal Data Sovereignty workgroup to with DOH to mitigate access issues. After two years of conversations about Tribal data sovereignty, the state agencies and the Washington State Tribes are preparing to build Tribal Data Sovereignty principles and exercise Tribal data sharing agreements to ensure access to and protection of Tribal data in state systems.

Governmental Public Health System



¹¹ Iron Crow v. Oglala Sioux Tribe, 231 F.2d 89 (8th Cir. 1956); Merrion v. Jicarilla Apache Tribe, 455 U.S. 130, 149 (1982).

Section 4: Institutional Barriers to Health Improvement for American Indians and Alaska Natives in Washington

The State of Washington collects and distributes resources across its residents, often aiming to maintain and improve the current quality of life and health status of its residents. The collection of resources relies on the control of land through property ownership, taxation, and determining use. This collection of resources only exists due to the displacement of Indigenous people who lived on the land since time immemorial. The state has greatly benefited some of its residents, but for much of its 132 years, the benefits have been inconsistent and at the expense of others.

It is important to understand the role that assimilation plays in institutional racism within state government. State agency systems, policies and programs were created and have been maintained from mainstream western culture view of the world. Communities from other cultures, with differing values, are forced to assimilate into the culture, values and views of those who create and maintain the system, policies and programs. Not only does this cause health barriers to populations with different cultural values, but it can also traumatize and retraumatize people each time they interact with the system. To force the AI/AN population to work with agencies that only see the world from mainstream western cultural views is a form of assimilation and, compounded with intergenerational trauma, can make maneuvering through State programs and requirements emotionally exhausting. Institutional barriers to health improvement must be eliminated to raise the health status of AI/AN and improve the Indian health delivery system in Washington.

The State of Washington offers many programs to Washingtonians. Tribal members, no matter where they live within the State of Washington, are also citizens of the state, and as such, have a right to access state programs. The lack of consideration for Tribal governmental programs and the Indian Health system of care by the State and State agencies when creating systems, policies and programs causes chronic barriers. Systems have been built without input and collaboration with Tribal governments or an understanding of programs that are available to the AI/AN populations across the state. Once built, these systems, programs and services are difficult to change. Many of these services are part of the federal government's trust responsibility to provide health care to AI/AN. By accepting federal funds, the state assumes these trust responsibilities.

Eligibility for Indian Health Service (IHS) is based on where individuals live in relation to the nearest Indian Health Service, Tribal, or urban Indian health program or Indian Health Care Provider (IHCP), as well as Tribal descendency. An AI/AN can be "IHS-eligible" but not able to access care simply because they do not live within the service area of an IHCP. In Washington State, there are no hospitals or medical specialty care facilities operated by an IHCP, with the exception of the Puyallup Tribe's Salish Cancer Center. AI/AN in Washington State must access all specialty medical care and hospital care from non-Indian facilities, and must navigate the eligibility, payment, and cultural requirements before and while accessing care.

Tribal members face numerous barriers that result from state systems built without input and collaboration with Tribal governments or AI/AN subject matter experts. When Tribal members access services outside their Indian Health delivery system, they must assimilate, suffer microaggressions and/or adjust to the mainstream western values and culture of state-created programs. This experience of maneuvering through state programs and eligibility requirements is often emotionally exhausting. Compounded with intergenerational trauma, this can result in diminished efficacy of the care or an inability by the individual to access or continue receiving the services.



Tribes and Tribal and urban Indian health organizations are the experts in designing and delivering culturally competent and effective programs and services to their community members and understand the jurisdictional complexities that arise when AI/AN need services from the state

system.

Public health practice often uses Evidence Based Interventions or a “one size fits all” approach to addressing health needs. WA public health resources have traditionally been focused on Local Health Jurisdictions, and now Accountable Communities of Health, to trickle down and include Tribes and UIHOs. These approaches to disease prevention and public health have not worked for AI/ANs in Washington. Health disparities continue to exist and have even increased for many chronic diseases and mental health diagnosis in Washington for AI/AN. Successful public health for AI/AN population will need to be community-based and culturally tailored to eliminate health disparities for future generations of AI/ANs in Washington. Evidence for the need for a community-driven approach to public health for AI/AN populations was clearly demonstrated in the COVID-19 response.¹²

Practices, processes, and procedures that state agencies are accustomed to will need to change to be effective and legally consistent with Tribal sovereignty and federal and state laws. To eliminate institutional barriers, state agencies must meaningfully include Tribal and urban Indian health leaders

¹² McLeroy KR, Norton BL, Kegler MC, Burdine JN, Sumaya CV. Community-based interventions. *Am J Public Health*. 2003;93(4):529-533. doi:10.2105/ajph.93.4.529

and AI/AN subject matter expert in the design and management of programs, services, and systems and adequately fund the AI/AN and Tribal relations functions within each agency. Institutional racism within our state governmental agencies must be addressed before the state can move the needle in improving the health of AI/AN and Tribal communities.

Critical Tribal Data Issues

To raise the health status of American Indians and Alaska Natives (AI/AN) and improve the Indian health delivery system in Washington, the critical limitations on AI/AN and Tribal data must be corrected. The Governor's Indian Health Advisory Council (GIHAC) must have dedicated public health staffing with the skills and support to access and utilize quality data to accurately identify and define areas in need of improvement, design targeted programs and interventions, and evaluate over time the efficacy of these strategies.

As a result of chronic underfunding of health care and public health services, Tribes and Urban Indian Health Organizations (UIHOs) lack the infrastructure required to conduct self-determined community health assessments and community health improvement planning. This includes workforce, health information technology and governance systems to collect, manage, analyze and utilize their own data. These systems are also needed for Tribes and UIHOs to utilize the existing state health datasets. In addition, Tribes and UIHOs have typically not been included in planning and implementation of community health assessments in Washington. The Urban Indian Health Institute's recent report, "Review of Community Health Assessments in Washington State: Implications for Tribal Foundational Public Health Services," states that only three of seventeen community health assessments (CHAs) by local health jurisdictions with one or more Tribes within their service region specifically listed a Tribe as contributor or participant in the CHA. None noted an Urban Indian organization or Tribal epidemiology center as contributor.¹³

Most data currently available regarding the health status of AI/AN reside in federal or state datasets. In Washington, these datasets include, but are not limited to, the following: Behavioral Risk Factor Surveillance System (BRFSS); Youth Risk Behavior Survey (YRBS); Healthy Youth Survey (Office of the Superintendent of Public Instructions or OSPI-HYS); Washington Immunization Information System (WAIIS); Washington Vital Statistics; Washington State Cancer Registry; Pregnancy Risk Assessment Monitoring System (PRAMS); and Washington State Health Care Authority (HCA) Analytics Research and Measurement System (ARM).

The data in Washington State systems have significant limitations, including incomplete information and racial misclassification of AI/AN. According to the Northwest Tribal Epidemiology Center (NWTEC), misclassification of AI/AN in Washington, Oregon, and Idaho health datasets can range from 10%-60%.

¹³ Urban Indian Health Institute (2021). Review of Community Health Assessments in Washington State: Implications for Tribal Foundational Public Health Services. Seattle, WA: Urban Indian Health Institute.

Many of these state datasets do not include a large enough sample size of AI/AN to provide a valid representation of the health status of the state's AI/AN population at the local or Tribal level. Accurate and complete data are necessary to assess health disparities, develop policy, conduct strategic planning, design and deliver services, and allocate resources for AI/AN in Washington. Efforts must be made to improve the quality of data available by resolving the systemic factors that diminish the quality of AI/AN data in state datasets and investing in Tribal and UIHO health care and public health information technology, workforce, and systems.¹⁴

Additionally, policies, procedures and protocols are needed to protect Tribal data sovereignty regarding data held in state datasets. Tribes must have:

- access to AI/AN health data in all state agencies' datasets;
- ownership and control over how state agencies collect, use, and share data regarding Tribes and AI/AN;
- support for infrastructure for Tribes to collect, store, analyze, and share their own data, including the following: information management systems (software); hardware; codes; data sharing agreements; data management plans, infrastructure, and workforce;
- support for infrastructure for Tribes to access and utilize existing state datasets; and
- resources for Tribes and UIHOs to conduct self-determined community health assessments.

There has been little to no investment in Tribes' and UIHOs' health assessment infrastructure from the federal and state governments. Adequate infrastructure is essential to assure quality data are available, Tribal sovereignty and self-determination are respected, and public health data can be managed, analyzed and applied at the Tribe and urban Indian community level, where the most effective interventions will happen. This infrastructure includes the resources needed for Tribes and UIHOs to conduct self-determined community health assessments and access and utilize the existing state health databases.

Various efforts are under way to improve access to quality data and institutionalize systems that respect Tribal data sovereignty. These efforts include:

- Washington State Health Care Authority's (HCA's) State Medicaid Comprehensive Health Record (Epic Electronic Health Record as a Service) Project – HCA is undertaking an effort to provide outpatient electronic health record (EHR) functionality to rural, behavioral health, and Tribal providers. The project aims to provide Epic's electronic health record (EHR) system at little to no cost;

¹⁴ NWTEC- (need complete citation)

- Implementing Tribal Federally Qualified Health Center (FQHC) and Care Coordination Agreements – Tribes and HCA are nearly ready to implement and capture the new savings created by these agreements. These savings will be deposited into the Tribal Reinvestment Account to fund projects determined by the Tribal Reinvestment Account Committee made up of members from each of the Tribes and the two Urban Indian Health Programs in Washington State.
- Exchanging Data with Tribal Jurisdictions – The pandemic brought attention to the need to address this topic with state agencies gathering health data. Since this discussion crosses all agencies involved in health, the Governor’s Indian Health Advisory Council will begin discussing this topic. It is imperative that the State and Tribal governments engage in discussions and agreements around:
 - 1) access to existing data sets that contain data on a Tribal community,
 - 2) ownership of data,
 - 3) collection of data (IRB should be guiding this),
 - 4) data management (are IHCPs involved or consulted in how the data is managed);
 - 5) Data sharing (ie: data provided to third parties for “public health”, “research” or other used for a state agency’s own publications)
 - 6) Use of data to inform policy authorities. Guidance to state agencies for developing and implementing policies and systems to assure the protection of Tribal data sovereignty.
- Tribal Foundational Public Health Services Community Health Assessment Infrastructure Projects/Funding – Tribes and UIHOs are receiving important state funding for staffing and infrastructure building to provide Tribal Foundational Public Health Services. AIHC will provide technical assistance for Tribes to develop self-determined Tribe-specific community health indicators and conduct Tribally driven community health assessments;
- AIHC Coordination with Washington Office of Financial Management (OFM) – AIHC has initiated efforts with OFM to improve the quality of data regarding AI/AN in OFM datasets, increase Tribes’ and UIHOs’ access to OFM data, and include Tribes and UIHOs in decisions regarding the collection, analysis, and publication of data;
- NPAIHB IDEA NW Project – NPAIHB conducts record linkages to correct misclassified AI/AN records in state surveillance systems such as cancer registries, vital statistics, hospital discharge data, trauma registries, and communicable disease systems; and

- UIHI Review of Community Health Assessments in Washington State – UIHI conducted a review of community health assessments conducted in Washington State to assess the availability and completeness of data on AI/AN populations.

An abbreviated set of health indicators is included in Appendix C to provide a snapshot of the current health status of AI/AN in Washington State. These data are from state datasets and the federal American Community Survey. Future editions of this report will contain more comprehensive health assessments with additional indicators, including self-determined Indigenous health indicators and improved quality of data, as Tribe and UIHO population health infrastructure is strengthened and the quality of AI/AN data in state datasets improves. Additionally, Tribes and UIHOs will be engaged in determining the indicators to be included in future statewide AI/AN health assessments and selecting data sources.

Tribally- and UIHO-led health assessments will likely include Indigenous Quality of Life Measures (IQLM) and Indigenous Community Resiliency Measures. IQLM extend beyond physical and mental health and include factors that make life enjoyable and worthwhile. These variables are based on core values, and thus can be different from those that resonate for western communities. Community resiliency measures are firmly grounded in culture and reflect the factors that have sustained and allowed Indigenous peoples to survive and thrive. These measures encompass individual development and self-identity, family relationships and expectations, and community norms and guidance on each individual's contributions and importance to the community.

Section 5: Reinvestment Account Status: To date, there have been no investments from the reinvestment account. Work is still being done to ensure claims are able to be entered and tracked in both Tribal Clinic's electronic health records (EHR) and the Health Care Authority systems. Many Tribes are ready to initiate Tribal Federally Qualified Health Center (FQHC) Affiliate agreements to gain access to specialty care for their Medicaid enrollees. Future editions of the Biennial Indian Health Improvement Advisory Plan will include a review of how programs, projects, or activities that have received investments from the reinvestment account have or have not achieved their objectives and why.

Section 6: Recommendations

Per (RCW 43.71B.030), this report “shall include: Specific recommendations for programs, projects, or activities, along with recommended reinvestment account expenditure amounts and priorities for expenditures, for the next two state fiscal biennium.” (See Appendix B for a list of eligible programs, projects, or activities).

Actions for State and State Agencies:

Implement 20% Tribal set aside based on NIHB recommendations across all GIHAC agencies.

Work with state data to establish Tribal set aside based on actual health disparities.

Support the Tribal Behavioral Health Bill and establishment of Washington State Tribal Opioid and Fentanyl Response Taskforce.

Funding to reconvene the Pulling Together for Wellness Leadership Council to develop a statewide set of Indigenous Quality of Life Measures (IQLM)

Establish the use of the term “Tribal Health Jurisdiction” across all GIHAC agencies.

- Recognize self-governing rights of Tribal Health Jurisdictions across all state agencies.
- Support capacity building for Tribal Health Jurisdictions (THJs) so that THJs align with the similar resources, staffing and abilities as Local Health Jurisdictions and Behavioral Health Administrative Services Organizations.
 - Allow access to state data platforms needed for public health functions.
 - Build capacity (staffing and targeted training) for THJs to perform public health data analysis, tracking and management for their community.
 - Ensure access to bed availability information for behavioral crisis.
 - Ensure funding for IHCPs/Tribal governments providing behavioral health crisis services.
- Recognize the role of Traditional Ecological Knowledge and Tribal self-determination for structure and resources identified by each Tribe to establish a community-driven Tribal Public Health Jurisdiction.
 - Utilize traditional gatherings and communications mechanisms unique for each Tribe.
 - Recognize the importance of traditional healing, traditional foods, and intergeneration teachings as the foundation of "public health efforts" such as effective healthy lifestyle adaptation and public health response.

Develop a report and methodology to identify and track the new state savings for the reinvestment account with advice from the advisory council as required by RCW 43.71B.040.

- Develop a data sharing agreement between Washington State and Tribes to increase access for Tribes to state datasets and respect Tribal data sovereignty;
- Draft and implement state legislation to exclude Tribe-specific data from public disclosure laws;
- Require that all state agencies establish mechanisms for Tribes to access state datasets for information relevant to the Tribes' health;
- Require that Accountable Communities of Health (ACHs) adequately include Tribes and UIHOs in planning and implementation of programs and services and remove barriers to Indian health care providers' participation in initiatives;
- Invest in Tribal and UIHO development of health data technology systems and infrastructure (hardware, software, workforce) for Tribes and UIHOs to adequately manage their own public health data;
- Fund electronic health records (EHRs) for Indian Health Care Providers (IHCPs) and health information technology (HIT) workforce; and
- Fund and broadly implement training on issues related to improving the health status of AI/AN, including:
 - government-to-government training for state agency employees, including Tribal sovereignty, Indian law, agency-specific laws and requirements; and
 - training for private health care providers on billing, care coordination and culturally competent care.

