

**Tribal Communities Transforming Mental Health  
Policy Track Follow-up Meeting  
April 6-8, 2010**

**Prepared by  
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**Meeting held at  
North Quest Casino, Spokane, WA**

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**Native Healing and Wellness Conference  
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**Project Period: 07/12/2007 – 03/31/2011**

## **Description**

The primary focus of this meeting was to continue the conversation begun at the September 2009 Tribal Communities Transforming Mental Health conference about state policies to address tribal mental health needs and issues. This was an invitational meeting rather than an open conference. The goal was to begin developing a state-wide tribal-centric mental health plan with the support and guidance from the state's many tribal communities. A short session was offered on Wednesday, April 7 for tribal and Recognized American Indian Organization (RAIO) input and guidance regarding Native Mental Health Specialist certification training. Attendees included Tribal leaders from across Washington State, members of the Washington State Indian Policy Advisory Committee (IPAC), and members of the Washington State American Indian Health Committee (AIHC).

We have attached the resulting mental health plan goals, as well as notes from days one and two of the meeting. A full report is being prepared by the Northwest Portland Area Indian Health Board which will include a draft, proposed Tribal-Centric Mental Health service delivery program.

**Tribal-Centric Mental Health Plan Meeting**  
Northern Quest Resort & Casino  
Tuesday April 6, 2010

**Short-Term & Long Term Goals**

**Short-term** - Think it should be required in contract language with RSNs that consultation and communication is necessary (and that staff be required to have training in unique status and needs of AIAN Tribes).

**Short-term** – identify an advocate at the state level when “non-admissions” occur, e.g. when there is an identified crisis situation but we are unable to get the client into a tx facility/bed.

**Short and long-term**– develop procedures where providers who are providing services through the RSN can be held accountable by the tribes.

**Short-term** – look at areas in the state where the RSN-Tribal system is working to identify components that contribute to the successes.

**Long-term** – Have own tribal mental health facility - one in East, one on West.

**Short-term** – Do an inventory of the RSN resources and see how tribes can best use those to meet the needs of their tribal members. Also inventory of what’s working in the community and of the mental health status and disorders that are occurring.

**Long-term** – insure that we are serving the members of our communities regardless of enrollment status – especially important for our children.

**Short-term** – develop a process where Tribes are notified when their members are in the hospital for a mental health crisis that respects confidential information.

**Short-term** – 1) HRSA should get out RSN appeal process out to all tribes, 2) tribal mental health professionals need to write to your tribal governments and ask them to improve relationships between tribal governments and county and RSNs.

**Short-term** – do an assessment of the appeals process with the RSNs and identify and address problems with the process

**Long-term** – need to be able to “override the county MHP determination and have tribal authority for treating and hospitalizing our people.

**Short and long-term** – get funds from RSN and treat own people.

**Short-term** – inventory contracts and look for waivers of sovereignty – take back control of the contracts. Build accountability into the contracts with RSN that includes measurements of the success of the RSN.

**Short term** – amend the RSN contract to require them to recognize the tribal mental health professional so we can force-feed the system even if there are no beds. In order to get our MHP we need to have that AIAN mental health certification boot camp program in place.

**Short term** – One suggestion would be discharge planning with the department of corrections – add DOC to list of entities to communicate with and collaborate with.

## **Tribal Centric-Mental Health Plan Meeting**

Northern Quest Resort & Casino

Airway Heights, WA

Tuesday April 6, 2010

### **Day One Discussion**

Invocation

Welcome and Opening - Liz Mueller, IPAC Chair

Introductions

Additional Welcome – Marilyn Scott, AIHC Chair

#### **Roger Gantz (HRSA) / Steve Kutz (Cowlitz)**

RSN's have been serving AIAN populations in a continuum of effectiveness – from serving well to not serving well at all. There are 32 Tribes offering mental health services in all sorts of ways.

Some Tribes choose to only serve their own tribal members. Others include others in their community. (Mental health services for people who are non-Native but in a tribal community, are often provided by mental health managed care organizations/delivery system.)

Will be impacted by recent legislation re: GAU. Don't know if there are options around this issue of mental health being under GAU. Tribes need to be ready for the need for increased hard dollars to provide dual dx care.

For individuals on GAU (not Medicaid eligible) – they will be able to access outpatient mental health services that they weren't able to access in the past. Challenge is that about a third of the people on GAU, eventually migrate to the Medicaid program – there are 750 or so people who are AIAN and who are being covered by GAU.

Someone expressed concern that Native people are being singled out to have a fee-for-service delivery system, while others are under a managed care program. Why is this? Could be viewed as discriminatory.

Response to this was that tribes did ask for this back in 1993. Also – it's not mandatory that the tribes enroll in fee-for-service – instead they have a choice, they can either enroll in managed health care delivery system, or a fee-for-service. So they have a choice – where others in the general population are automatically placed in the managed care system. In 1993 - asking Tribal leaders/providers what they wanted, having a choice was definitely

what was viewed as the best option. Colleen gave summary on how this decision was reached 17 years ago – many different tribes gave input.

When Provider One is operational want to be able to provide services on a fee for services basis rather than through managed care. (only for psychiatry services?)

GAU not Medicaid eligible so reimbursement rate is at the medical physician rate NOT the Medicaid encounter. With Healthcare reform, all GAU/disability lifeline will all become Medicaid clients and therefore reimbursable at the Medicaid encounter rate

Dec 3 – Tribal consultation after 3 meetings in Sept, Oct, Nov culminated in RSN waiver to develop tribal-centric mental health system or system that links behavioral and medical services. 23 tribes – said yes. In letter to CMS would be engaging in govt to govt journey. Also there is a need to develop a new system for delivery of care for children.

There will be a series of meetings beginning in Jan/Feb.

In developing a Tribal-centric mental health system it is important to remember that not all AIANs live or receive services on Tribal lands/reservations

Today we want to develop a stronger relationship between the Tribes and the existing RSN system – as we work towards a Tribal-Centric Mental Health Plan. Three goals:

- 1) Need to strengthen AIAN discharge planning to link back to services in Tribal clinics when they return.
- 2) Develop tribal designated mental health professionals to make referrals to inpatient mental health facilities
- 3) Within the available tx modalities available to Tribes need a discussion about what is available today? Believe there is a wider range of services that Tribes can be reimbursed for.

A need for resources for Tribes to have access to resources – to do a needs assessment and inventory of available resources and needs not just in Tribes but in urban areas. Plan to announce that \$\$ become available for FTE to develop that inventory and to document attributes critical to a tribal-centric mental health system – plan to announce those funds available – June or July.

Two-fold Track for the next few days: 1) improve the relationship between tribes and RSNs, and 2) hear ideas about what a new Tribal-Centric mental health system should look like.

2014 – will see an unprecedented expansion of Medicaid program to provide services to up to 500,000 more people. There are currently a number of AIAN on reservations who don't qualify today for Medicaid due to categorical barriers. Building a system for tomorrow.

Question: Timelines – now looking at June or July. Is there anything we can do to catalyze the timeline a little bit?

HRSA – struggling with resources, but now have some access to more grant dollars.

### **Identifying what is and what is not working in the current system**

**Bob Brisbois** – Interesting to look backward and forward. Back in 1984 as an IHS mental health therapist we saw clients and billed and it was straightforward. Have been working on these issues for a long time. Now we are here in a gov't to gov't relationship partnering to work together to improve our . Today, I can't imagine being an adolescent needing mental health services being able to navigate the mental health system and come out healthier, sane, unmedicated, and receiving culturally relevant services. Talking about what works and what doesn't work. Don't want to dwell to long on what's not working and on going after the RSN's to get improved services. We have the opportunity to do that now. Want to ask what works? Consultation process is working between State and Tribes. Consultation, collaboration, communication policy is working. The meetings are working – if we can keep meeting regularly (call in if not able to make it). If we aren't Tribal leaders but have been appointed by our Tribal Leaders as delegates the state must acknowledge and understand that we represent the Tribal Leaders. Eastern WA and Western WA are two different worlds. What is working and not working with RSN's will be different – some working and not working.

**Jim Sherrill – H and HS Cowlitz** – what's working – clearly dependent on who the RSN director and staff are. It is clearly a situation where if those individuals are sensitive to the needs of AIAN and sensitive to the unique status and needs of AIAN Tribes you can have a good experience with RSN/Tribe. It is not a systemic solution – can't hope that counties will hire the "right" person. Other thing working – recently – our health service delivery is from King Co South down the I-5 corridor to Skamania county crosses the Cascade trail to Eastern Washington. We work with numerous RSN. Quite recently RSN directors seem to be getting the word that they are to include Tribes in their area on their advisory boards and in the development of the 7-01 plans. Have been getting invitations to sit in on these planning meetings. Meet quarterly, work on issues, network with RSN providers to improve services to clients.

Communication and relationship is important? Yes, it is dependent on the personality of the RSN staff. **Short term** - Think it should be required in contract language with RSN's that consultation and communication is necessary (and that staff be required to have training in unique status and needs of AIAN Tribes).