Reinvestment Account Investments- when funds are available:

- Fund and support Traditional Healers including efforts to seek Medicaid reimbursement for traditional medicines and coverage for traditional formularies;
- Invest in a 24-hour AI/AN Nurse Line;
- Fund a program for behavioral health integration for Indian health care providers (IHCPs), including staffing of behavioral health aides, development of behavioral health patient registries for IHCPs, training of health care staff, co-location of services, and integration of screening for mental health and SUD in medical visits;

- Fund and support Tribes to adopt Tribal behavioral health crisis codes and implement Tribal Designated Crisis Responders (DCRs); and
- Fund a program for Native doulas.
- Funding to support Community Health Aid Program (CHAP) Board

Appendix A: Governor's Indian Health Advisory Council

The Governor's Indian Health Advisory Council (GIHAC) consists of:

(a) The following voting members:

- (i) One representative from each Tribe, designated by the Tribal council, who is either the Tribe's American Indian Health Commission (Commission) delegate or an individual specifically designated for this role, or his or her designee;
- (ii) The chief executive officer of each urban Indian organization, or the urban Indian organization's Commission delegate if applicable, or his or her designee;
- (iii) One member from each of the two largest caucuses of the house of representatives, appointed by the speaker of the house of representatives;
- (iv) One member from each of the two largest caucuses of the senate, appointed by the president of the senate; and
- (v) One member representing the governor's office; and

(b) The following nonvoting members:

- (i) One member of the executive leadership team from each of the following state agencies: The Health Care Authority; the Department of Children, Youth, and Families; the Department of Commerce; the Department of Corrections; the Department of Health; the Department of Social and Health Services; the Office of the Insurance Commissioner; the Office of the Superintendent of Public Instruction; and the Washington Health Benefit Exchange;
- (ii) The chief operating officer of each Indian Health Service area office and service unit, or his or her designee;
- (iii) The executive director of the American Indian Health Commission, or his or her designee; and
- (iv) The executive director of the Northwest Portland Area Indian Health Board, or his or her designee.

Appendix B: Reinvestment Account Programs, Projects, Activities

The list of programs, projects, and activities may include but are not limited to:”

- (i) The creation and expansion of facilities operated by Indian Health Services, Tribes, and urban Indian health programs providing evaluation, treatment, and recovery services for opioid use disorder, other substance use disorders, mental illness, or specialty care;
- (ii) Improvement in access to, and utilization of, culturally appropriate primary care, mental health, and substance use disorder and recovery services;
- (iii) The elimination of barriers to, and maximization of, federal funding of substance use disorder and mental health services under the programs established in chapter 74.09 RCW;
- (iv) Increased availability of, and identification of barriers to, crisis and related services established in chapter 71.05 RCW, with recommendations to increase access including, but not limited to, involuntary commitment orders, designated crisis responders, and discharge planning;
- (v) Increased access to quality, culturally appropriate, trauma-informed specialty services, including adult and pediatric psychiatric services, medication consultation, and addiction or geriatric psychiatry;
- (vi) A third-party administrative entity to provide, arrange, and make payment for services for American Indians and Alaska Natives;
- (vii) Expansion of suicide prevention services, including culture-based programming, to instill and fortify cultural practices as a protective factor;
- (viii) Expansion of traditional healing services;
- (ix) Development of a community health aide program, including a community health aide certification board for the state consistent with 25 U.S.C. Sec. 1616I, and support for community health aide services;
- (x) Health information technology capability within tribes and urban Indian organizations to assure the technological capacity to: (A) Produce sound evidence for Indian health care provider best practices; (B) effectively coordinate care between Indian health care providers and non-Indian health care providers; (C) provide interoperability with state claims and reportable data systems, such as for immunizations and reportable conditions; and (D) support patient-centered medical home models, including sufficient resources to purchase and implement certified electronic health record systems, such as hardware, software, training, and staffing;
- (xi) Support for care coordination by tribes and other Indian health care providers to mitigate barriers to access to care for American Indians and Alaska Natives, with duties to include without limitation: (A)

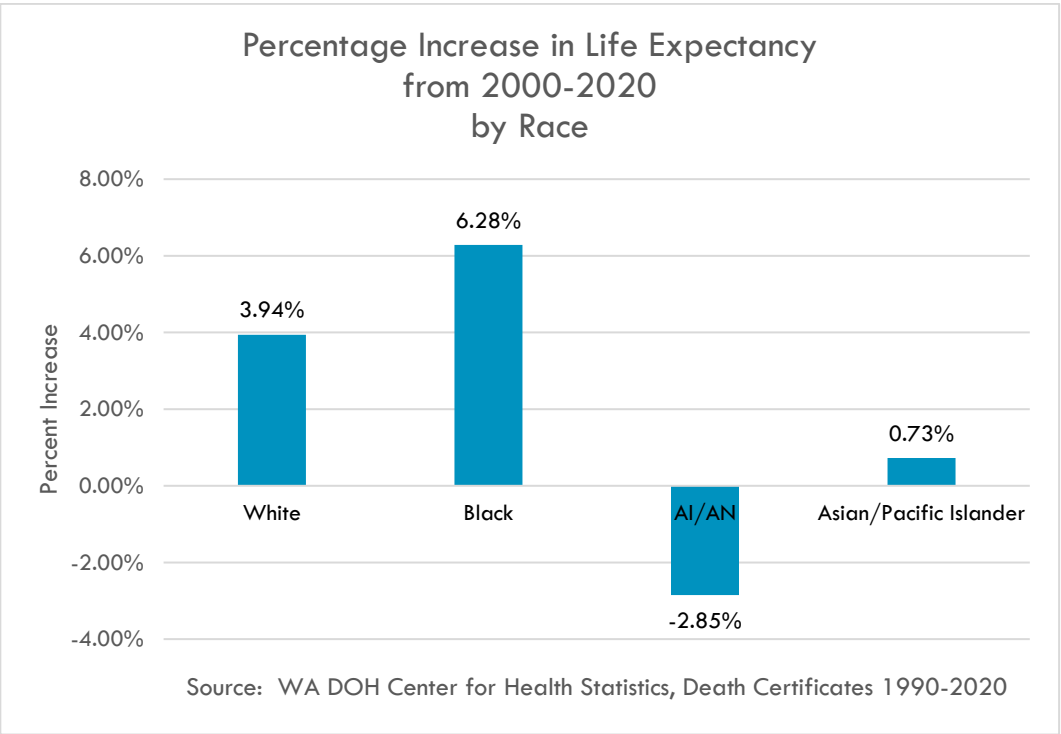
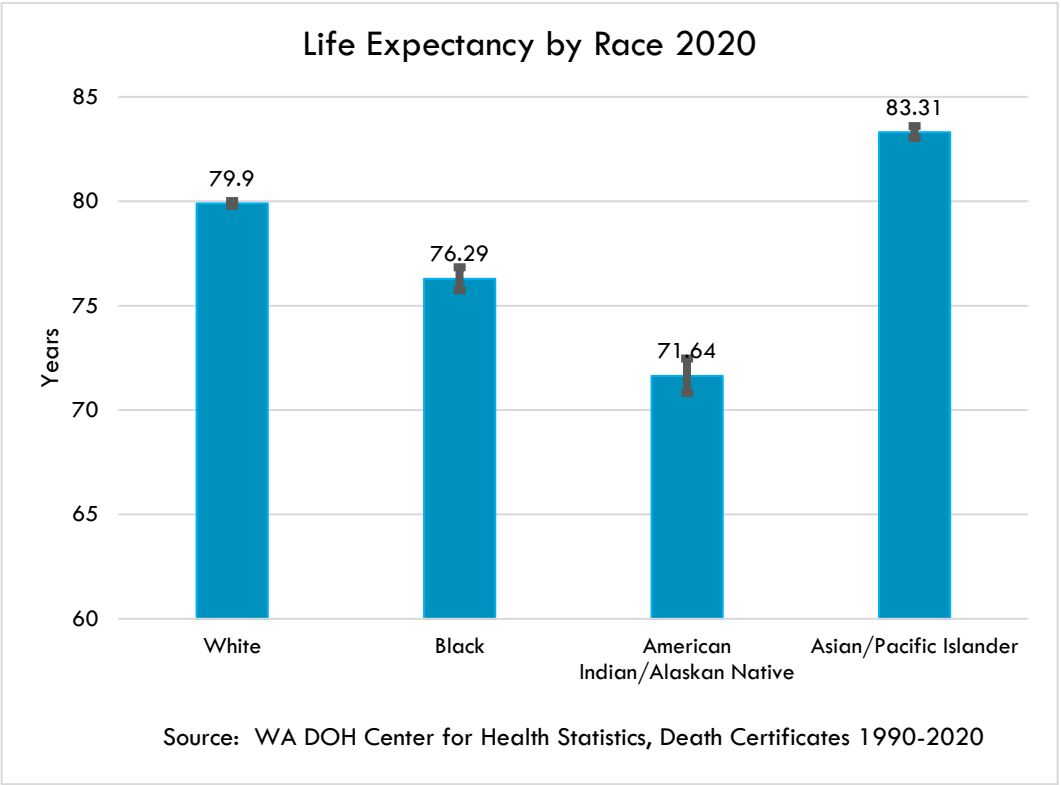
Follow-up of referred appointments; (B) routine follow-up care for management of chronic disease; (C) transportation; and (D) increasing patient understanding of provider instructions;

(xii) Expanded support for Tribal and urban Indian epidemiology centers to create a system of epidemiological analysis that meets the needs of the state's American Indian and Alaska Native population; and

(xiii) Other health care services and public health services that contribute to reducing health inequities for American Indians and Alaska Natives in the state.

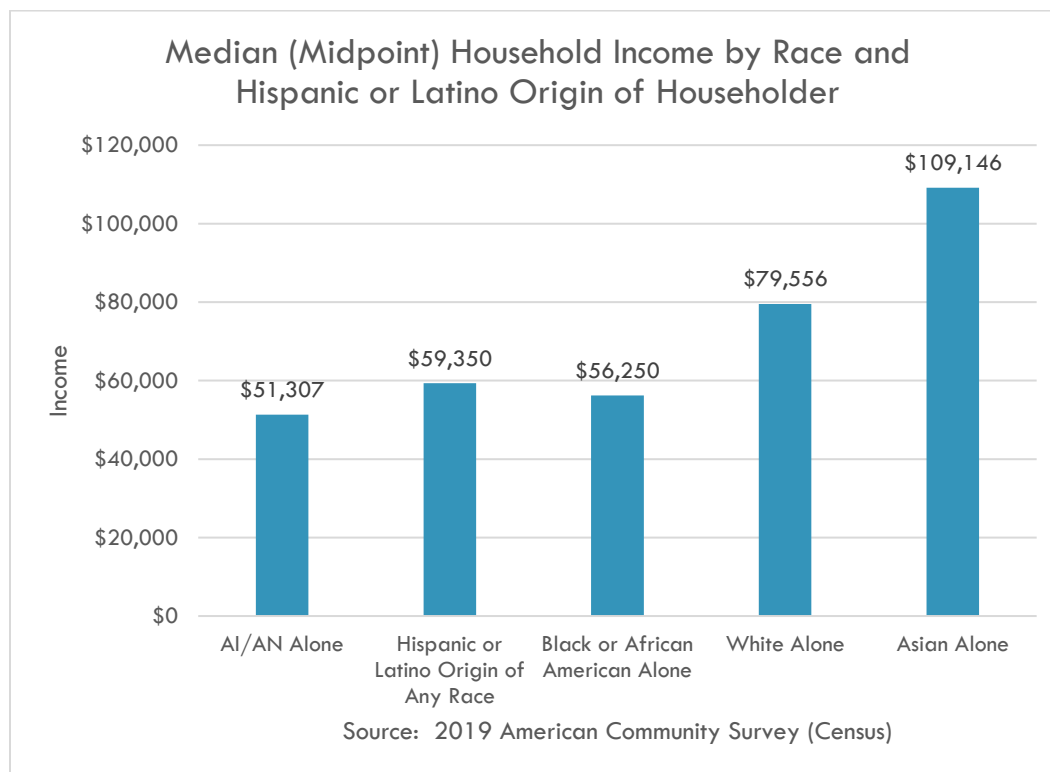
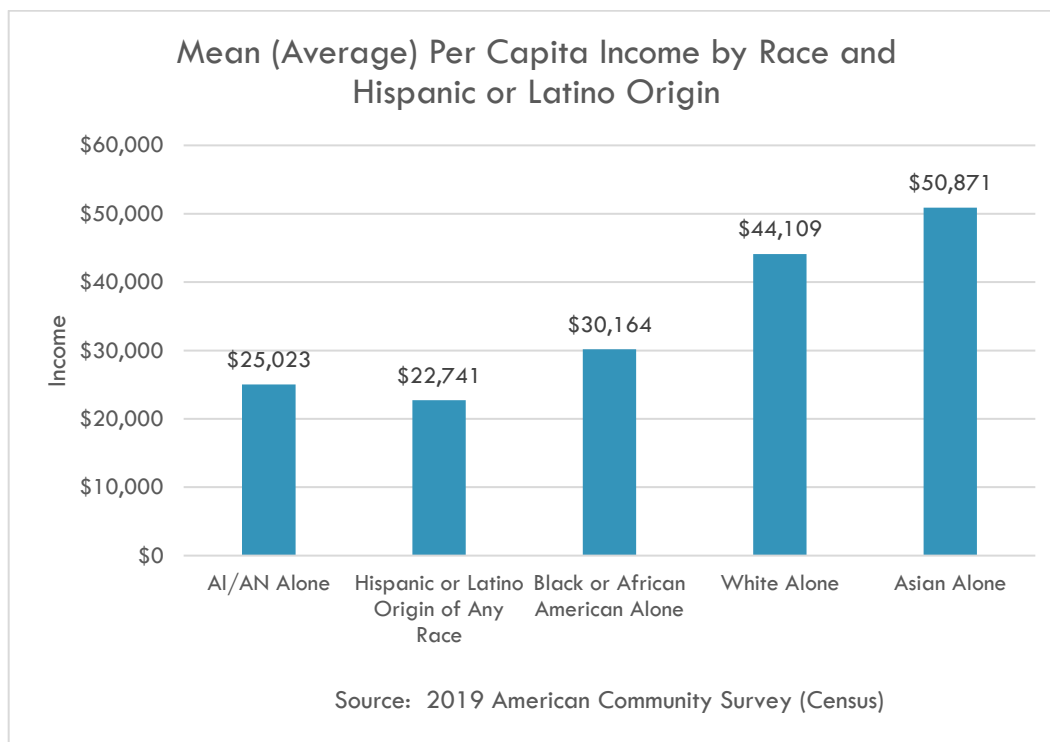
Appendix C: Assessment of the Health of American Indians and Alaska Natives in Washington

Life Expectancy

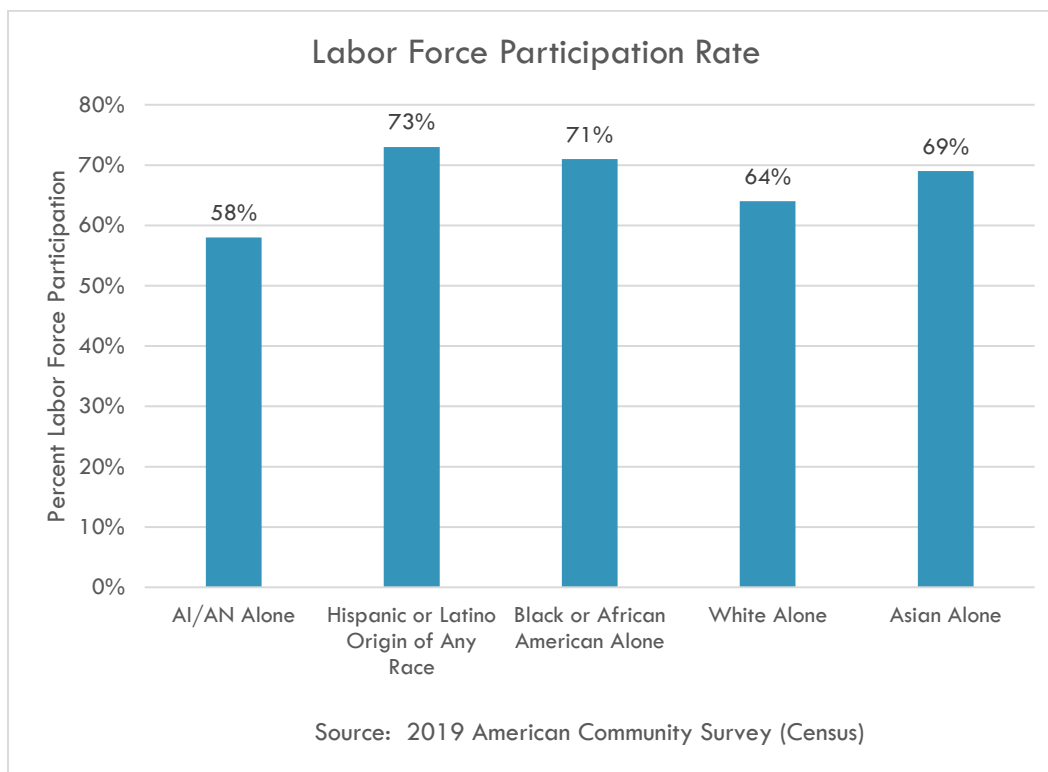


Social Determinants of Health

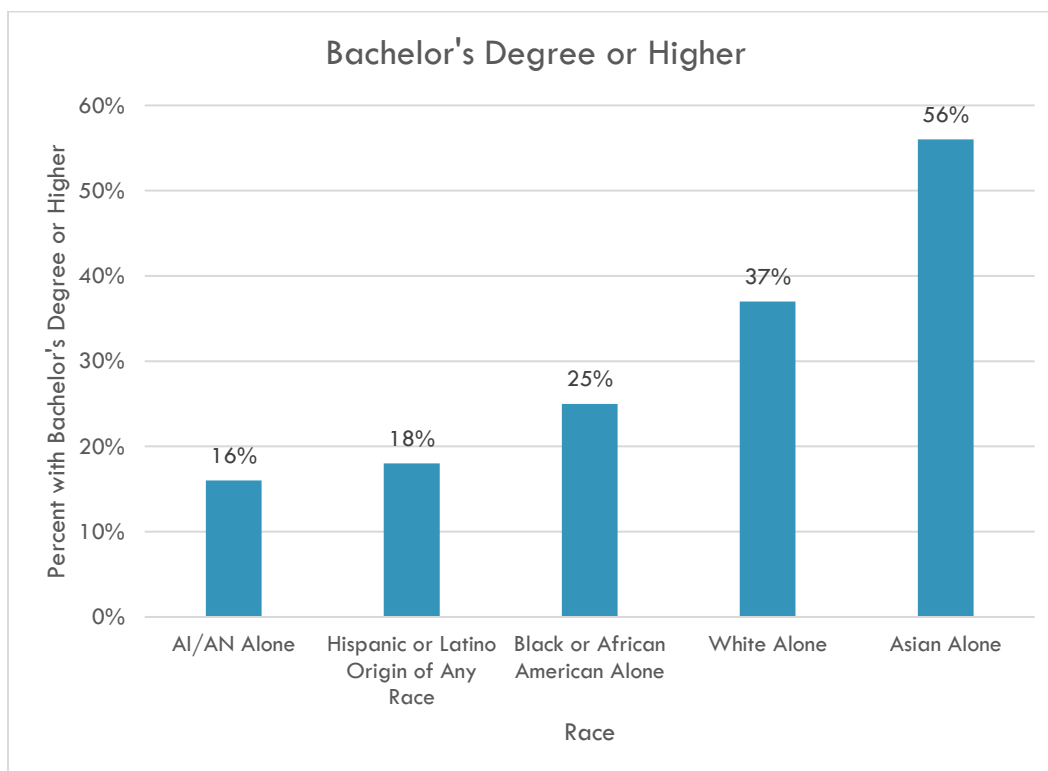
Income



Labor Force Participation Rate

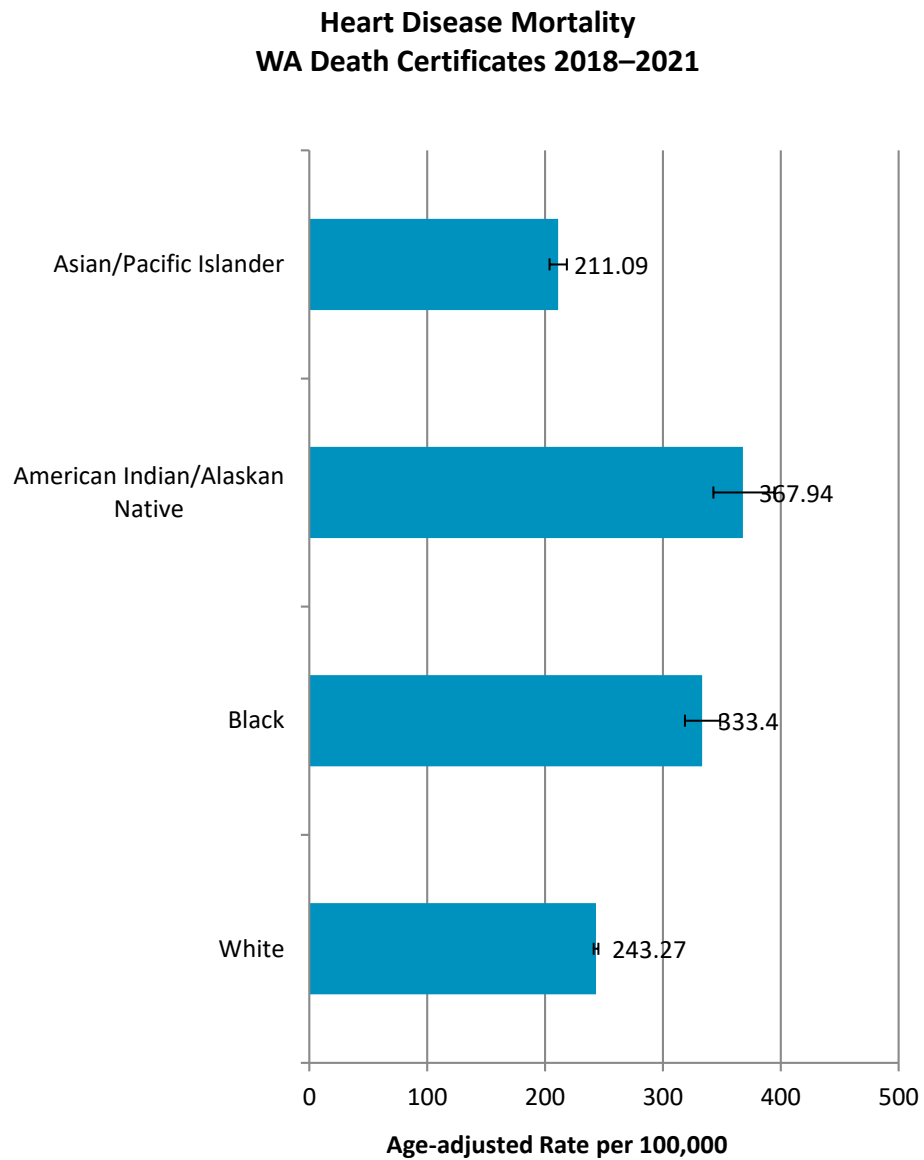


Educational Attainment



Physical Health Indicators

Heart Disease Mortality



* Non-Hispanic
Source: WA DOH, Community Health Assessment Tool

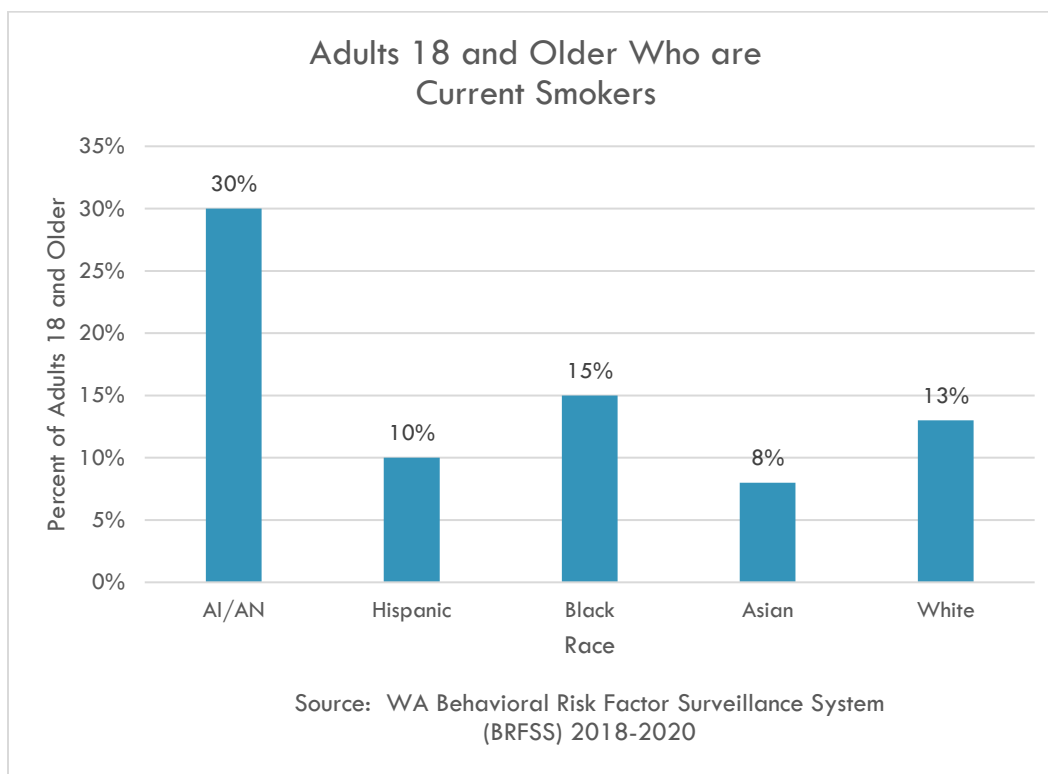
Cancer Mortality



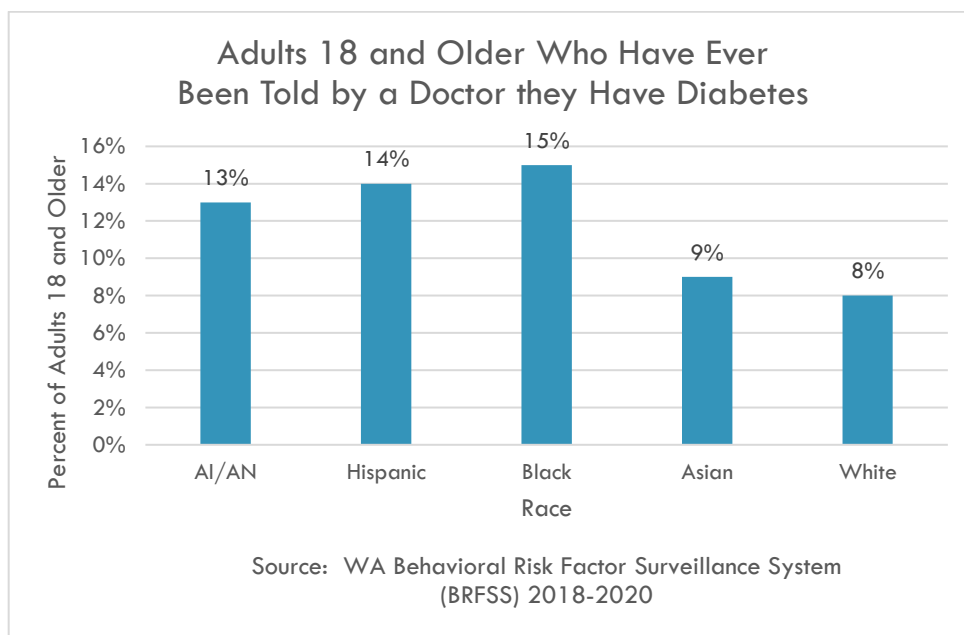
* Non-Hispanic

Source: WA DOH, Community Health Assessment Tool

Smoking Prevalence

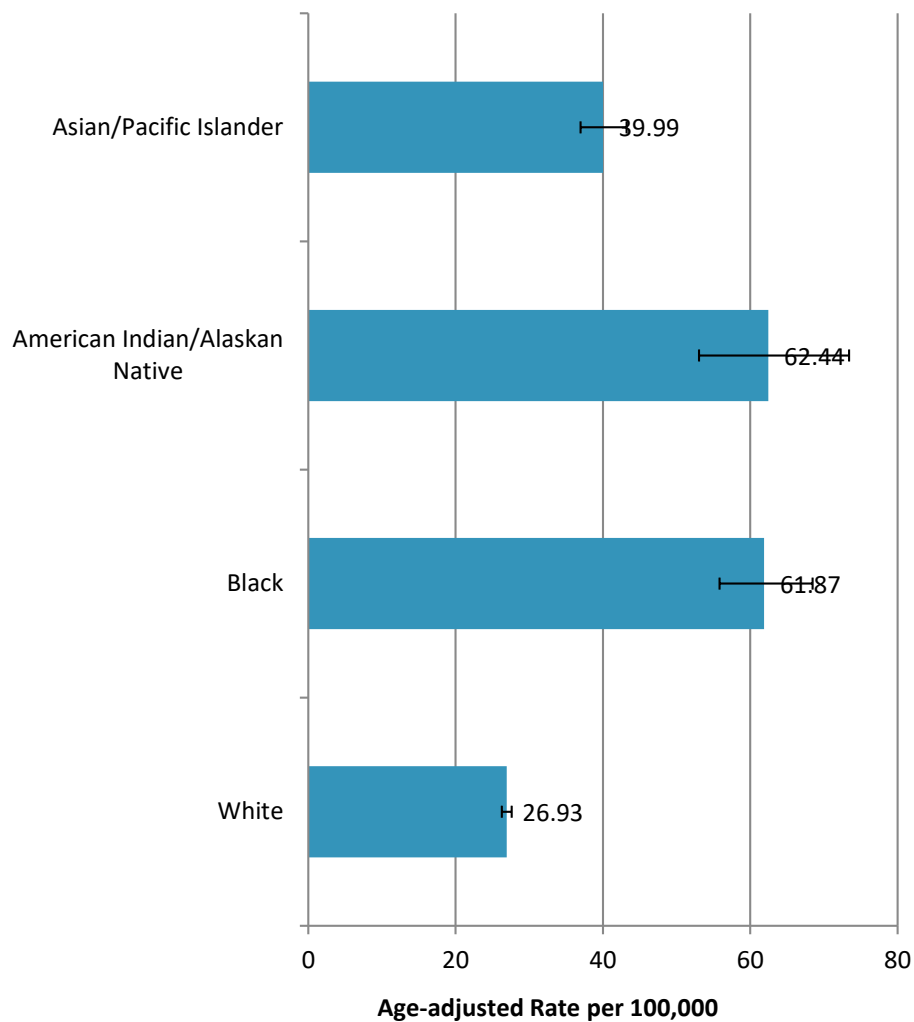