**Carlene Anderson, Colville** - Our relationship with the RSNs – I don't think there is one. IF there wasn't for law enforcement, we would be shooting at each other in our county. I don't know what the problem is; I think that there is an attitude that "Indians don't know what the hell they are doing – so why are we dealing with them? They have their reservations, they should stay there." If Indians have mental health problems, it's not a priority.

We had two suicides that happened in the last year, young vibrant people. When you lose young people like that, it has an impact on all of our communities. It's not isolated, we know each other – we are community. And the RSNs have not responded to that. I think that's really unfortunate, I would like to see something put in the agreements where they **MUST** talk to us, not an option. The U.S. constitution says that our relationship is with the federal

government. In our testimony, in talking with federal legislators, we have stated the example of the RSNs.

Our people go to the same schools get the same licenses, the only difference is that some are designated to do in hospital placement – we are not. We need the services. Even though we are surrounded by RSNs, they are all around – they don't respond in a timely matter at all. When you are in crisis, you are in crisis. If we could get the designation, we could get people placed. I'm asking for statistics on the number of people who are suffering depression on our reservation – that's a potential indicator for suicide sometimes. I think these numbers are not just on our reservation but also on other reservations.

**Steve Kutz – Cowlitz** – one of the issues that came up in one of our meetings. Could there be a mechanism when a problem comes up with non-admissions. You have an identified crisis but not the ability to make an admission or get a client into a bed. Need someone at the state level to act as an advocate. We've had those conversations but not sure what has happened with that. (Carleen/Spokane Greg Twiddy has offered to be that advocate for us)  
**Short-term** – identify an advocate at the state level.

**Marilyn Scott** - One of the things that we are hoping to get started as part of this transition – tomorrow not next year – is looking at the regions of the state where the existing system does work in some manner. In our region (Region 3) we have 8 tribes that work with the RSN. I'm not saying that everything is perfect and that all members get the care they need, we need to get some things worked out. But we actually have active monthly meetings – and we are talking about stretching them out to every 2 months since it's getting to be a bit much.

But one of the things that I would say is NOT working, is yes we have the centennial accord, yes we have the consultation policy, yes we have the communication protocol, yes we have the 701 policy for the agency-wide. But one of the gaps that I have identified is not the RSNs but the county governments that participate on the RSN board, that direct the policies of the RSNs – that have the purse strings and the votes. At the same time, it's not the RSN itself that provides the services, it's those contracted providers that we cannot hold accountable for the policies that the tribes have with the state. The 701 policy cannot be enforced with the providers. The tribes can request accountability for the contracts that they have with the RSNs, but it's the providers that we cannot hold accountable. So yes, the 701 policy – the tribes have participated with the RSNS in the development of the 701 policy, and yes we have a positive working relationship with our RSN in our region. But it's the access to the services that is the problem. Even though some of our tribes have a psychiatrist and a psychologist that can make the diagnosis – we still have the go through the process to get access to the services they need when there is a crisis.

**Shirley Charley** – Marilyn, you said it can't be enforced with the providers to provide –why not? **Alison Robbins** response – they (RSN/providers) are mandated to provide those services and if it is not happening that is when it is time to call and ask for advocacy. Call “us” if providers not providing services. **Steve Kutz** – response – according to our contract with the RSN if someone is supposed to be admitted and they're not there is supposed to be an appeal process that is supposed to happen within 24 hours. **Shirley cont'd** - I don't know when enough is enough. A whole bunch of times we need to stop being passive. To

me, a lot of time the good ol' days are still happening. Why can't we do our own facility with our own beds with a collaboration of Tribes (like Healing Lodge)? Enough is enough – we're tired of people talking for us because they don't talk to us. I'm tired of the constant education – the need to constantly educate providers. Why should we be treated differently? Because we're special, we're the first ones here. I say if we put in our own facilities we wouldn't have to do so much education. Who cares if it's the recession – we've been in recession our whole lives. We're survivors. I say let's do our own, start providing our own services without having to ask for it. The alcohol facilities are always on the other side of the mountain. By the time a bed opens up (30-45 days) the person doesn't even want help. **Short-term goal** – Having own mental health facility (shared goal with Marilyn Olson). One in East, one on West.

**Helen Fenrich** - Well that was going to be question – do you contract with your RSNs? We do, but we are finding that we can't even get the people to come with us with their problems. We had some many young people committing suicide on our reservation, that we started our own suicide prevention programs. A lot of times we found that it was physical and sexual abuse that led to the ending of their life before they are even 20 years old. And it is epidemic in all of our reservations, I know. What I really want to stress is that we all want the RSNs to do their bit. If you think about it they don't have much money either. We use it for prevention. We are special in Region 3 - not only do we contract with RSNs, but they are part of our regional coordinating council – all of us meeting with tribal heads and staff to bring our issues forward and try to address them before people are maimed, hurt or commit suicide. I lost my sister in October – direct mental health reason, her alcohol use was a way to deal with her issues. It was only 3 months after she passed away that I discovered she was molested when she was little. We have state providers so we can refer out - but sometimes it's a long process because sometimes the county shows its muscles and says, "No only our providers can refer out." That's when we lose and other tribes lose – because when some people are brave enough to bring their stuff forward – and then are told that they have to go repeat the process again. **Short-term goal:** Do an inventory of the RSN resources and see how tribes can best use those to meet the needs of their tribal members. Also inventory of what's working in the community and of the mental health status and disorders that are occurring.

**Dorothy Hamner** - Behavioral Health at Colville – we happen to have four different counties bordering our reservation so we have to work with all of those RSN's. Some of those RSN's refuse to work with us and for the others the services are never, ever culturally appropriate. We have tried everything to get them to discuss this with us but we have been unsuccessful. They won't come or they send their mental health professionals who have no authority. We have invited some of the RSN's to come to a meeting and they will not come – they won't even call to say they won't come. If we need to do something to change this we are willing to – write letters, other things? Tell us what we can do. We have 3 DMHP's working for our Tribe right now and they can't do anything. Mental Health – same thing. If a tribal member comes forward with a mental health need and the tribal MHP is ready to refer but then they need to go to the county and tell their story again – how can we expect them to want to do that? People who have been raped, abused – why would we expect them. I've never heard about the appeal process – we've never ever seen a contract, an agreement. I know there are limitations on their side, too but we have to work together. If you have any ideas, please share them with me. **Two short term goals:** 1) HRSA should get out RSN appeal process out to all tribes, 2) tribal mental health professionals need to

write to your tribal governments and ask them to improve relationships between tribal governments and county and RSN's.

**Cindy Roberson, Spokane, Native Project** - I'm a Behavioral Health Therapist – I've worked in the field since the 80s. I think we have somewhat improved our relationship with our RSN in region 1. We just heard that we can hire another mental health specialist for children. I work under an IHS contract, so I can only serve those who can show enrollment and proof of descendency. One of my great joys is that now we have hired someone who can work with non-Medicaid individuals. We have a lot of Canadian natives that I couldn't work with before. My opinion is that the RSN does not know how to work with Native people very well. Many of our people are co-occurring and slip through the cracks. Trying to just address the mental health is not sufficient...we have to address both co-occurring alcoholism and mental health.

I sit on the advisory health board for our county – one of the things in the mission statement is that the RSN advisory board is there to advise the county. What Marilyn was saying is very important, at least in Region 1. You need to not only understand the state and the tribe RAIOS. Spokane County has one of the highest number of kids in foster care, many of them need mental health. At our facility we have a child mental health specialist – she is scheduling out 3 months – so they have to wait 3 months. So people who want to see someone who knows about Indians has to wait 90 days.

We need to be able to see people who are not enrolled – otherwise we leave out many of our grandchildren. Children's mental health needs to be a priority, I need to treat that teenager or 3 year old that has been molested – it should not matter if they are enrolled or not enrolled. Otherwise we leave them to a therapist who is not able to do a cultural consult. This is huge to me.

**Lana Hughes, Spokane Tribe, mental health therapist** – I'm brand new to this, sorry. Seems like we've been struggling for a lot of years with the RSN process. Why can't we get the funds ourselves and treat our own people? I think that might be a better goal – why are we still banging our heads against the same wall. **Short and long-term goal** – get funds from RSN and treat own people. (Comment) – the amount of money that is paid to the RSN for the tribes is not very much so for small tribes it may not be helpful

**Jim Roberts** – I understand that RSNs may not have the responsibility to carry out a consultation. There is a requirement that the state conduct the consultation. But there is some element of sharing the responsibility – there is a mechanism that those subordinate institutions have some responsibility for consultation. I think it extends to a federal requirement, not just a state requirement.