Diabetes Prevalence



Diabetes Mortality

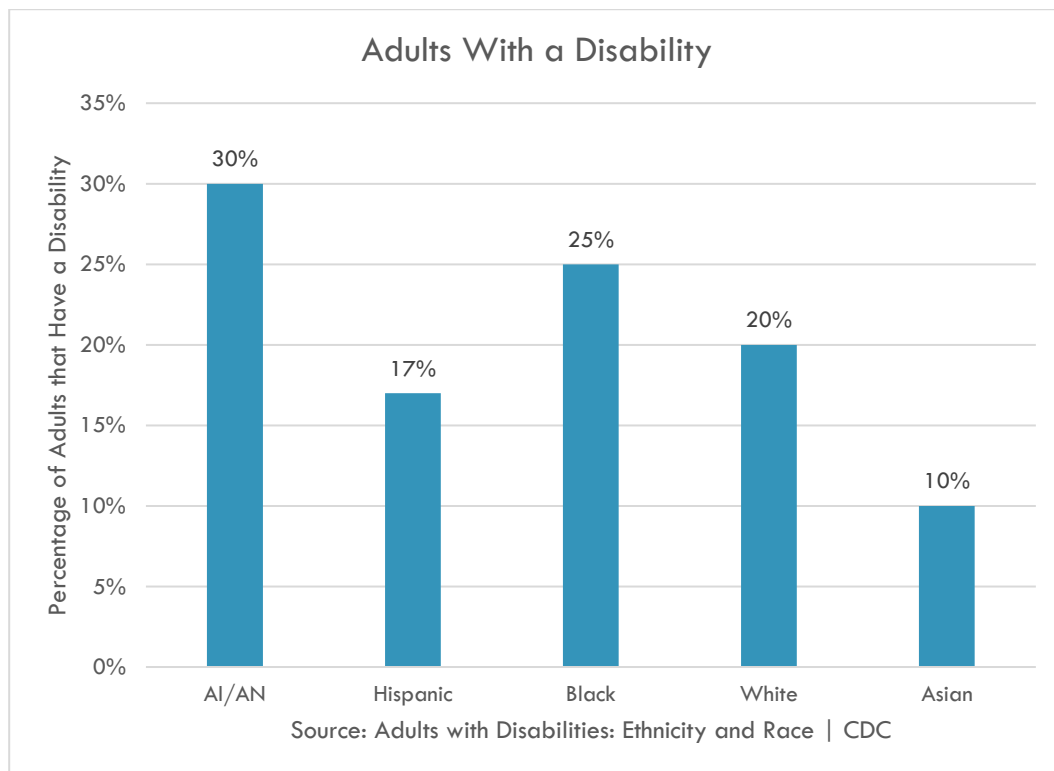
Diabetes Mortality
WA Death Certificates 2018–2021



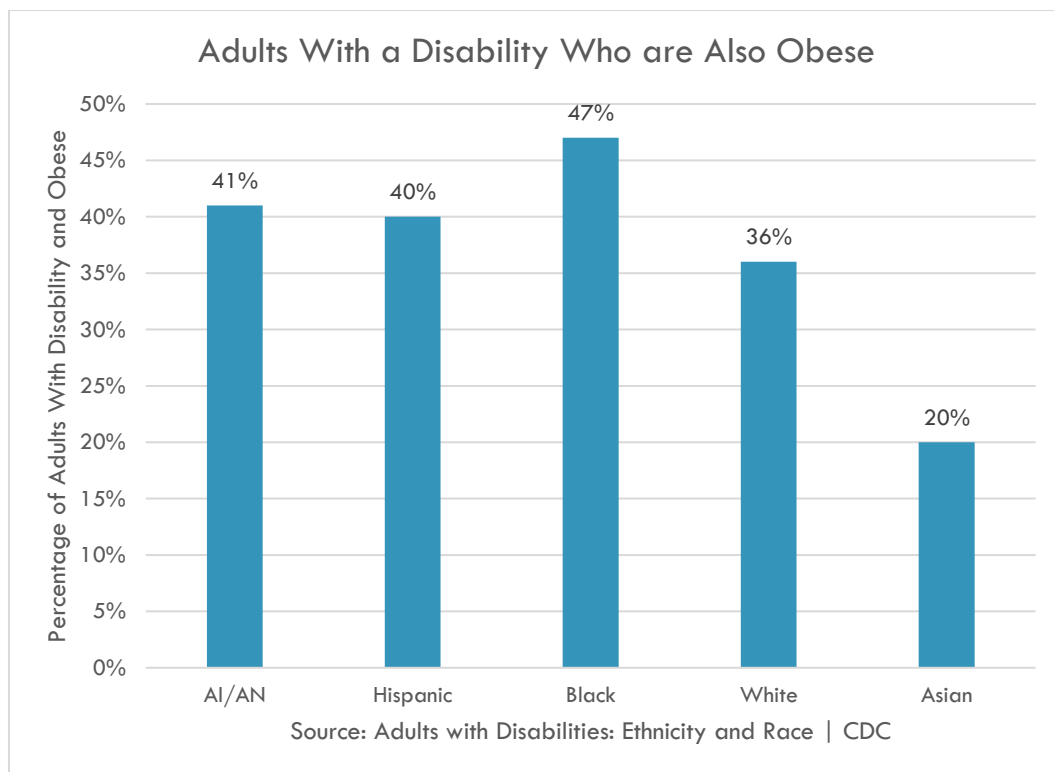
* Non-Hispanic

Source: WA DOH, Community Health Assessment Tool

Adults With Disabilities

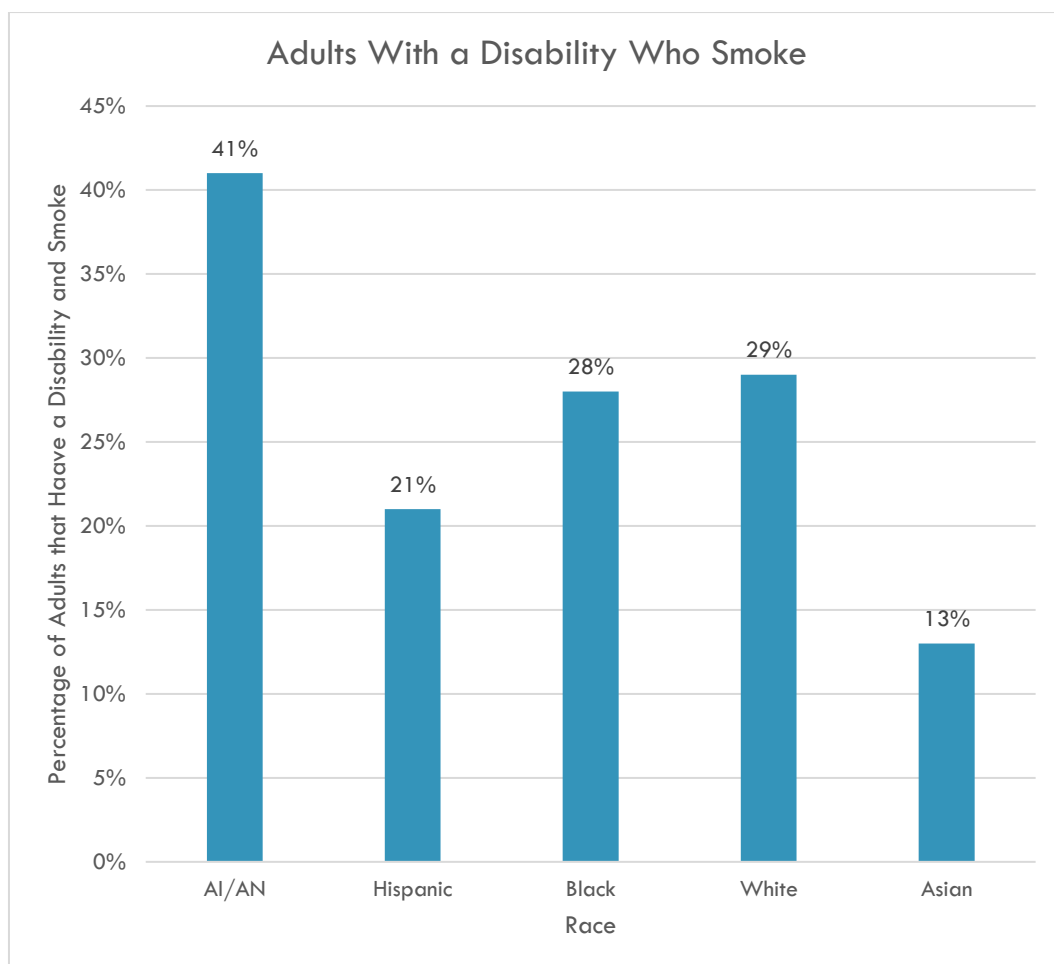


¹⁵ Infographic: Adults with Disabilities: Ethnicity and Race | CD



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¹⁶ Ibid

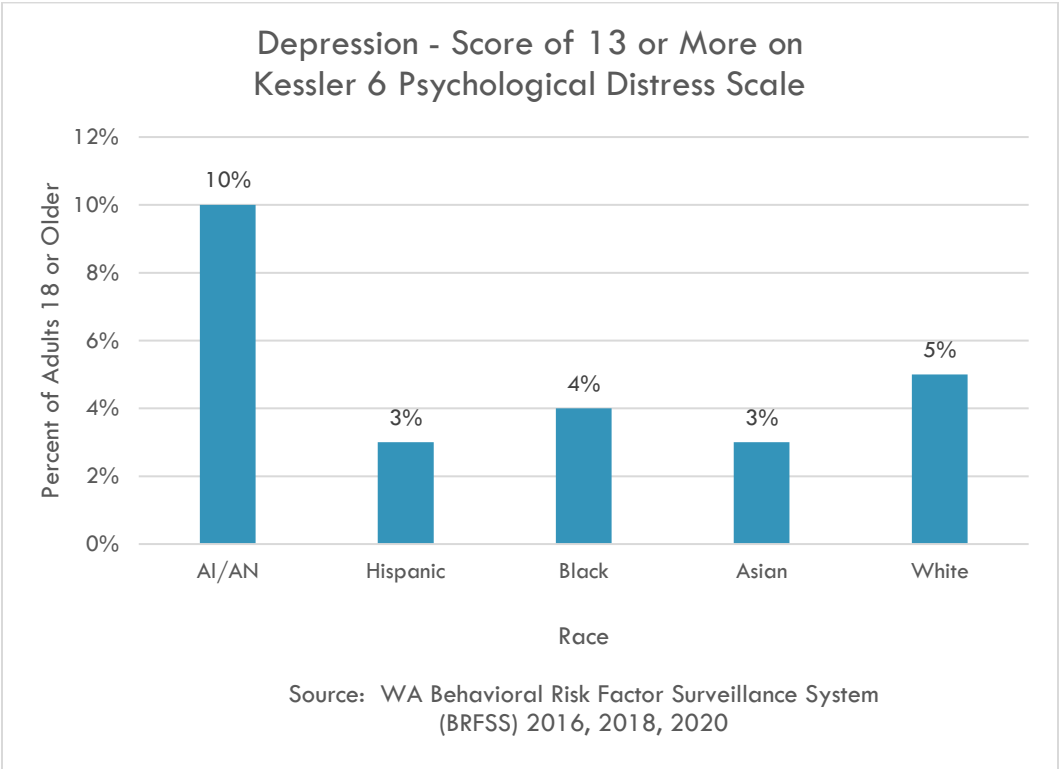


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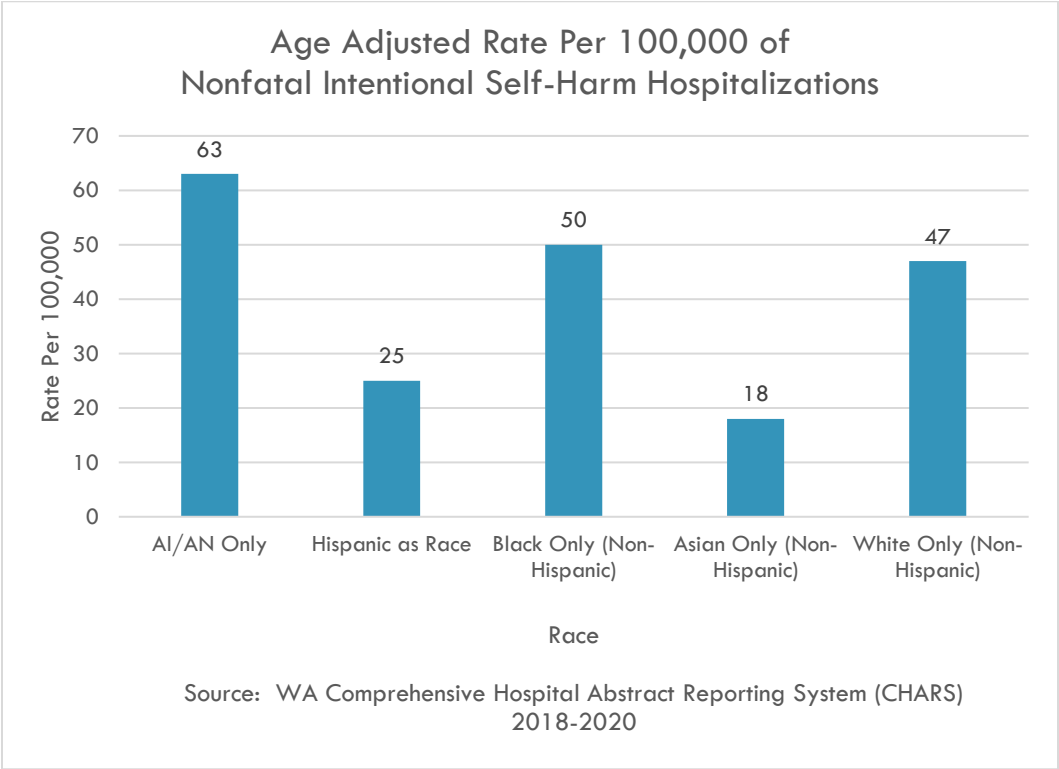
¹⁷ Ibid