**Jim Martin, Lummi** – appeals process. Need to jump on the assessment of the process and see if it's working or not (Alison will work on this). I've been through the appeal process when it didn't work in a life or death process. It took 4-5 months and then it had to be voluntary – RSN would not recognize a tribal court order. There is no place to treat them – what do you do with a suicidal patient who knows what to say in the ER room? Short term – assess the appeals process as in place. Need to be able to override the MHP designation and even better have own tribal authority for treating and hospitalizing our people.

**Greg Twiddy** – We had a referral that worked very well because there wasn't a bed available, but he ended up getting out of jail and into a facility – it was a perfect example of the right folks around the table and making that happen. I just want to reiterate that we would like to become that resource for all of you – if you aren't getting your needs met, call us. This is one example that worked. That's what we are here for. Maybe in the past the right pieces are in place. But I'm here to tell you that the right people are around the table – and we need to help hold providers more accountable – we want some accountability. Enough IS enough – you shouldn't have to be putting up with not getting services. I hope that our phones start ringing off the hook when this is happening. We don't have any magic wands but we can put the pressure on. But recently in Spokane it did help. So again, call us so we can know about these things.

**Marilyn Olsen** – PGST in Kitsap Co – we have county commissioners and XX (some other county officials) somehow think they have total control over the RSN and want us to waive sovereign immunity to have the relationship with them. The state has done nothing and yes the state is aware of this. We have one hospital in Kitsap County with a few beds for suicidal patients. Now, if a suicidal patient goes to the hospital, they go to the ER and once they have medically stabilized they ask if client okay, client says yes, and they are let go. Sometimes the tribe hears about it and sometimes not because the hospital doesn't have those beds anymore. Now our main option is to arrest them, which is not a good option. Reign in Kitsap County with regards to sovereignty.

**Liz Mueller, Jamestown S'Klallam** – When we have somebody who goes into the emergency in a crisis – we are not being notified. RSNs - we are providing some of the payment – we should be notified, but the hospital says because of the law we can't be notified. But the RSN says if we are providing the dollars for the patient, then we should be! We can't get anywhere with this one hospital (the only one in the area) – so if anyone has any help to offer on how to get through to the hospital, I'd really appreciate it. Because if someone comes in in a mental health crisis but they have alcohol on their breath – they get sent home in a taxi.

**Shirley Charley, Colville** – I believe you can put the stipulations and everything else – but you need measurements. You can have all the contracts in the world, but how do you make them accountable to them. Make sure you put the language in there to make it work – put some teeth in it. Read your contract and pretend that it's a deal you are going into on your own – so if you don't like the deal, the words – change the wording. We need to look at our tribe as our very own house. **Short-term goal** – inventory their contracts and look for their waivers of sovereignty – take control of the contracts back.

**Steve Kutz, Cowlitz** – appeals process is through the RSN administrator. If the administrator isn't cooperative it's not going to work. I want to talk about the hospitalization and crisis processes. It sounds like we're trying to fix a system that doesn't serve anyone well. One of the things that we asked for as a short-term fix is to get the RSN to recognize Tribal Mental health professionals recognized. Still, getting people into those beds is going to be hard – the beds in the state don't serve native people well. The E and W side tribal facilities may not work well either. If the client changes their mind and are voluntary – we lose them, even 6 blocks away. **Short term goal** – amend the RSN contract to require

them to recognize the tribal mental health professional so we can force-feed the system even if there are no beds. In order to get our MHP we need to have that certification boot camp program.

**Ed Fox** – we have some things that are working with our tribe – we are working with our children. Many of our children have been working with mental health providers since they were 6-9. We also sometimes have to call the police for our mental health patients. **Short term goal** – One suggestion would be discharge planning with the department of corrections – add DOC to list of entities to communicate with and collaborate with.

## **Tribal Centric-Mental Health Plan Meeting**

Northern Quest Resort & Casino

Airway Heights, WA

Wednesday April 7, 2010

### **Day Two Discussion**

Invocation – Bob Brisbois

Welcoming - Liz Mueller, IPAC Chair/Marilyn Scott, AIHC Chair

**Marilyn Scott** - Healthcare executive cabinet. AIHC works with DOH, HCA, DSHS, Office of the Insurance Commissioner regarding private insurance

Secretary Dreyfuss announced that Medicaid management will be moved to HCA as well under Doug Porter. Announced May 1 that Doug Porter will moving HCA; David Dickinson will continue to maintain activities DBHR and that RSN's will be directly under the Secretary of DSHS. Marilyn did ask if David D would be available for the meetings here; however, since the

How will be able to move forward with Tribal centric mental health system (with Medicaid at HCA) – there's going to be a separation – seems there may be some disjointed coordination in the work that we need to do for this. The Medicaid state plan will still move forward so assuming that there will be some coordination to move our TC system forward – will need to get David D to the table very soon. We're going to learn how to walk through different hallways with regards to who is making decision with regards to RSN's, mental health, chemical dependency – also for medical services. We've been trying to link mental health with medical health services. We'll need to get some of those gray areas addressed when Doug comes. Hopefully by the end of the day we'll have some hope about how we're going to move forward.

**Jim Sherrill (Cowlitz) and Alison Robins (HRSA- DSHS)** – when I read through the RSN contracts there are some clear and spelled out obligations on the part of the RSN's with regards to obligations to the Tribes – unfortunately those have been allowed to go by the wayside and some RSN's are doing well,

RSN must develop a coordination plan with each of the tribes in their area – if Tribe declines to participate this must be documented

They must extend an opportunity to the tribes to sit on advisory boards

Must let tribes know

Some county commissioners have demanded that tribes waive sovereign immunity

I would like to pledge that we will develop a monitoring plan – look forward to suggestions re: how to do this.

**SUGGESTION Bob Brisbois** – When you develop RSN monitoring plan – please include IPAC so they can make sure tribal representatives are at the table. Request that IPAC member sit on committee that determines compliance with these monitoring plans.

**SUGGESTION Steve Kutz – suggestion** When had conversations we discovered that there was an 701 plan that the tribe hadn't seen – suggest that documentation of okay on these documents on Tribal letterhead

**Allison Robbins**– we are at ground zero – so we can build a good system of developing and monitoring plans/contracts from here. Would like suggestions – she will take them back and incorporate into their planning. Will include tribal representatives.

**Jim Sherrill** - looked at contract with RSN – not just requires that Tribes sit on advisory board but also accommodate unique needs of Tribes

**SUGGESTION Kimberly Miller** – Skokomish – I believe there has been no checklist to see if those relationships have been honored (contractual) so that we have data about whether RSN's are following their contractual

**SUGGESTION Carleen Anderson – Colville** – when we do make a referral to RSN's that someone from the state get a copy to see if there is any follow-up so we can build a database of compliance for our waivers

**Jim Roberts** - When you are looking at what to include in monitoring and compliance – taking a chapter from the RCW that talks about inclusion of tribal authorities in RSNs. Unfortunately it's not being enforced – even though the chapter is in there – recommending that the tribes are included, especially in regards to cultural competency. We need to start there in talking about what is included in contracts and policy language.

**Liz Mueller** – I think it is important to distinguish the difference between the RSN advisory committee and the RSN executive board. The committee is where folks come together to discuss specific issues; the board is the decision making body – there is supposed to be a tribal seat. I've been working 4-5 years to get on that board. The RSN board for our RSN has not respect for tribal authority.

**SUGGESTION Jim Sherrill** – ought to be a tribal seat on the executive board (commission)

**Marilyn Scott (Upper Skagit)** The IPAC committee had previously spent a long time reviewing and revising the contracts that the RSNs have in place now. So very definitely the Tribal Reps that had served on those committees. Because we worked a long time to get the terms that are in the contract to comply with the federal requirements that the state has to allow consultation and coordination with the mental health state plan. And the requirement comes from the federal level from CMS that when there is a state that has tribes – the state must assure that Tribes have had input into those plans. The documentation starts there. We as tribal reps attempted to strengthen the terms in the contract with the RSN to assure the compliance went down the line. The legislatures assigned the RSN as far as mental health services in the state.

Some of the terms that are in the contracts were our way of enforcing govt to govt. The Executive Board of the RSNs is basically comprised of the county commissioners. In our region we have 8 tribes that are part of the one RSN. Initially when the tribes tried to step

up and participate and request a seat for each of the 9 tribes in the RSN board –of course we had resistance from the county since they each had one vote on the exec board. The exec board in our region objected to having a rep from each 8 tribes on the exec board. They did come around – they said we could have seat on the exec board, but we were only allowed one vote. We objected – we are individual tribes with different needs. The 8 tribes got together, we decided that not all the tribes had a rep that could regularly participate with the board – we agreed among ourselves that we would have active reps of the tribes and that if there were issues that came up that we wanted the reps of the tribes to communicate, there would be then an informed participation vote. We lost one of our reps this year – we had two other tribal reps that actively participated and were allowed to vote. So we have a different experience – but we regularly meet monthly with the RSN – now deciding to meet every other month while this tribal-centric plan is being developed. We still have the same issues that the other tribes have with the county reps not acknowledging the sovereignty of the tribes the way the exec board level is. They do not feel that they have any obligation to the tribes in the region. We as tribes are pushing our way back into the door – in doing so, we’ve actually been able to get that turned around in our region – we believe that we have been able to educate the county reps through the economic contribution that we have made to the county. We have a right to be at that table.