Mental Health Indicators

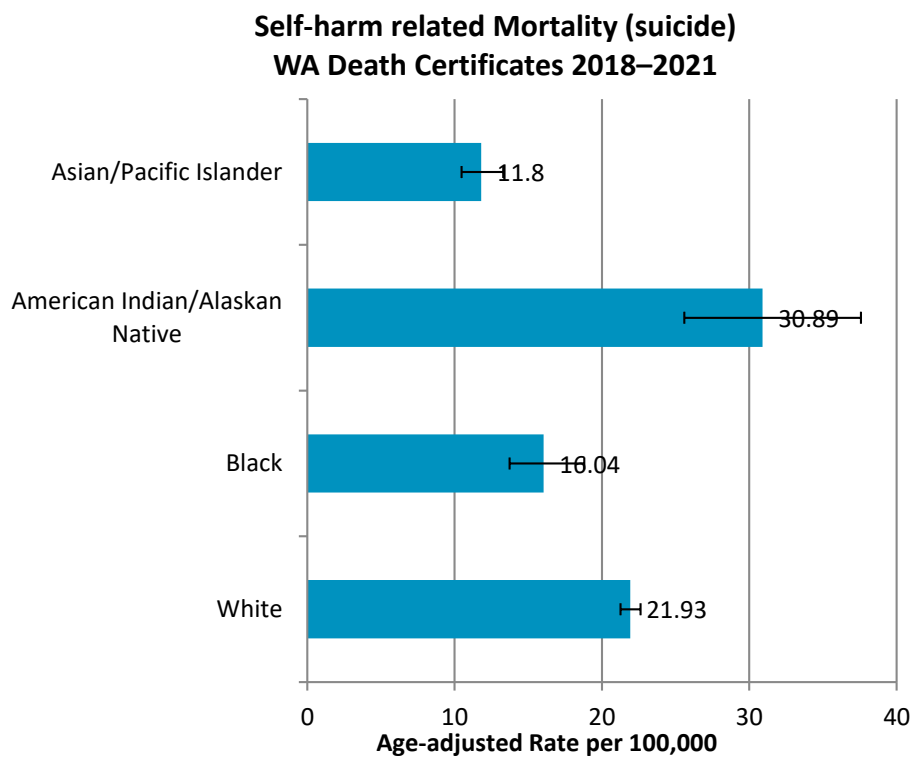
Prevalence of Depression



Nonfatal Intentional Self-Harm Hospitalizations



Suicide Deaths

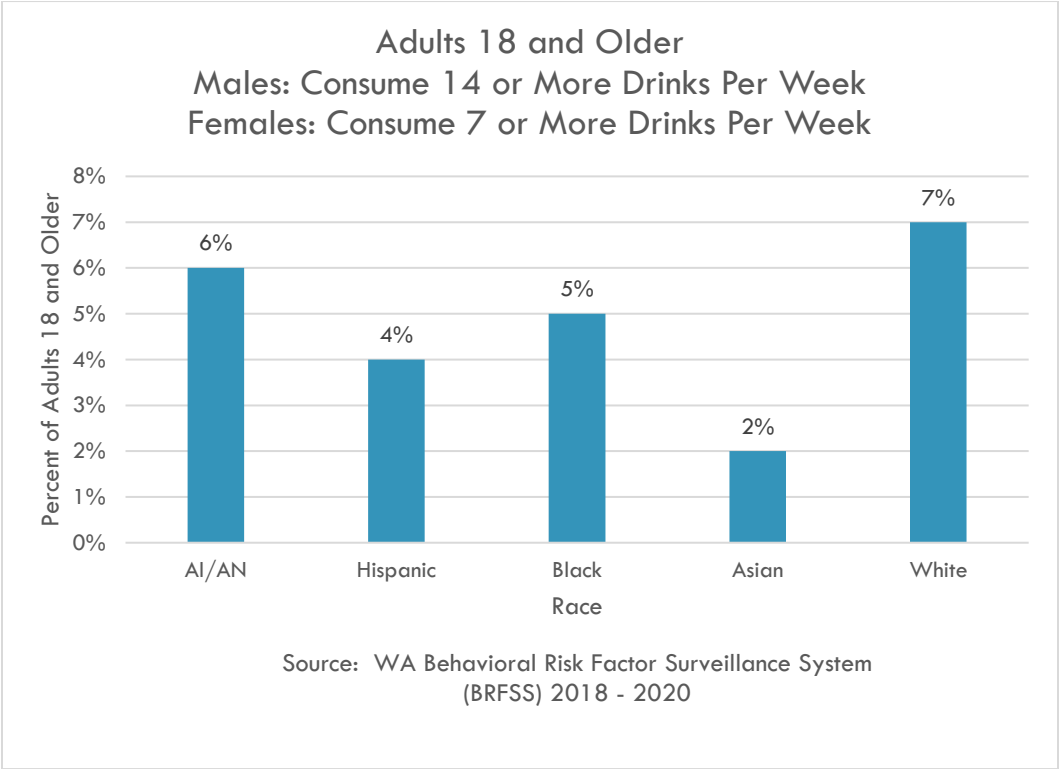


* Non-Hispanic

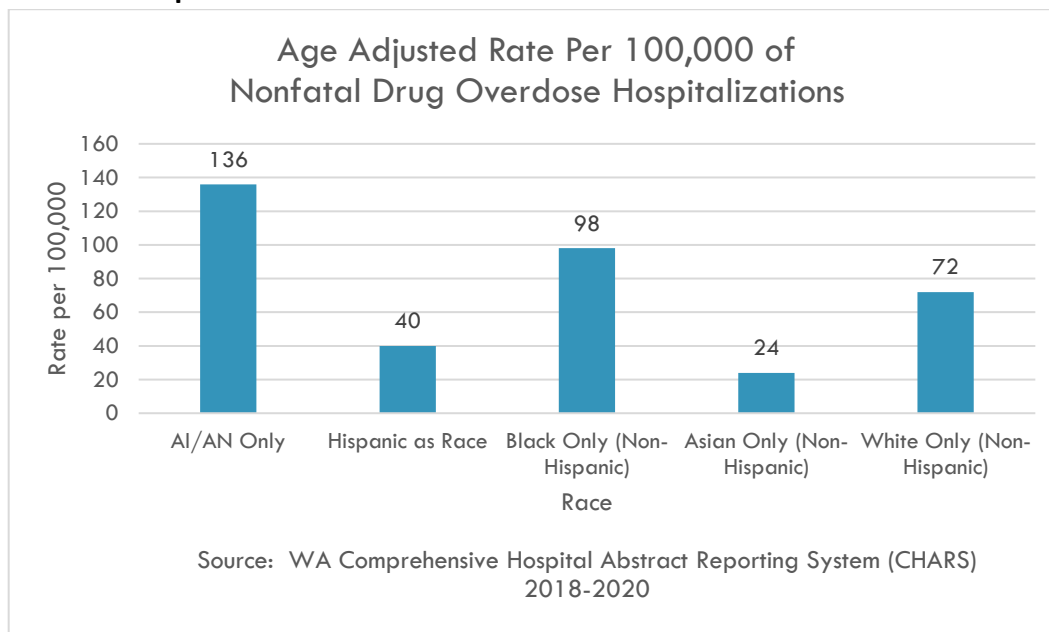
Source: WA DOH, Community Health Assessment Tool