**RECCOMENDATION Jim Sherrill** (response to Marilyn) – that tribes themselves pursue being on the board – how can DSHS support and advocate for that – put some onus on the contractor to

**John Stephens (Swinomish)** – In some ways this feels like we’re back to repeating some of the same discussions we had pre-September when Doug Porter opened the door for the waiver and the Tribal-centric system. By statute tribes have been put in an inferior position – commissioners have the power at the RSN level – no way around that. The state has legislation and RCW language which it has failed to enforce with regards to checks and oversight on the commissioners decisions and activities at the RSN’s. That may make some of our state allies uncomfortable but that’s why we’re here – to have this discussion. We can spend a lot of time at the tribal lever attempting to coerce, coordinate, etc but in the end it is insufficient which is why Doug opened that door. Anonymous state employees will state that commissioners are kings in their own fiefdoms with regards to exercising their rights and authority – power. The commissioners know they have the power – the state has been reluctant to provide oversight over this. Until this changes, the tribes are wasting a lot of time and energy. At the end of the day we hope that not only the RSNs have the contractual obligations in place, we have to also have compliance and follow-through – state

**Jim Sherril** Why are we worrying about the language of the contracts if we are going ahead with a Tribal-Centric model? It occurs to me that even in the TC model, there still could be a relationship that the state has with the RSN around culturally appropriate services that they subcontract. We may be using some of their contractors for crisis services or some other portion of services. So I think the topic of contracts and what needs to be enforced is still relevant.

**Helen Fenrich** (Tulalip) – I have a couple of concerns – one is the terms and conditions that we sign every five years. The state or county was trying to take ownership of what were doing in our services. Spirituality - As Lawrence said we are only loaned those songs

and dances. My stand on that a long time ago – I'd ask if they "knew what Indians was". We need to make sure that we protect our songs, traditions, spirituality.

**Liz Mueller** – There was a lot of fighting between the commissioners regarding sharing the risk since we have a large county with a large population. When this came up about liability and the Tribes having to share an equal part of that liability – decided that they would have to change and extend it to liability across four entities (Jamestown and the three counties). The RSN was sued by a patient in Clallam County and received over million dollars in a settlement regarding that. So we have to share the liability risk along with the counties. This became an issue with the county saying one of the counties with the biggest population should carry the risk. It has to do more with the commissioners than the tribes. I just wanted to make sure that it was mentioned (going back to the state enforcing the counties) the county is saying, "the state is not taking any risk...they aren't getting sued, we are the ones getting sued".

**Steve Kutz (Cowlitz)** – sitting here like most of you wondering what's next with this thing. The risk that the commissioners are talking about isn't just the risk of being sued but also a fiscal risk – if the RSN runs out of money they can't just fold up shop and stop providing services – the county is obligated to continue to provide services. I'd like to have some deeper conversations about what it means to have a seat on the executive board – not sure that the WAC states that we then have to take on those risks. Not sure what the WAC will do with this in a tribal centric system. I don't want to give up our right as sovereign governments in order to have representation on the EB. It's pretty clear in the contracts how Tribes have the right to sit on their committees – I think it should be pretty straightforward in how to have tribes sit on the executive board. How many people knew that the WAC provided that there is tribal representation on the EB? Very few people raised their hands. I would put in the 701 plan how quickly they needed to respond and then hold them to that. It is pretty hard for a tribe to do that if they're not even contacted when that happens.

**Jim Roberts** - Mentioned a form that is included as part of the RFP process and the documentation required for RSNs to submit to the RFP. We should perhaps require submission of this form that outlines how the RSN is going to consult/interact with the Tribe in their area. Tribal reps should sign off on this form before it is submitted to the state.

**Recommendation:** Have a consultation agreement developed in the RSN's proposal process that would be mutually agreed to by the Tribes.

**Cindy Robinson – native project/native health** – we do have the 701 policy agreement. We've met with the RSN folks, e.g. Eastern State Hospital, met with RSN administrators there. However, even when you have the policy it is not enough. You can request the numbers (data) – give us the numbers of Native people at the E hospital or in other services. We don't see the numbers <of our people receiving services through RSN>.

**Having the language is fine but need specific language about what those obligations mean, e.g. providing actual data,** Hearing this again – if we're going to go to tribal centric – some of this has to be between tribes and states or RAIOS and states specifically. I don't see any RSN people here today. To move forward with it I think we have to think with new eyes and new heart. Putting it down on paper is not enough.

**Shirley Charley (Colville)** I don't know if the consultation language has been defined. Has a statement been written so that every time we say consultation with a Tribe – it means the same thing, no matter what the issue is? Consultation needs to mean the same thing, no matter what you are talking about. When there is a different agency dealing with your tribe – consultation needs to consistently mean what we want it to mean. I think if we would have been stronger – saying this is what that word means – we wouldn't be in some of the dilemmas we currently are in.

I believe you have to have the RCW so the state knows what we are talking about us. But the agreement has to be in writing because the handshake just don't cut it no more. Sometimes even though it's in writing, we can't make the other person agree as to what it says, because of the interpretation of the third reader who wasn't in the room. So when we write it, be very specific – who what when why and where. Always remember it's for your tribe, but don't forget about mine – because we all have the same needs.

**RECOMMENDATION** – have one definition for consultation across the parties. Needs to be in writing.

**Liz Mueller** –we worked on the consultation process and have taken/used the one from federal gov't and tribes and president and tribes. **I think what we really need is a signature page on every single 701 plan so that it signed off by tribe, RSN, and DSHS secretary.**

**Dorothy Hamner (Colville)** – One of the things that astounded me about consultation – when I worked for Chelan Douglas behavior health, I wanted to be a person for Native consult. And the RSN told me, “Well, it's not good enough that you're an Indian. You have to pass all these tests if you want to be a Native Consultant” I was very angry because I have grown up with my people – why would I have to read or pass a test? It took over a year and a half to pass my tests. We need to deal with this with the RSNs this is ridiculous. Meanwhile – the RSNs were using a non-Native person to do consults who knew nothing about our culture – it was such a joke. I think what Shirley says is right –there needs to be specific language saying they have to go to the Tribe and get specific information.

**RECOMMENDATION:** look into requirements to be a consult. If you are a Native mental health specialist – you should qualify to be a consult.

**Colleen Cawston** – it becomes apparent that we are intermingling two key words here – consultation and consult. Government to government consultation is very specific process

In mental health world there is a Native American consult which is very different and very specific. These are two very different consults. Native American specialists who provide consult to clients. Why should our clients go to a NMHS with a piece of paper from 100 hours but who are not AIAN or have not spent time in AIAN communities when they can go to one of our own providers? We're working on that with Eric Trupin.

**Carlene Anderson (Colville)** – “Buying a pair of chaps don't make you a bull rider.” I feel really strongly that talk is cheap. Hundreds of years ago our people make agreements with

the govt when they didn't know contract law. We are getting smarter every year. We have learned to put it in writing – we expect the state to put everything in writing now. It exists – we need to make sure that it is being implemented. We can't go on the basis of "I'm from the govt and I'm here to help you." We need to have it in writing.

**Bob Brisbois** – back in the old days when we had tri-county RSN we had a delegate from each tribe. But that was before they moved. I've been back in my tribe for one year and I have not received a copy or cc from our RSN director, and I don't think our health director has. We don't even know who the director of our RSN is. **I don't think there is any standardization across RSN's about what level of training is necessary for designations of specialists and contractors.**

**Ann - Spokane** - We have been dealing with the RSN going on three years. This is the first year that we were invited to what they told us what a quarterly meeting. But the sad thing about it is I don't know if the Colville or Kalispel were invited – Spokane was the only tribe there. They made it pretty clear that they were going to do what they wanted to – we were just out of luck if we didn't know what they were doing. They had earlier met with us and put together a 701 plan, one of our mental health specialists was placed as the consult – but they were never called. It's like being on a seesaw.

**Jim Sijohn – Spokane** – Spokane Business Council member and IPAC delegate. In listening to what Ann has to say, not much has changed. In the old days you go to the meeting with county commissioners and I can recall when we (Spokane Tribe) would make a motion he (other tribal delegate) would second it but there would be no support from the other county delegates. The meetings would be held around the area and we would attend and we would be treated this same way. We hosted a meeting at Wellpinit in the middle of the Spokane Reservation and there were about 3 county commissioners there and you could tell that it was a pain for them to be there. My observation – we all talk about cultural competency but what these (state/county) people don't realize is that each one of us are different – we're from different tribes, different locations, different backgrounds but we're still brothers and sisters and we're trying to help each other. But don't throw a blanket over all of us! We're different. We're brothers and sisters but we're different. Things might be working for some of the tribes and RSNs' but I have not heard that things are working 110%. I think what Bob Brisbois did yesterday was important – to talk about the highs and the lows, what is working and what is not. I can guarantee that we're going to keep doing this, with new governors, new commissioners, etc. We gain 5 inches and we have to hold onto it. We as Indian people walk our talk and that's why we're here. That's what we do. I've been on IPAC for years and years and it's an honor. We work hard to keep this going. We have Liz Mueller (IPAC) and Marilyn Scott (AIHC) working hard for us – if you think we get frustrated, think what is like for them. We on the east side of the mountains are very fortunate to have these two ladies fighting for us. Where do we go from here? You take this Elder here, you follow this elder who will support you all the way. I hope I don't have to come here 10-15 years from now when Ann stands up and says nothing has changed. Where do we go? We can't give up – we can't do that. Look at all of our children and adults who are struggling. We talk about mental health, substance abuse, etc. but we forget about our young ones who are having mental health problems because they are obese. We can't forget our younger ones. Don't give up. Take a little bit of what I said and continue.

**Steve Kutz (Colville)** - Thanks Jim – you stand up periodically and bring us back to ground zero and let us know that this is a long-term issue. And so we constantly, with the RSNs there is frequent turnover – and it's a re-education process that goes on and on and on. I wanted to say that we don't sit back and wait to get the letter from them, generally. For example, I look at Ed – if we don't continually nudge each other about the things we need to work on with Tribes, it's easy for it to drop off our to do list. Encourage tribes to contact the RSNs and hold them accountable – and when they send someone to the meeting who has no decision-making authority – tell them to send someone with decision-making authority. It trains them if we keep telling them. If we don't do this across the state – pretty soon all these people change, and let me tell you, they don't have any built in sense of direction or what they need to do. This doesn't take the responsibility off the state – the push needs to come from that direction also.

## **FUNDING**

### **Bob Brisbois and Roger Gantz**

**Roger Gantz** - With the realignment of the healthcare under HCA (missed part of the dialogue here)

A couple of comments on national Healthcare reform – excellent document from Jim R at NPAIHB re: patient protection and application for AIAN. Document dated March 23 – was sent out to all tribes and Jim will bring copies for everyone here.

There was a monumental change in healthcare especially for care for comprehensive and affordable healthcare for all.

Items – beginning in Jan 2014 Medicaid reimbursement will be increased to 124% or poverty level. Make Medicaid access for up to 5,000 new people. Also beginning in 2014 states will develop insurance exchanges to make health insurance available to those who don't have access to health insurance through their workplace. Through the exchanges will make available to those who don't have access to Medicaid will make insurance e available to those to up to 400% of the poverty level. Some major policy issues for WA – what markets should be in the exchange. The national reform makes it possible that can have individuals and small groups in multiple exchanges and also across states. We could consider having a health insurance exchange with the state of Oregon and Idaho for example. With respect to the health exchanges – cost sharing requirements that exist would not be required for AIAN's with up to 300% of the poverty level. Once challenge will be the identification of membership (tribal) to make sure that AIAN's are not underrepresented in the numbers.

Two other aspects – mental health and behavioral health reform – need to insure that mental health/cd tx parity will be included in the insurance exchanges.

We'll have a major undertaking in the next few years with regards to tribal centric system but will also have a challenging undertaking for all the citizens of the state.

**Steve Kutz** - Are you going to have consultation with Tribes when WA comes up with this plan? Are you going to provide coverage to descendents? Descendents are eligible in our Tribes to be served – and yet descendents are not necessarily federally recognized – they have to prove descendency. So I hope when you have these conversations you talk to

Tribes – because we don't want to see any of our people left out. Many of those people, by the way, are those going to the urban centers. **Roger Gantz Response** – very good question. I don't know. It's an issue we'll have to wrestle with.

**Jim Roberts** – while you are on the subject – in some instances, the provisions are fleshed out. There's reasons why there was variation in some of the provisions – budget, etc. Whatever the state decides to do – we'll have to follow the law. This is going to be an issue for debate not only for the state but also – in some provisions the definitions are spelled out and in some not and they vary. Not just a state problem but also a national problem.

**Carleen Anderson – Colville** – Serving descendents is something that tribes are going to have to grapple with in the near future – serving descendents with IHS. Many of us have been dealing with IHS Priority One – unless you are in risk of losing a limb, your opportunities for contract services are limited. Many of our tribal members are not receiving the services they might need because we are serving descendents, too. This is something that we are going to have to deal with and think about.

**Liz Mueller** – do you think that the RSNs will still be around after Health Care Reform? If so, how much energy would we be putting into changing our relationship with the RSN's if things are going to be changing by 2014?

**Doug Porter** – will the RSN's be around after healthcare reform? A couple of things are going to happen. The CD services will have to be performance driven rather than a capped budget. Rather than stopping services when you run out of your budgeted funds thing will look different when we add 300-400, 000 people on the Medicaid roll. Same with children, foster children not being served will be RSN. With regards to accounting RSN's will have to develop ways to provide reporting. The RSN's that are in existence today will not look like the RSN's tomorrow.

**Roger Gantz** – I think you raise a good point. One of the dilemmas we are facing is the commitment that Doug put forth in our meeting in September – to commit to going forward with a Tribal-Centric Mental Health system. That commitment is in place today. Our challenge is now that as we put this new system together – how much time and resources should we put toward meeting the near xxx?

#### **Four important points via Bob Bribois:**

- 1) Will have consultation with tribes when provide services
- 2) Will RSN's be around after mental health reform – not likely – need to have Tribal consultation as the “replacement” processes are developed
- 3) If 300,000 more people will be coming on the rolls as eligible for substance abuse tx, need to have a letter of notice to tribal leaders and consultation about how this new funding will be allocated

- 4) Accountable care model for RSNs – if in the making need to have tribal consultation in the making of the accountability model.

**Helen Fenrich** - Want to speak to descendency/identification: My problem is I just got custody of my nephew, my sister just passed away recently. Getting him on my Medicaid plan – but it's not happening [because of descendency issues]. We are having to wait a month and are still not on plan. If I'm having these problems, how many other people are experiencing this – can't get services because they aren't registered as a tribal child, or be able to pay the co-pay. Identification is a biggie – it needs to be paid more attention to by these departments. We have some good programs out there, and they could be saving money. **Roger Gantz Response** – we do have an expedited system in place – so that if a situation like that occurs we can get the family member or youngster into the fee-for-service system in an expedited manner. **Helen** – I had the 1-800 number but it said that it would be open the next month. **Roger** will look into it for her.

**Kimberly Miller – Skokomish** – the idea of us having to ask you who we can serve makes me shake in my seat. I think it should be up to the tribe to determine who they should serve with the dollars they receive.

**Ed Fox** – Since the NW territories were set up and they realized they could steal Indian land they did three things: build state capital, build state universities, and build state institutions. Mental health has always been funded by Indian land. Currently we have health reform bill – we need to learn how comprehensive it is and we need to know the timelines. Over time Medicaid goes down and health insurance goes up – we need to think about that and be ready. I think what are the timelines, what are the changes in benefits, and we need to think about what changes there might be in guaranteeing benefit to members of tribes who may not be enrolled/descendency issues. We need to learn how to say no to people because we can't spend all of our dollars on health care. We have learned how to live under a budget, how to prioritize health care, that prevention is better than acute care, and you don't kick people out of the community just because they are sick. We try to keep a lot of people out of jail – non Native communities could learn from that. Priority: Education of state tribal providers.

**Steve Kutz (Cowlitz)** – I would propose that we need to continue to be engaged with this RSN process and this mental health process because I think this is going to be a continual battle. Healthcare reform isn't going to all of a sudden bring parity for healthcare in Indian country. Take mental health – when RSN's start going away and the need for mental health is still there – need for care is still going to be there, access to healthcare is still going to be there because healthcare services are and will be scarce. We need to stay engaged in the process or we will find ourselves left out of the process as we always have.

**Marilyn Olson** – How much mental health coverage is in mental health reform? I've always had health insurance for myself and my family since we were first married. When my child became seriously disable from a mental health issue – it paid some. But treatment in an inpatient facility – it almost bankrupts you. It works better to see foster care kids weekly instead of monthly – but it's expensive. Son's policy says they have mental health coverage – to the tune of four visits. It doesn't seem to do a whole lot of good to have everyone

covered when insurance companies can decide who is going to get paid. Real good to have coverage – but doesn't ensure that everyone will get good mental health coverage.

**Short term goal** – How much mental health coverage is in the health care reform?

**Marilyn Scott – Upper Skagit** – I was just sharing that I had a copy of the director of IHS's bulleted summary of the IHCA – there is a section that shows authorization for not less than one inpatient facility or equivalent to serve Indian clients in each IHS service area. It behooves us to work with the state to create such a facility as it would be 100% reimbursed as it is included in the national healthcare reform. There are many other exemptions listed such as Roger stated such as exemptions for cost sharing for AIAN's in the insurance exchanges.