Substance Use Disorders Indicators

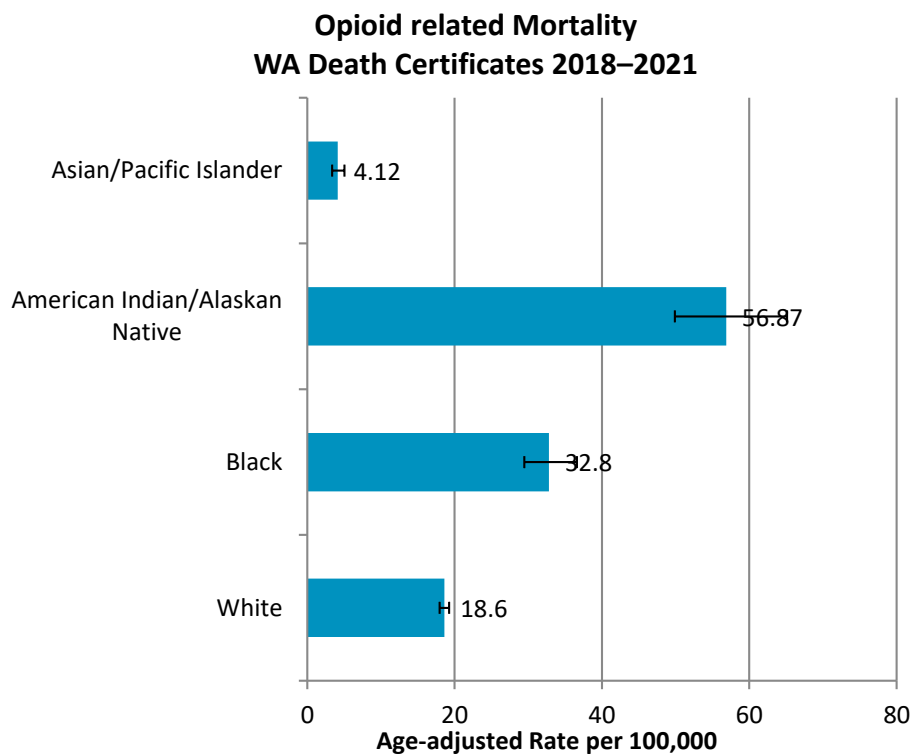
Alcohol Consumption



Nonfatal Overdose Hospitalizations



Deaths by Overdose

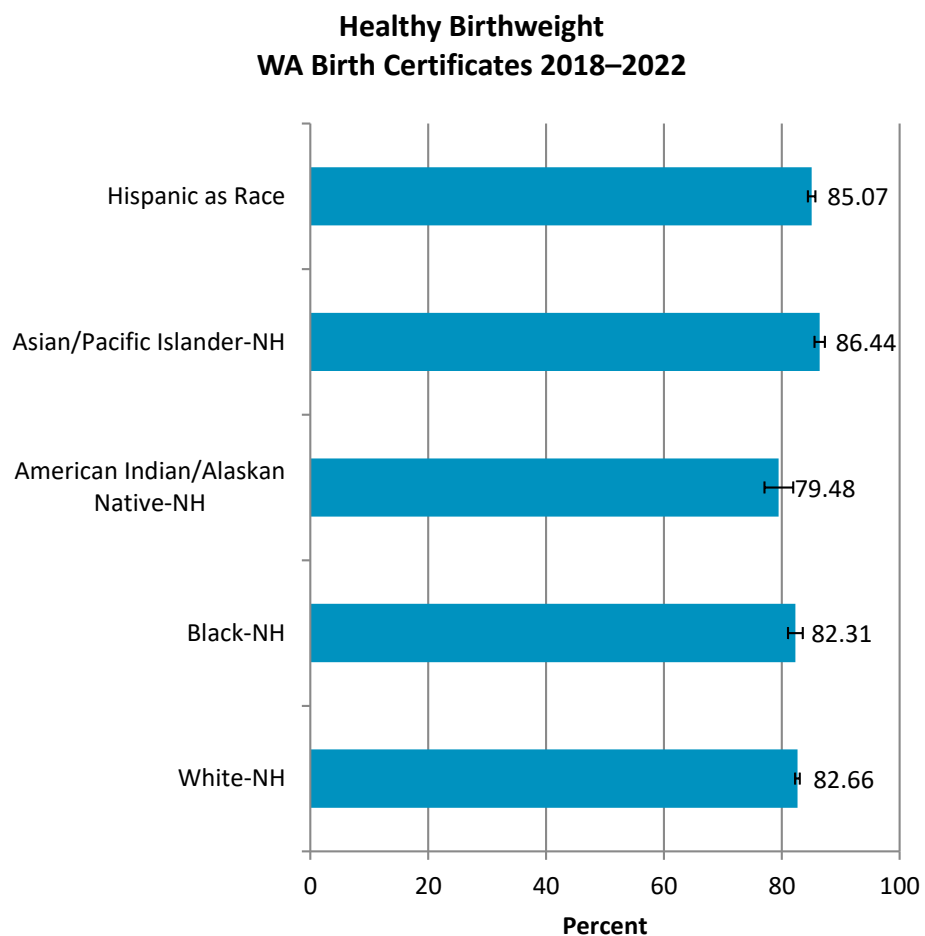


* Non-Hispanic

Source: WA DOH, Community Health Assessment Tool

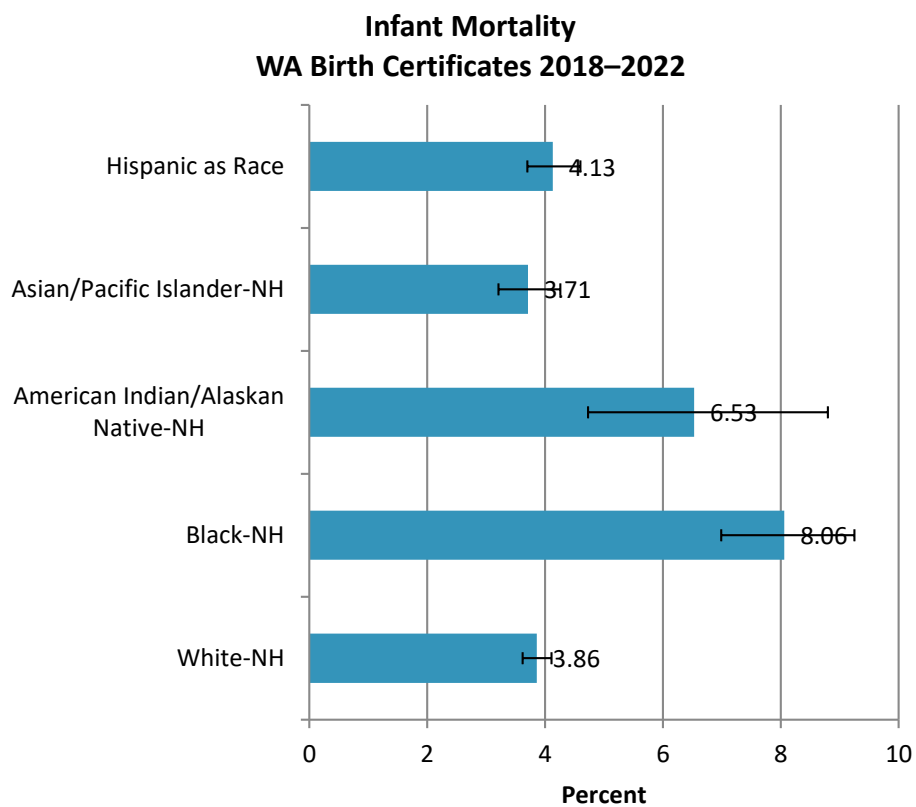
Maternal Child Health Indicators

Healthy Birth Weight Rates



* Non-Hispanic
Source: WA DOH, Community Health Assessment Tool

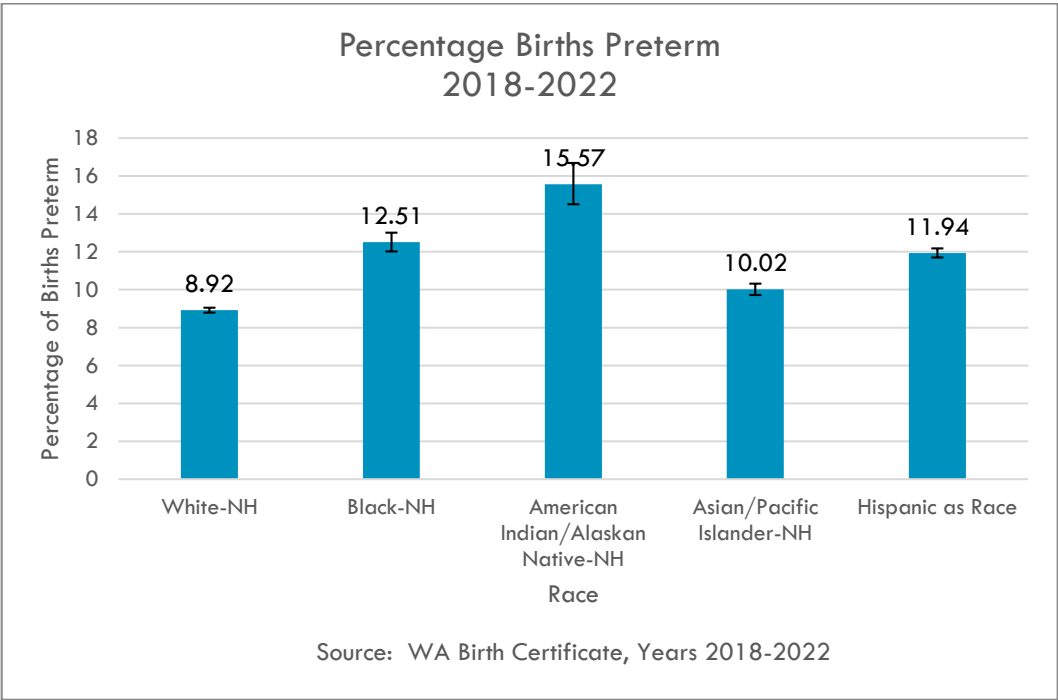
Infant Mortality



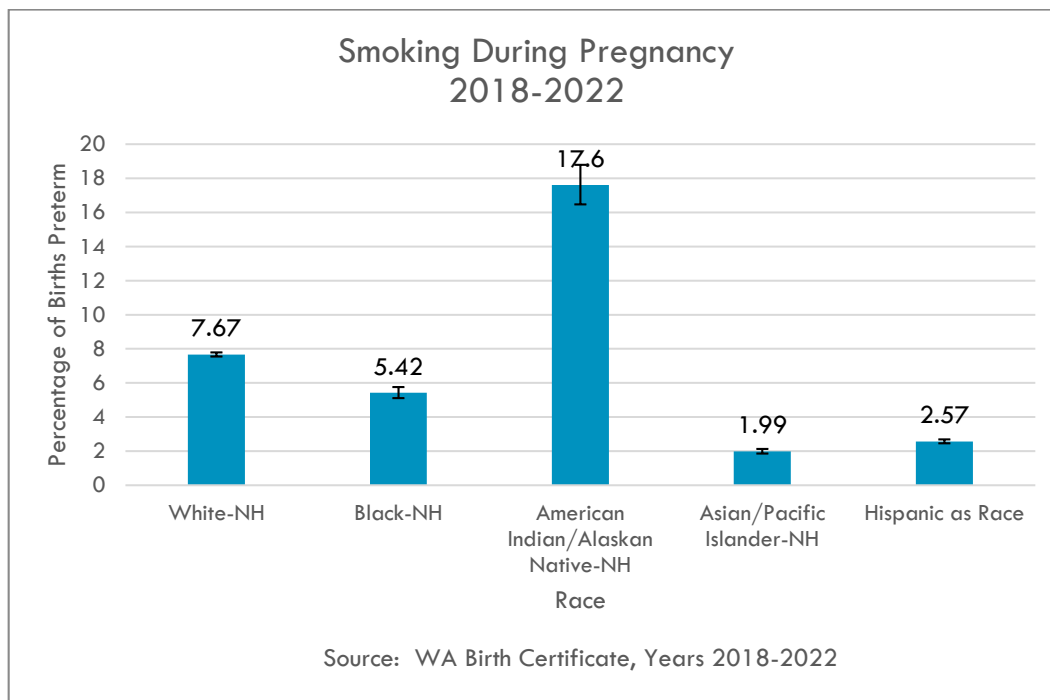
* Non-Hispanic