There is some authorization in the national legislation that specifically addresses Indian healthcare and the expansion of behavioral health. We're going to need to look at the national reform along with what the state is doing AND the IHCA which gives authority for the tribes to be part of the healthcare reform and IHCA process. We must look at all of the documents side by side and it needs to be a part of this group's charge. There are numerous funding streams as well as authority given in the IHCA that can support our work.

**Assignment NPAIHB, AIHC, Doug Porter's shop – this workgroup needs to take healthcare reform legislation, IHCA, and what Doug is doing and coordinate the efforts.**

**Short and long term goal** - The work group needs to take the health care reform and put it here, the Indian health care improvement act and put it over there – and look at both and come up with the best solution for Native health care.

**Roger Gantz** – what the health reform calls forward is the Medical Eligibility. For the state's existing medical programs, and for the state's children's programs – states are obligated to maintain those programs at those coverage levels until such time as national health reform is implemented. So there are some federal requirements with respect to maintaining medical eligibility in these challenging financial times. One other piece in respect to trying to sustain the services and programs we have today is that Gov Gregoire has directed both department of social services and HCA to seek Medicaid waiver. What that waiver is going to be seeking to do is take advantage of early expansion of the Medicaid program beginning April 2010...States can do it if they can. We are going to take advantage of these Medicaid funds to help fund our existing medical programs and disability lifeline clients. We hope to have a funding stream in place to help sustain those programs.

**Steve Kutz** – important takeaway (to Roger's comments) is that the RSN would no longer be responsible for the hospitalization of AIAN's. That means the removal of a barrier for hospitalizing our clients but that doesn't mean that because we have the funding we have the beds.

**Bob Brisbois** – don't know what the data is from RSN's re: services provided to AIAN clients.

Three agenda items to discuss today:

- 1) Security of funding
- 2) Assure that the tribal programs are not future areas to be cut
- 3) Data of current funding processing for RSNs

**Marilyn Scott** – one of the questions that have been asked with regards to funding is data from the state for funding for what the RSN's do. The RSN's received block grant funding, direct funding from the state. The tribes have asked for this info to track funding streams for when we are trying to develop the tribal centric system so we know what the funding streams are, what the requirements for the funding streams are, and whether or not the tribes want to take those on.

**Roger Gantz** (Response to Marilyn). In the handouts that we brought for the work group meeting – pg. 16 – is a pie chart that lays out where the general dollars expenditures went in 2009. One of the commitments we made to our work group is to break that pie chart out into dollars and resources that are associated with services to AIANs. We are in the process of putting that info together. The other things that we have available in our research and data analysis division is the ability to take the existing information we have and break those out between AIANs and non-Natives. We've done some preliminary work in that area. We've been asked to see it broken out by each of the 13 RSNs. People would also like to see it by age category. So we are putting together for our work group the capacity to do that analysis. We are always going to face data challenges – that is going to exist in this data system as well.

**Short Term goal** - Transparency in the funding arena of mental health and transparency in the requirements, and transparency in the data from the state to the tribes with a complete picture available for the tribes. Regardless if there is a misnomer in the reporting – we still know what percent we are of the population.

**Shirley Charley (Colville)** - I believe that we need the starting point for our data. Some of the divisions in our Tribe believe that the statistics are confidential. I'm trying to teach them what confidentiality means – it's not numbers that need to be protected but it's names. If we can have each of our divisions provide us with their numbers than we can give our statistics to the state and they will need to prove our data wrong rather than them giving us the numbers and us having to prove them wrong. The census is our powerful tool. Long term goal – revisit our data agreement with the state.

**Marilyn Olson** – please explain data on page 17. It looks like the state of WA is spending considerably more dollars on AIAN than they are on everyone else. It might be misleading to those who are skeptical and they might ask “why do the Indians get more?”

**Roger Gantz response** – does not include inflated by higher encounter rates, etc. I think we're going to have to look at these data patterns. Trying to do risk adjusting – denominators are either all AIAN or all non-native and does not take into account all those who actually need.

**Cindy Roberson** - Does this also include children that are listed with CPS? We were told that all of those children were seeing private providers contracted under Medicaid. Now that's going to be moved back under RSN. I don't see a place where that is being defined. Is that ALL the children that are being paid for? **Yes.**

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### **David Reed – Evaluation of Mental Health Treatment Centers**

In order to provide the service, it has to be provided in a treatment service. Has to be a residential facility and has to have the capacity to have 16 people with capacity for seclusion and restraint.

There can be ENTs for adults and ENTs for children. There is a severe shortage in the state of child treatment facilities. Many are waiting for a bed to open up. There are all kinds of exciting things are happening across the country. More trauma focused care. Inpatient facilities that try to minimize trauma have a higher record of restraint, medication, etc. Doesn't make sense to further traumatize people who are already in trauma. Now more trauma focused care that reduces negative incidences – which makes more sense for patients and also makes business sense (even staff take less sick days because it's not such a scary, negative place to work).

Would look at a facility that is dually credentialed and can provide detox at the same time. Often people sit in an emergency room while waiting for a bed. Need to have a facility that can meet both needs – mental health and alcohol/substance abuse detox.

Issues for regional ENT – weighing the odds of taking someone out of their community and transporting them away from family and support.

Question/Comments:

**Ed Fox** – Squaxin Island has an inpatient tx facility –how much work would it be to do a transfer over to being an ENT. Would we be paid the encounter rate for a hospital?

Answer: Must have a room with a window for observation that also protects privacy, Must have audio/visual capability from nurse's station for observation of those in seclusion and restraint. Also have to have reverse ventilation. Would have Medicaid inpatient rate if providing services as ENT.

Bed date costs are usually around \$650/day – MHP, 24/7 nursing, doctor on call, for 16 beds can have ~4 staff. Also need to have secure, confidential meeting rooms to meet with family, staff, etc. for better treatment.

Comment: We need to address the trauma that people are coming in with – and the traumatization of the therapists who are working with that on a daily basis.

A: Within the ENT there should be a room where they can comfortably meet with the family and the patient and meet among themselves.

**Carleen Anderson (Colville)** – point made about family involvement in treatment of trauma and crisis is an important point. We've been training the hospitals about this. There needs to be an understanding in our hospitals that when there is a family in crisis that we will gather – at times there can be >20 people at the hospital. As we think about developing ENT's we need to keep this in mind. This is an important cultural thing.

**Cindy Roberson, Native Project** - Part of the dilemma for many of our people is that they fit both into alcohol & drug and mental health. And since those two worlds are not yet one, many are caught in the limbo because they happen to get drunk before they get the interview for their SSI completed. I see this over and over, seems very punitive and very costly. Usually for a while they lose all benefits, end up in ER, and get jailed. Just pushes them further away from the help they could receive. Under tribal evaluation and treatment that needs to be addressed for the people who need disability status.

**Cindy** – a prime component is housing. Many addicted people end up with felonies and it's almost impossible for them to get housing. So as you discuss the health care model – there needs to be a focus on getting housing. Imagine not having a home to go to at night, how would you be stable? This needs to be part of the discussion also.

A: PAC model – was looking at housing but it was a drain on resources.

**Cindy Robison** – is the PACT model being looked at and is that being looked at in the Tribal models. Program for Assertive Community Treatment (PACT) or hospital without walls. Person stays in the community and care is wrapped around them – is an intensive care model – nurses, prescribers, vocational specialist, chemical dependency specialist, etc. A team of 14 can serve around 100 people in a community. Need to maintain a 1 to 10 ratio of providers to clients.

**Steve Kutz** (Cowlitz) – we have a pact team in our community too. All that's required to have a high user in their ER or hospital system and then they want to develop a pact team. Pact team can be very efficient in coordinating care for a patient if you get everyone at the table and on board, including the patient. For one community member they are beginning to plan for the release of a client from prison to best serve the client and the community.

**Ed Fox** – disability lifeline – where do those dollars come from? **Roger Gantz** response - The legislation calls out for those who used to be on GAU they have access to mental health. When provider one is up and running will need to build in the capacity for AIAN have access to mental health care – don't have that right now. For those who need chemical dependency tx they must be willing and ready to seek tx or they will lose their eligibility status. **Ed Fox** - We run a tx center are we going to have more demand or go out of business?

**Kimberly Miller**– I want to put my hands up to David – he doesn't just talk, he offers and puts up ideas. He also shares his experiences of what he's seen out there in the field. Not just sitting there doing his job. [clapping]

**Marily Scott – closing.** I want to thank David as well. I learned another way of providing services in the mental health realm – from what you shared this morning it sounds like there are other opportunities. I can feel the ideas forming based on what you shared. I want to

share with the group and assist in wrapping up the discussion – I am listening to the idea of trauma focused care. Now that we know this I think that many of our tribal communities have been doing – but we typically haven't had the facilities in which to do the care.

There are tribes in the state that are working with aging and disability services to develop adult family homes on the reservations. We are looking at how we can fund those types of facilities because most of our people who need long term care are not willing to go to long-term care. But if we can develop adult homes in our communities; that would be ideal. If we can get a track moving for looking at existing tribal programs and expanding it to include mental health evaluation and tx.... Need to add the components that would meet the requirements for ENT that David Reed described. Would be a priority to look at having mental health staff that can meet both substance abuse and mental health needs. Exciting to hear the descriptions of what is out there – it's hopeful.

### **Communications – Dave Reed, Kimberly Miller, Colleen Cawston**

Colleen introduced Doug Porter, Kimberly Miller and .

**Doug** said as few things from today as possible will change. Things that are working now will continue. Doug will continue to be responsible for the payment system for Medicaid, interagency cooperative effort, Health care Cabinet. Steve Hill, (retirement systems), Mary Selecky, Susan Dreyfus, maybe DOC in the future. Medicaid Director and HCA Administrator. Went over the new org chart. Will take at least a year to sort and make proposal to legislature for what other functions will stay at HCA or move to HCA. May know by fall. Talking with legislators, Tribes, Providers, Advocacy groups. Will talk to the tribes about soliciting their input.

Transition. Everyone working in that administration sit at Cherry Street Plaza, lots of cross training and knowledge transfer, better integrated services. They will not move to Lacey, but will stay as they currently are collocated. Richard Kellogg will report to Chief of Staff Tracy Guerin.

Committed to making the current process continue moving forward and will continue to make Roger Gantz available for the process.

**David Reed:** process not working for communication, and not necessarily at the RSN level. Many of the people at the last meeting had not heard of denial letters from RSNs about a hospital denying services. Letter is required with appeal process. RSN medical director, a psychiatrist, is the only one who can deny. About a yr and a half ago regulations changed for RSN and inpatient facility so no denials could happen without this process. Request for hospitalization can only happen from admitting facility. However, if inpatient facility is far from patient, family has to drive patient to facility for interview, and possibly be denied admission. The hospitalization request no longer has to originate at the facility, but not sure where it now can originate. Will have someone at next meeting to explain. RSN authorizes inpatient management, hospitals might not admit without authorization of payment. Case managers CANNOT make a denial. Will need to make system where if the person saying no must be the RSN authorizer. Providers down the chain cannot say no. If they do you don't get the denial letter, can't appeal, system doesn't work for appeal.

Can request authorization from field, not once they get to hospital. Voluntary vs. involuntary: after ruling out alternatives can authorize voluntary or involuntary for hospitalization. When we meet with hospitalization guy, will look at different authorization processes for different RSNs. Some don't have beds, will try to not transport to hospital if there are no beds. Without authorization number, it is not authorized. If someone says no, ask: are you speaking for the RSN and is this a denial. If they say no, ask to speak with the RSN for formal request. A clinical opinion is not a formal "no".

Who is giving the authorization: BHO, 24/7, contracted to do inpt and out pt authorization. Will issue an authorization number for admission if approved.

Would the process work the same for non Medicaid clients for an inpatient admission? If the person has no resources or funding, or if they have Medicare, often the authorization is requested in case there is no other insurance, etc. something is added to the authorization number to cover the person in case they would be authorized.

**Steve Kutz:** people with multiple crisis events, suicidal deemed by tribal tx providers who know them well, now engaging with the system that has no background knowledge. They are now talking the patient out of voluntarily committing themselves, is that accurate? The tribal tx staff and the family know, but the provider or authorizer doesn't? State calls it finding a less restrictive alternative. In involuntary tx, the DMHP has to rule out any less restrictive treatment first. People lose civil liberties with involuntary treatment. Usually family and community have information the DMHP doesn't have. One thing that needs to happen is the DMHP asks for collateral information. Families should fill out affidavits to make sure the case will hold up in court if necessary. Must withstand scrutiny of courts and commissioner.

Linda Thomas: they are supposed to investigate, which included talking to other professionals, get a history. Every DMHP may view it differently. If a person is afraid of the client, that counts as "danger to others". Investigations are not always as thorough as they need to be. Person might not be detained but family would still be afraid of the person and their lives disrupted. The difference in DMHP perceptions can be a problem in not getting the same experience.

**Robin Sigo:** we do all we can to help that person avoid the ER, by the time they get to that point, they meet with the DMHP for a short time and are denied based on too little time observing, etc. We spend lots of time working with this person to voluntarily commit, only to have the DMHP suggest they do something else, which has already been tried. Sometimes it feels they are erring on the side of cutting costs.

**Colleen -action items:**

- presentation from David Johnson from DBHR at next meeting
- ID who from RSN can make the authorization. That way they can do their due diligence with maybe a checklist from tribe.
- Copies of affidavits to have prepared when meet with DMHP, preparation already done.
- Can also provide DMHP protocols, how they do investing, what needs to be done.

**Jim Sherrill:** DMHP vs ?? has been involved in involuntary commitments, thought solution to roadblocks would be to have own DMHP, still not convinced it's not true. Would you give us the same advice to ask the DMHP whether they are speaking for the RSN or how to get hold of them? David: for involvement: **if DMHP says they don't meet criteria, cannot be appealed to RSN.**

Evaluation is to be in the moment, so if you have it reevaluated, get a different DMHP. RSN gives different authorization number for each person detained. For transport to hospital, authorization number tells admitting hospital there is payment authorized.

**Avreayl:** when we worked on this a few years ago, for IHS to access authorization, the tribe needs denial letter to access IHS dollars.

Kimberly thanked Doug Porter for continuing to work with the group. It's hard to make it to all meetings so when meetings are cancelled at 5:15 the night before, it adds to the challenge. We are thankful Doug has committed to making sure the progress continues without this sort of roadblocks.

Liz called Marilyn up.

### **Tribal Models: Liz and Marilyn**

**Colleen:** the core group that has been meeting doesn't know ALL the nuances. We don't want to create any canyons that people will fall in and not get services. From your perspective, what works and what doesn't? Want to create system that will serve all, no matter where they live.

**Marilyn:** other purpose of this topic is to give opportunity for those of you who have participated in the process to share with us some of the programs that are currently serving rural, urban and other Indians, what has been going on to meet the needs of our community members no matter what setting. In the orig. meeting at GWL, we said we hoped to develop system to meet needs of all members, while tribes hope to access services wherever the people live, as if they were getting them from the tribal facilities. Has gotten

calls from tribal members in other states who are seeking services where they are and she's had to look for HIS facilities there. Wants to build system that will be available no matter where. Mentioned work of NATIVE Project and AICC. Know they have services available to the urban Indians in their area, also SIHB, UIATF. But we are not always sure where to access, what services are available. Develop matrix of services available and where gaps are – inventory of what services are available in what areas.

Linda, as CDP, the Green Book DASA puts out is reliable reference for services. Seems like that wouldn't be hard to replicate for Tribal programs. Provide name and contact information.

**Jim:** before we start going into what services we have available, would like you to do when you talk about what is available and working, keep in mind our silent warriors returning from Iraq and Afghanistan, remember what they need. They are coming back with much pain and many are silent. Might be jailed for something that has nothing to do with their jailable behavior.

**Liz:** at Jamestown, we took our HIS dollars and bought insurance for our tribal members. HIS didn't cover it all so we pitched in with \$\$ from the casinos and other businesses to supplement it. Looked at eligibility for basic health, etc. We have a manager who does nothing else but figure out which ins. Plan is best for each. They must live in our service area thought. Many of our population live in urban areas so there are not so many resources available for them. We have set aside an amount for each member, no matter where they live, to help pay copays, insurance premiums, dental or whatever. They just have to send their receipts. With healthcare reform, we'll see what happens, but recognize people have to live where the jobs are. **Shirley:** how many members benefit? 600 members, 200 in service area. Also didn't get very many health service dollars being recognized late in the game.

**Cindy:** in Spokane, Native Health is a HQSC; we are obligated to serve everyone. They will be billed if they don't have health insurance. We do have a resource specialist who will help find resources. Have a CSO worker onsite who will help people determine eligibility for state/fed programs. Resource list would be very helpful, such as what Liz just described. When people see me they might not be tracking too well, it would be helpful to know this information.

**Marilyn:** another barrier is co-occurring disorders – individual might be coming in to access CD services, maybe court ordered, as assessment is being done to id level of care needed. Sometimes during assessment might ID further need for MH services. Client might have problem besides CD, is ongoing issue for tribal programs. Hope the system we are developing can address how some of the programs, evaluation and tx David described might work to ID allowable crossovers. Lummi youth programs, funding, youth academy, home for CE, safe home, one of the things we discussed is if they had the facility capacity to expand youth academy, to consider the evaluation and tx, have some of the staffing that

would match. Was picking the tribal rep brain on how they operate their brain that could benefit the programs in our areas. At Upper Skagit is maxed out in their development, want to develop waste treatment plant to increase capability at the tribe, but are restricted in developing more facilities in existing base. Know neighboring tribes operate programs and their physical plant allows them to expand. If they could serve additional tribes in the area would be a workable model to explore. Pull together to offer services to other tribes

**Bob Brisbois** – director of IHS has directed her agencies to coordinate across agencies. Our core work group could check to see how much progress IHS has made and possibly build on their successes. My wife and I are both Tribal members and when we need services we Google clinics to see where they get their funds and how they use them. There are a lot of different models out there already that we can look at. Another idea is a regional tribal facility – would have to have an appropriations committee to work on that to identify funding sources.