Source: WA DOH, Community Health Assessment Tool

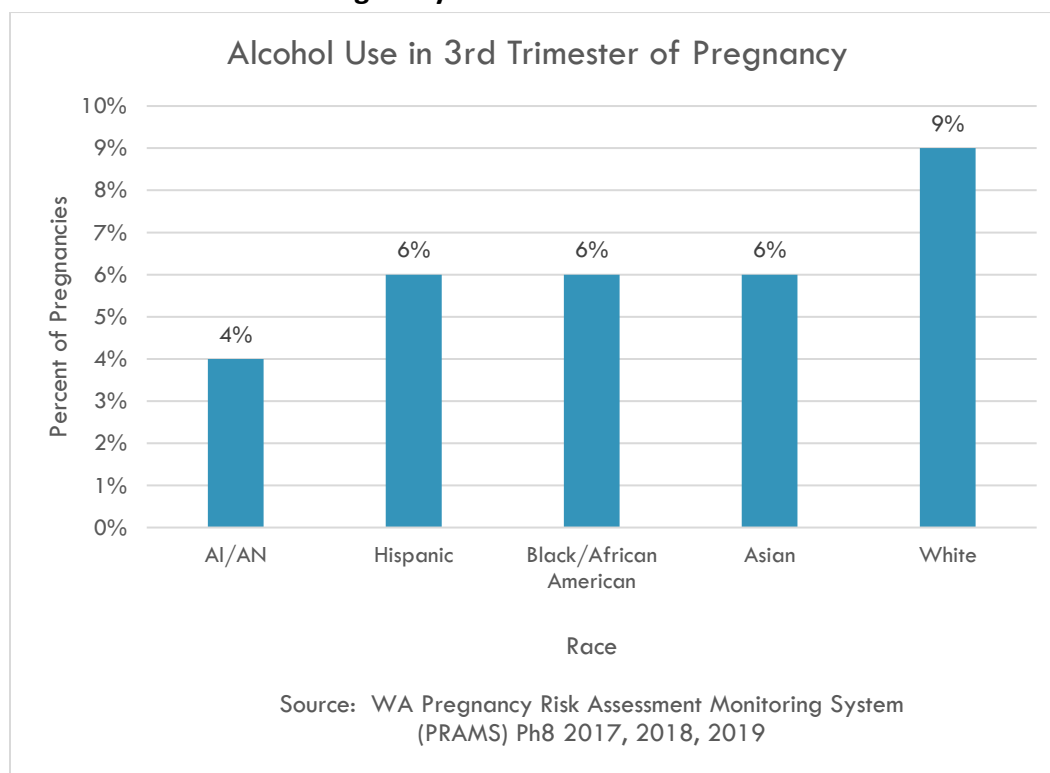
Preterm Births



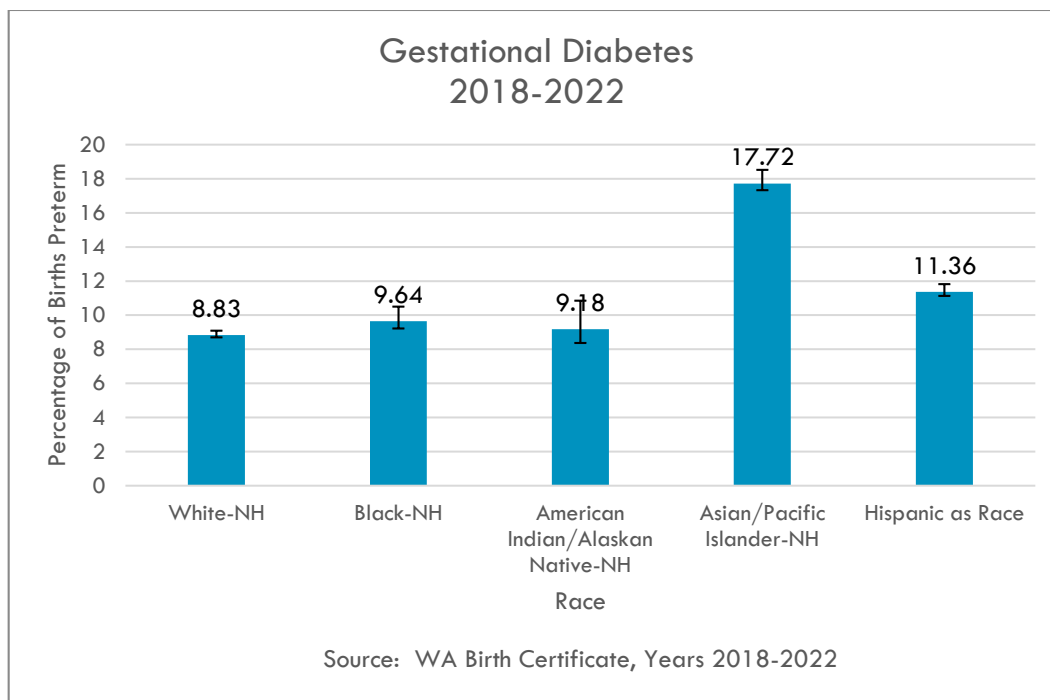
Smoking in Third Trimester of Pregnancy



Alcohol Use in Third Trimester of Pregnancy

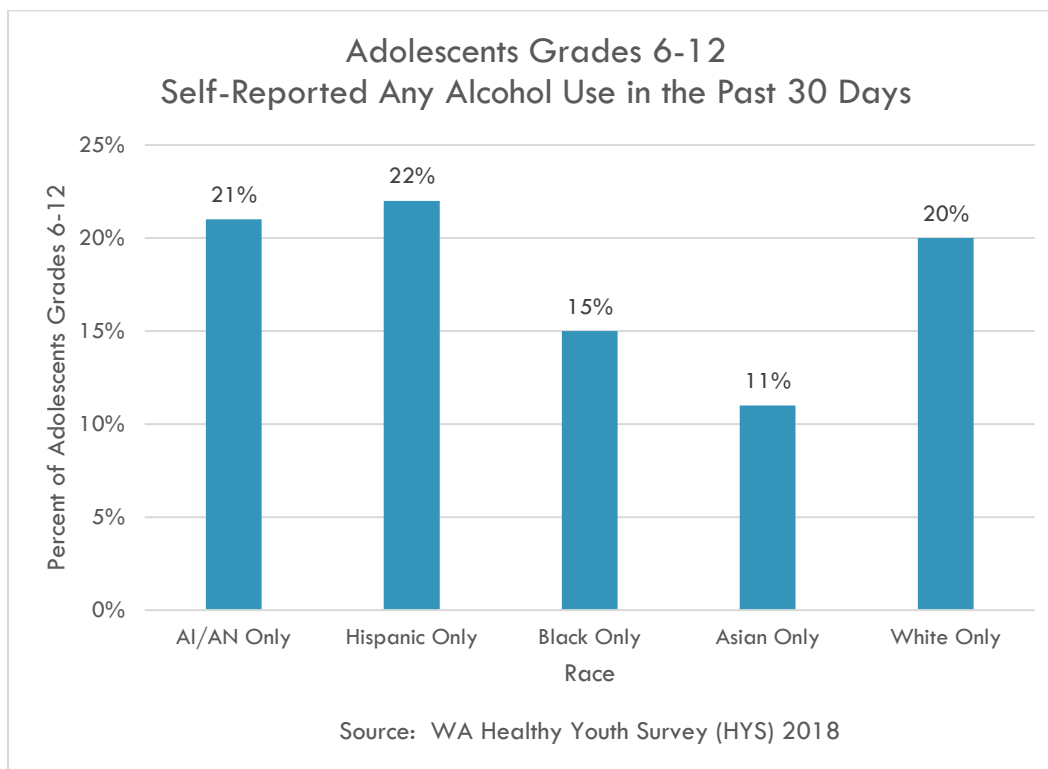


Gestational Diabetes

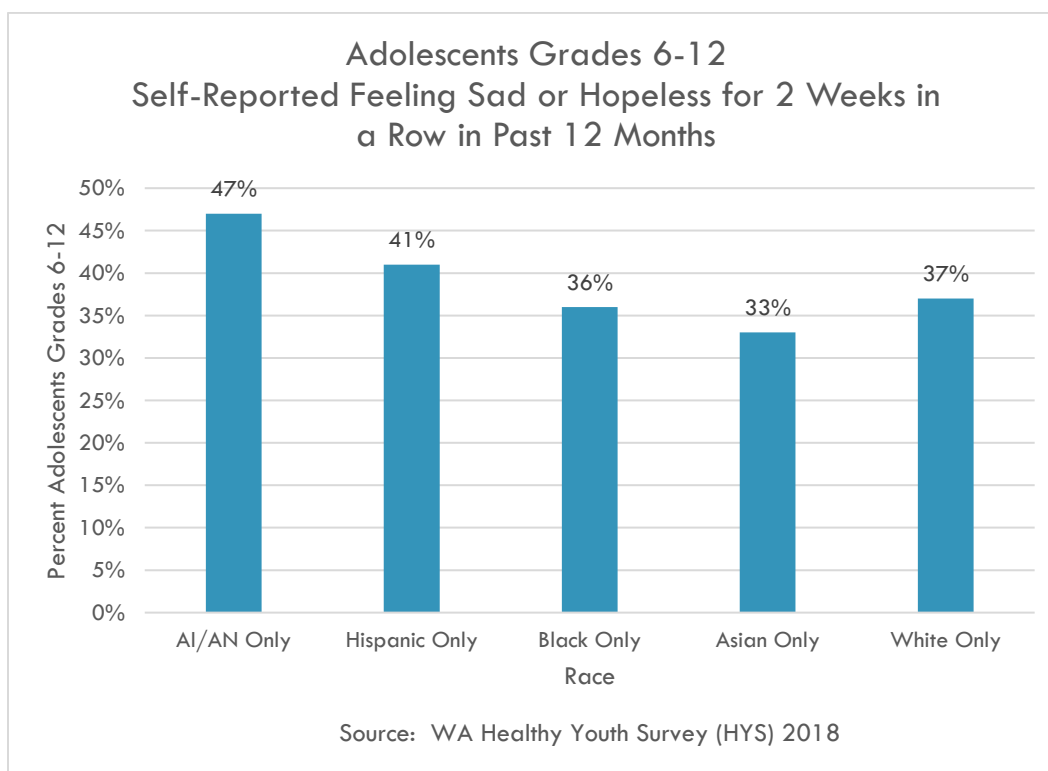


Adolescent Health Indicators

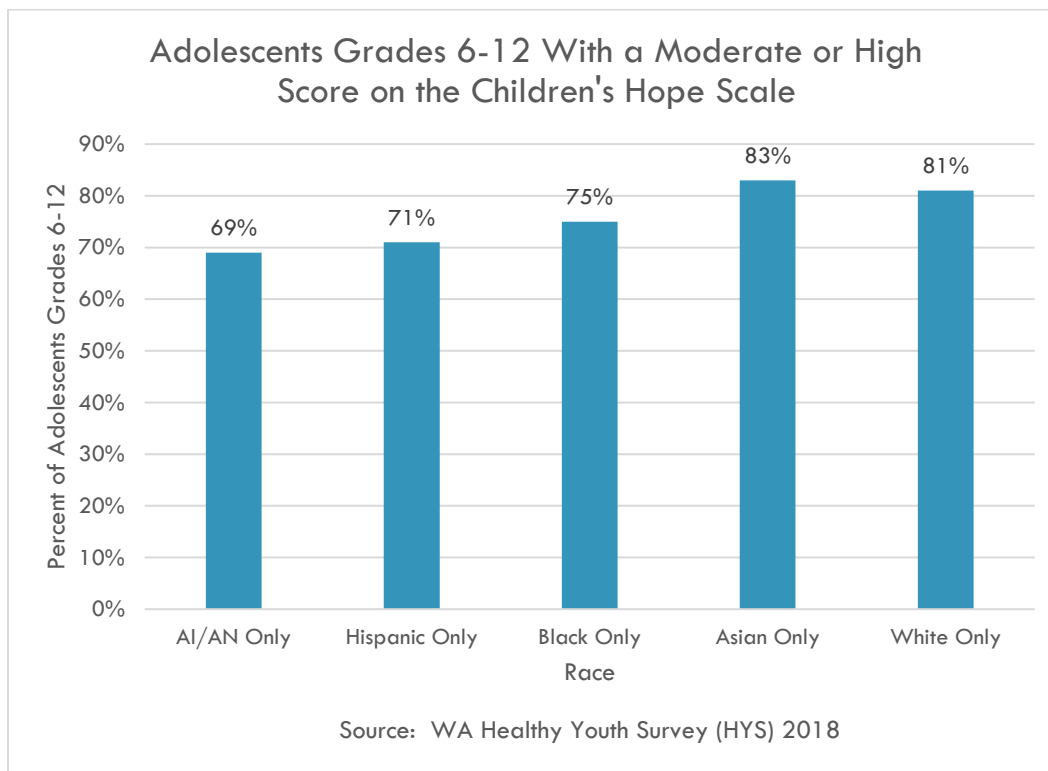
Alcohol Use



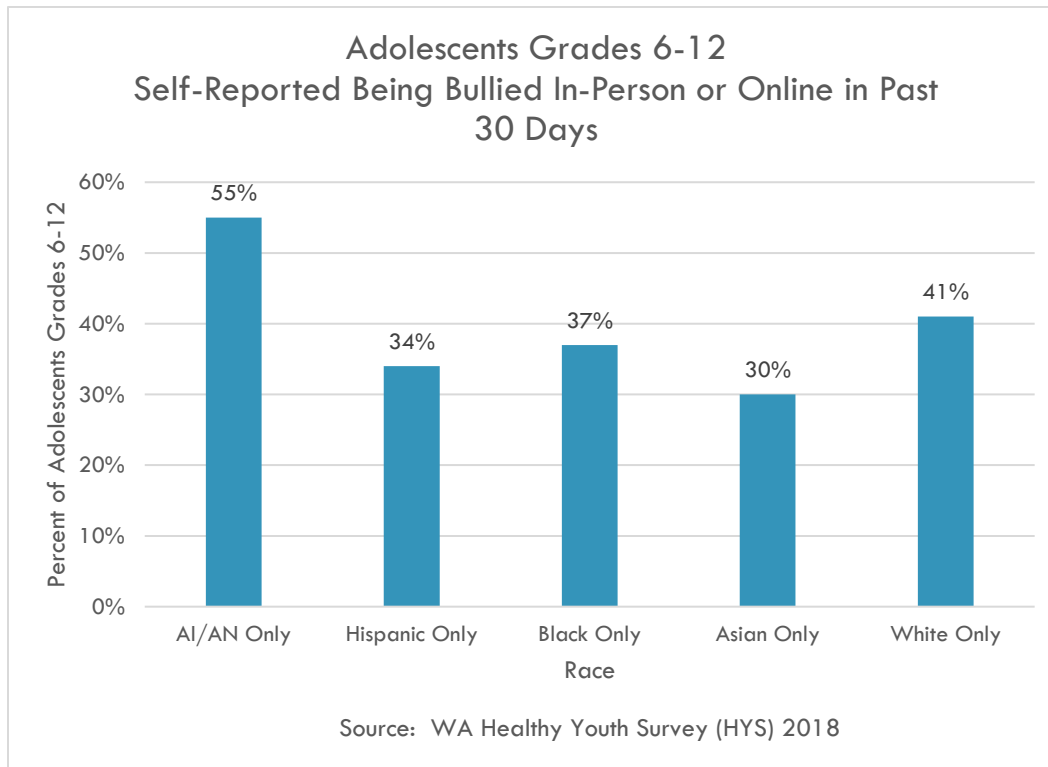
Feeling Sad or Hopeless



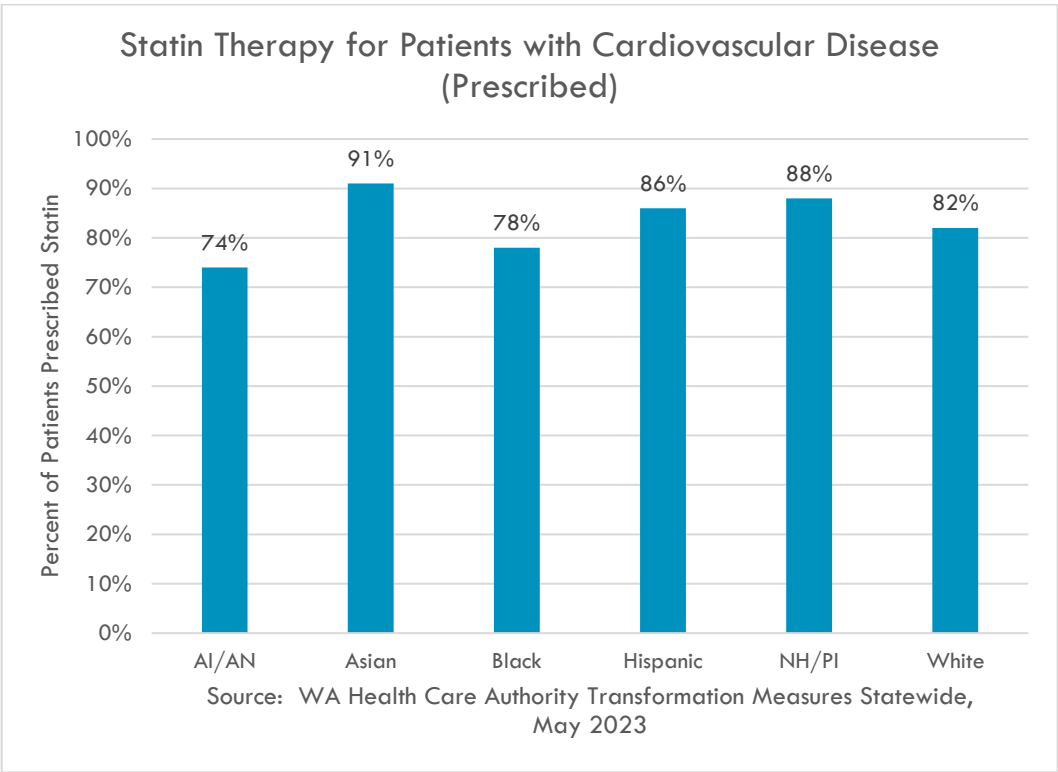
Moderate or High Score on the Children's Hope Scale



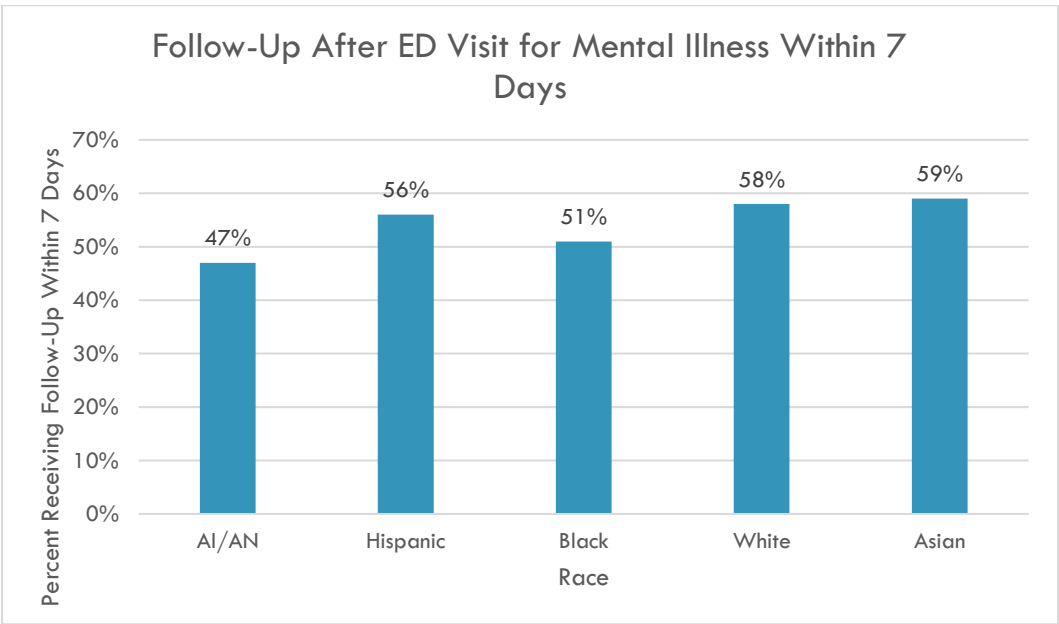
Have Been Bullied



Health Care Indicators
Statin Therapy

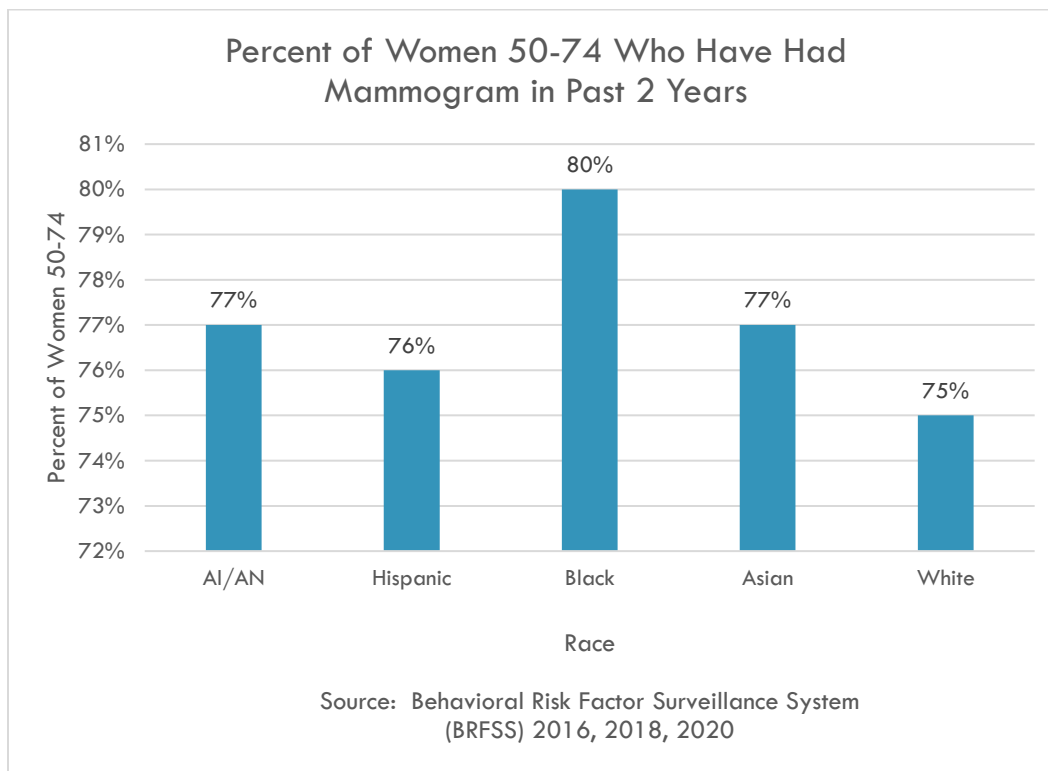


Follow-Up After ED Visit for Mental Illness

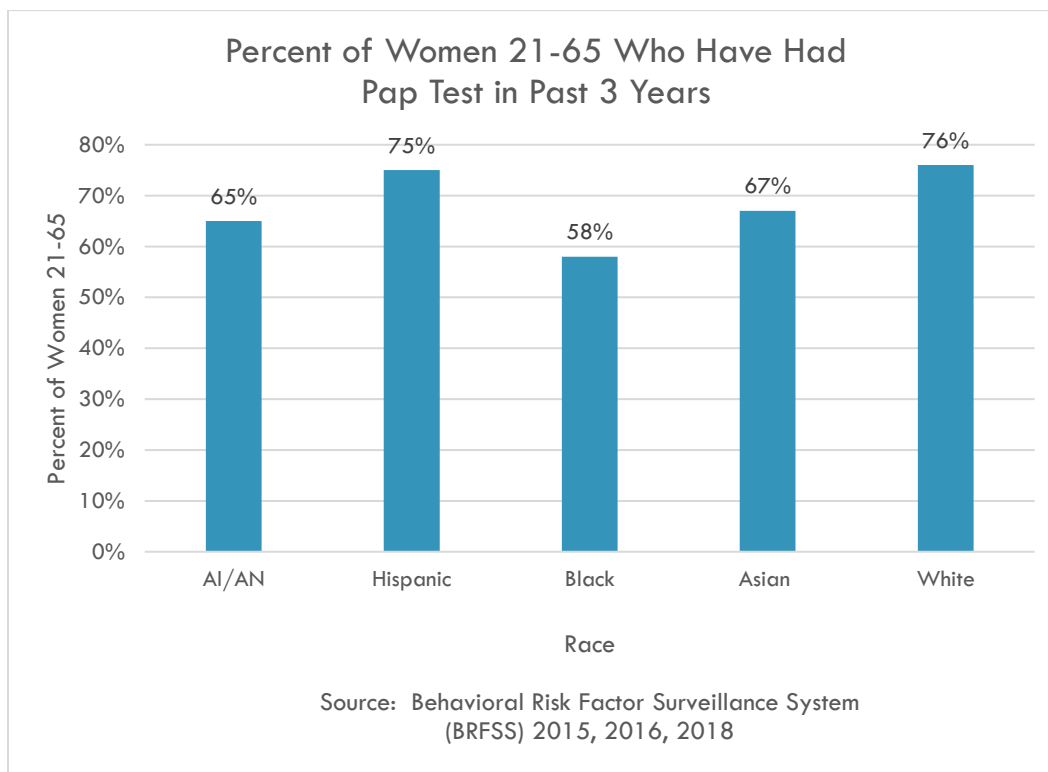


Source: WA Health Care Authority Transformation Measures Statewide, May 2023

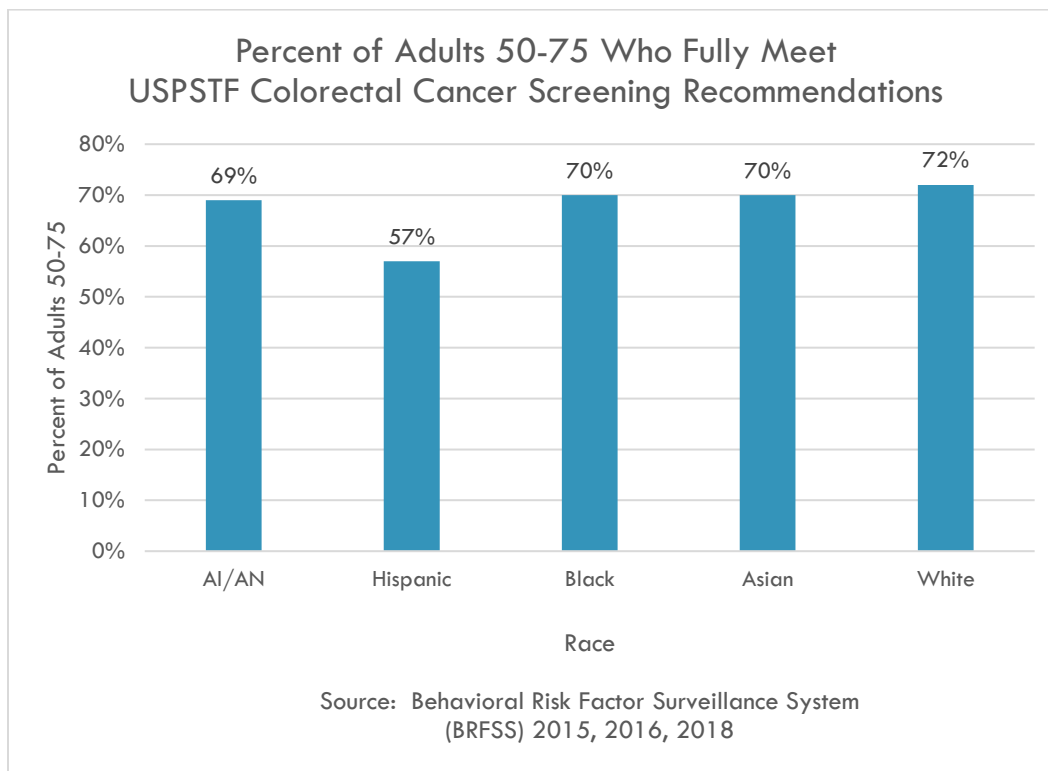
Breast Cancer Screenings



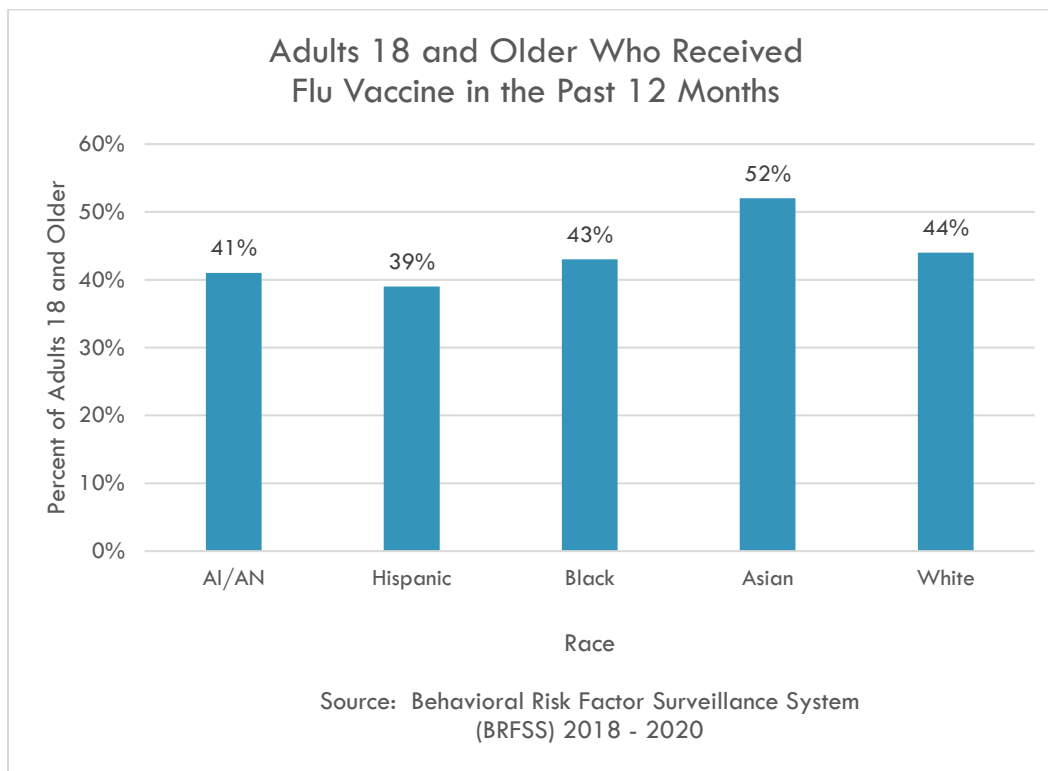
Cervical Cancer Screenings



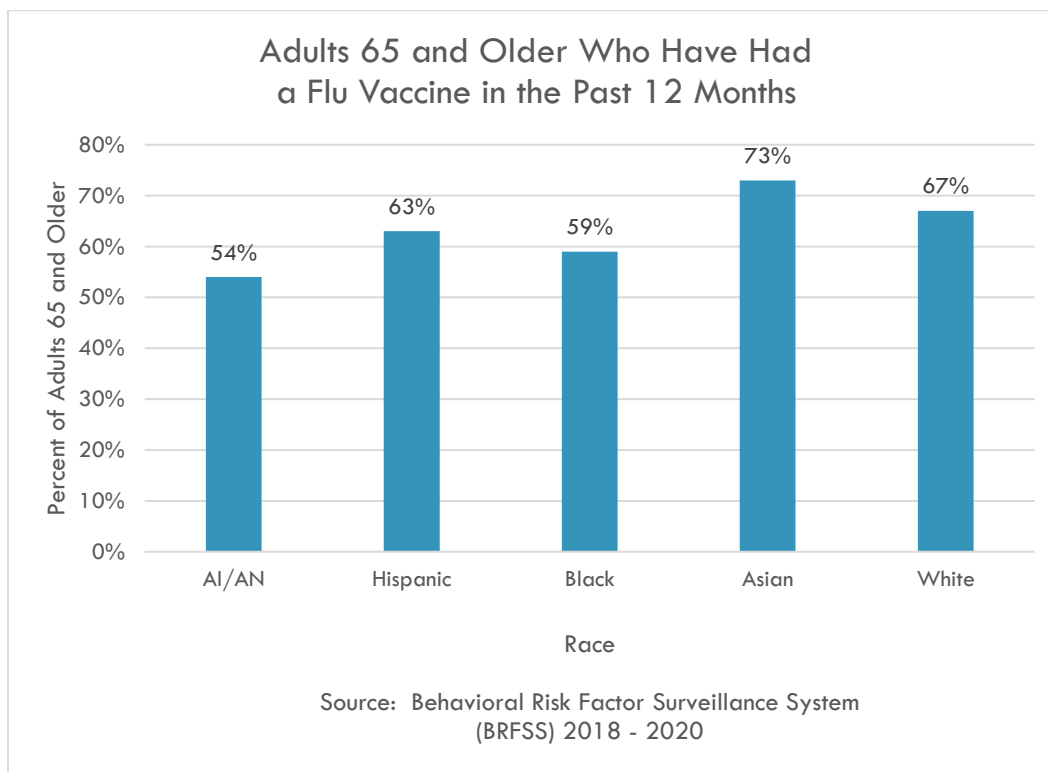
Colorectal Cancer Screenings



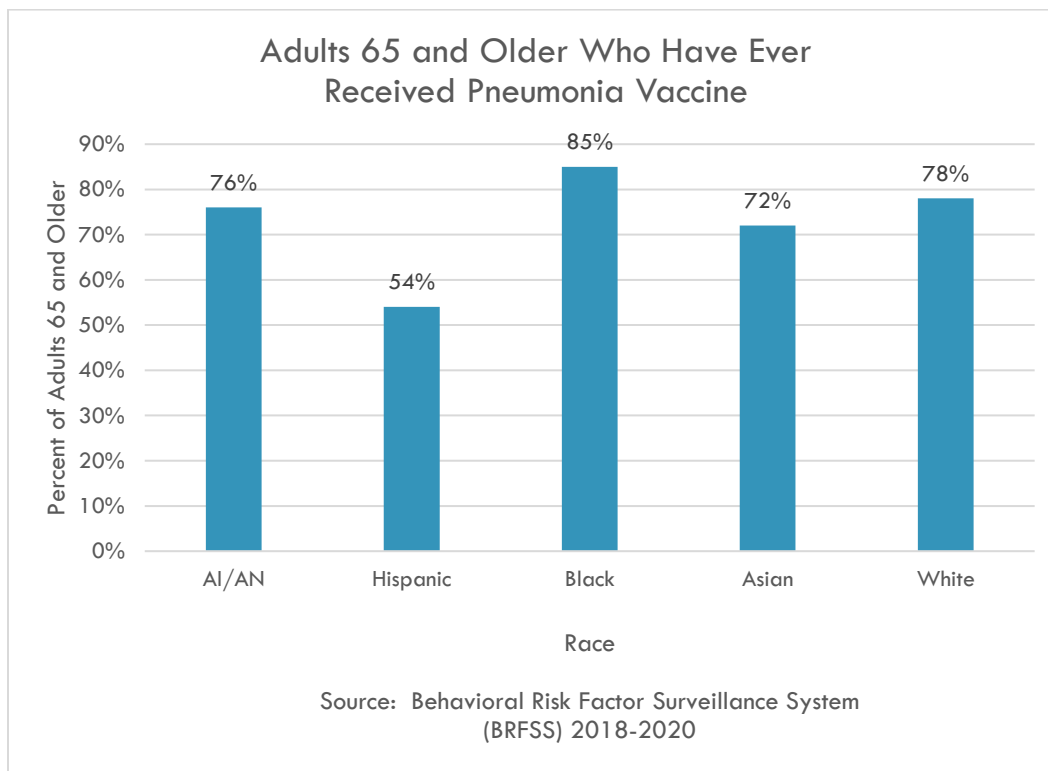
Flu Vaccines – 18 and Older



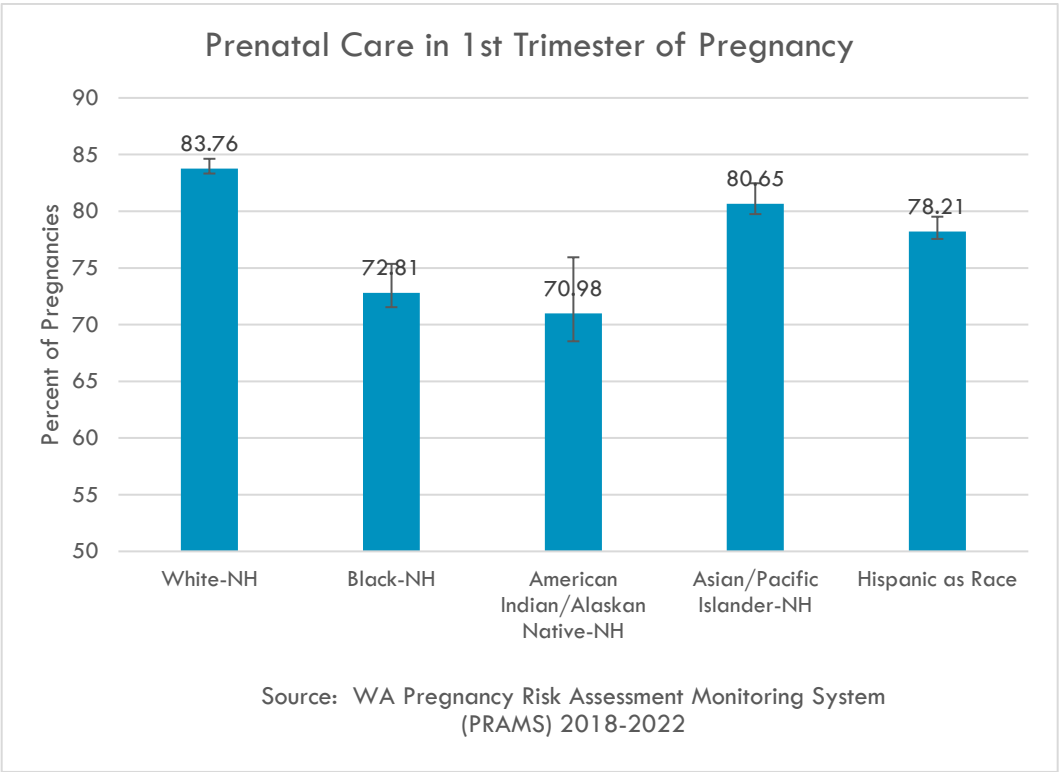
Flu Vaccines – 65 and Older



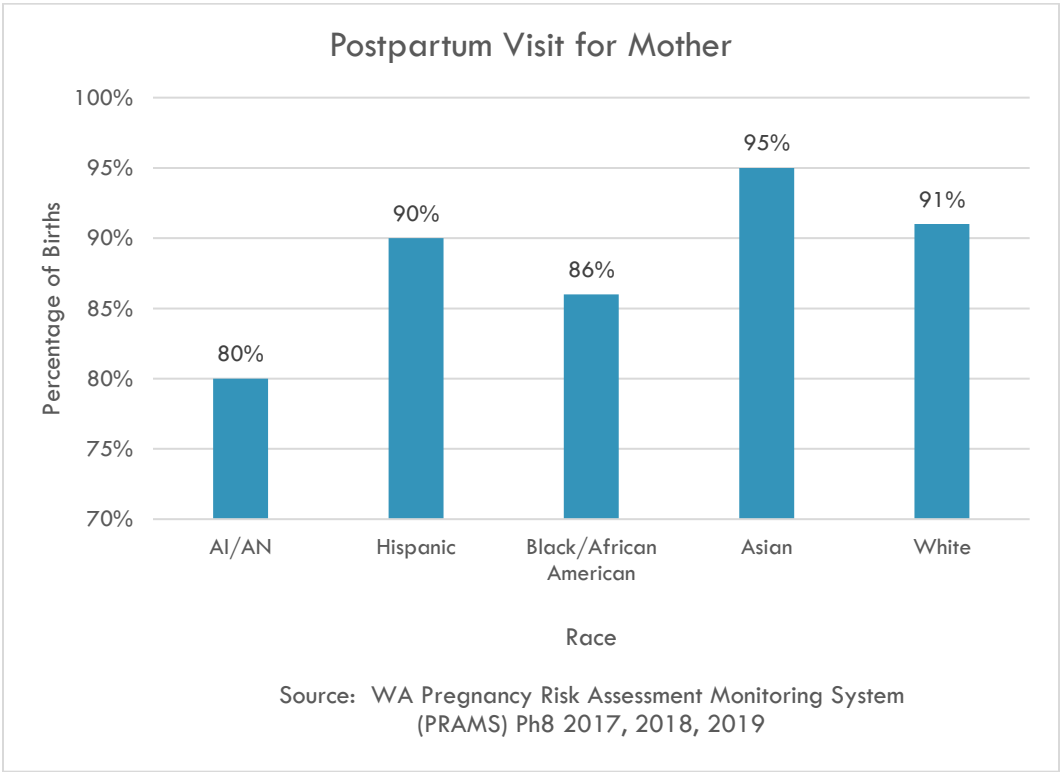
Pneumonia Vaccines – 65 and Older



Prenatal Care in First Trimester of Pregnancy



Postpartum Health Care Visit for Mother



ⁱ World Health Organization. *Report from the Commission on Social Determinants of Health*; World Health Organization: Geneva, Switzerland, 2008.

ⁱⁱⁱⁱⁱ “WHO defines Quality of Life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns,” WHO continues. “It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment.”

Graphs from Washington State Department of Health, Center for Health Statistics, Death Certificate Data, 1990–2021, Community Health Assessment Tool (CHAT), October 2022.