**Ed Fox (Squaxin Island)** – in some states the state has ponied up to build a tribal facility. When Sheryl Lowe met with health chairs and Senators McCoy and Kauffman it looked like they didn't all know that could get 100% reimbursement at a tribal facility

**Steve Kutz (Cowlitz)** – one of the topics that was brought up in our work groups was something that David brought up where the mental health inpatient facility was put together in a model that was inviting rather than punitive. When our patients currently go to an inpatient facility forget about any cultural sensitivity our patients are treated like prisoners – is a good model.

**David** – facilities like that are built on the premise or belief that the patient or guest know what's best for them as do their families. Patients and families know what is best for them (rather than having us push our college wisdom on them). We also need to stop convincing people that they are broken. Need to instill hope and that they will get through this bad phase.

**Jim Sherrill (Cowlitz)** – Attend to mental health activities I've been involved in with regards to veterans. There were a number of us invited to participate in workgroups to go back east and begin to develop plans for how to deal with returning veterans. We were the only state that had any tribal representation. Also, there was no representation from IHS. We came back and began meetings but it felt like we weren't being taken seriously. In WA State we have a WA state dept of veteran's affairs that agency provides mental health services to veterans. We need to know about that and we should have them at our AIHC meeting to learn more about that and those services. Also, there is VISIN 20 which is a collaboration between the VA and IHS – that is another entity that has been dysfunctional. At the next NPAIHB meeting we need to remind Donny that this is an effort that should be going forward. In Centralia the VA announced that they're opening up a clinic. I've been advocating that the VA look at tribal clinics as a venue to provide services.

**Kimberly Miller (Skokomish)** – During this time together I appreciate all of this information and I wonder how people who have been working on this are feeling – are we repeating things? It is important to use this history as education to make small steps forward. We at Skokomish are ready to help. If anyone has a story to share about a success in their community please share it with us. We can have all the programs you want but they won't be successful if you don't involve the families. We as tribal members have a responsibility

to move our successes and programs forward. That's had a larger impact on what we could have done as service providers.

**Liz Mueller (Jamestown S'Klallam)** – we have that on our agenda for tomorrow, to collect those stories.

**Kevin Collins (Nooksack)** – we go to a lot of trouble to put in elaborate systems, medical, dental, mental health, CD. A client comes in and we put them in the center of client centered treatment and wrap-around. What's missing is uniform and consistent funding. We have to look at the acronym on their coupon or insurance card and have to divide up their services financially. A good story – I was asked, what do you know about PTSD? I know what I learned in college – Elders said that's not enough. The Elders identified a person who is a Vietnam vet as a liaison who set up a training. 8 PhD's came out for a full day to provide a training on PTSD and also were interested in setting up some networking to try to provide services closer to home.

**Cheryl Sanders (Lummi)** – I don't know how to stress this more about the communication – we get bombarded with emails and other forms of communication. We need to work on communication as we move through this health reform. Hands up to providers as you are all in the trenches. The tribes were working together in the interest of the children and family and the state doesn't get that. I applaud you ladies (Liz, Marilyn, Colleen) for all the work you do - you have been serving us for many years.

**Jim Sijhon (Spokane)** – I want to speak to Jim Sherrill's comments. Thank you for sharing your experience with the committees for veteran's – and no need to apologize – you tried. Right at this point in time I have a grandson who is in Afghanistan – been there 6 months. He sent a picture and he looked okay, then another picture and he looked okay. But I have a brother who was in Vietnam; he has many medical problems that can be possibly related to Agent Orange. When my brother came back there wasn't much for him. I don't want to see that happen to anybody's grandson or granddaughter. And who is going to make sure that happens? It's us – the AIHC, IPAC. Jim shared a moving story about a Vietnam vet.

### **Future Meeting with Tribes/RAIOs and RSNs Greg Twiddy, HRSA**

Next meetings to develop Tribal Centric Behavioral Health System are May 18 & June 15

Last fall at the last meeting there wasn't much representation from the RSNs – not sure we got a lot out of that one. History hasn't been very good between the tribes and RSNs – we are to help build a better system.

When do we want to meet with the RSNs next – do we want to do that soon?  
When would be a good time?

**Greg Twiddy** – RSN's meet at 3<sup>rd</sup> Thursday of every month. Might be a good idea to get this on the agenda for ½ day.

**Steve Kutz (Cowlitz)** – our RSN's wanted to attend this meeting and would have attended this meeting. I told them they weren't invited. I told them that the tribes are all trying to get

together on the same page before we meet with the RSN's. I asked our RSN if the RSN's are talking about this at their meetings and they said yes.

**Ann** – I don't know how many tribes are in the middle of election season – but it seems like it might be good to organize something for June or mid-July. Mid-July might be better – our tribe for instance, we have a swearing in around July 10 or so.

**Greg Twiddy** – Canoe journey is in July – might want to look after that time, or before then – if possible. Any other input? Is it even practical or effective to meet with the RSNs at this time?

**Marilyn Scott** – what is our primary goal for the next workgroup meeting scheduled May 18? What is the primary goal for that work group meeting? I see on the handout that there is no meeting in July – because of the Canoe Journey. I think it is imperative that we get the funding for the position – and get some of the work plan/tasks laid out. And then bring the RSNs into the process once we've started the work on the inventory and determined what the Tribes want to move forward with – and establish subcommittees. We also need to participate with our tribal service providers when doing our inventory – and also need to engage with tribal leaders as we look at the changes with the national health reform and what the states are doing, and discuss what the tribes are planning to do to restructure their mental health/behavioral health services. So what are we going to do May 18 – after that we could then invite the RSNs to the table.

**GT** – so we should talk about meeting with the RSNs after the May 18 mtg. As far as the May 18 meeting – David Johnson was going to talk about some of the hospitalization issues. Might also be a good time right now to discuss what we want on that agenda?

**Kimberly Miller** – wanted to say that it would be history again, but at the Great Wolf Lodge it was eye opening for the RSNs to see what some of them were doing and the others weren't. I think that couldn't hurt. Well we have our own meeting with them to keep that relationship going, but I do think we've had some great relationships things happen since that meeting that wouldn't have happened if we hadn't met. I would like to have a meeting involving the RSNs whenever everyone else thinks it would be reasonable.

**Colleen Anderson, Colville.** At the Wolf Lodge meeting, none of our Eastern RSN people showed up – if you recall. If we have another meeting – would they show up? Can you inspire them to be there?

**GT** – not sure we can inspire them, but we can certainly ask.

**Marilyn Scott** – if they meet the 3<sup>rd</sup> Thursday (RSNs) – so for the June 15<sup>th</sup> meeting, is there any reason that we couldn't also plan for a half day (June 17<sup>th</sup>) to go to the RSN meeting when they regularly meet? At the May 18<sup>th</sup> meeting talk we could work on the work plan and start the inventory process from the Tribal perspective – and we could also discuss what we could talk to the RSNs about in regards to crisis management and patient care. That way they would know ahead of time what the tribes want to talk about on the day of their regular meeting.

**GT** – sounds like a great idea, if we can get on their agenda.

**Colleen Anderson (Colville)** - Affiliated Tribes meets that same week of ATNI – can prove a challenge for some Tribal leaders with that conflict.

**GT** – at the May 18 meeting we will develop an agenda for the prospective meeting with the RSN at their regular June 17 meeting. As far as our May 18 meeting, we will talk about hospitalization as well as the RSN meeting agenda. If there is anything else you want on the agenda, do let us know and we'll get it on there as well.

I wanted to remind you that if things aren't going well – please do contact us. We recently had good success with the Spokane tribe recently. Trying to reach out more so that we can improve the existing system and make it more productive for all of you. So issues with the RSNs or whatever – we are waiting for your phone call.

**Steve Kutz (Cowlitz)** – I was just wanting to say that we're continuing to have conversations with our RSN about how it's going and will continue to do so. That's one way to develop a working relationship. Our RSN is still interested in continuing to have these discussions. Just call them up and talk with them.

## **NEXT STEPS**

**Doug Porter, Marilyn Scott**

**Marilyn Scott** – the info that Doug shared with the group addressed some of the things that there were questions about re: next steps. When you put the blank slate out to the tribes and said, okay what we have is not working, what would the tribes like to do – what would that look like. This meeting is a follow-up to that invitation/challenge. Do the tribes still want to move forward looking at a waiver to allow the tribes to develop a tribal centric system? Another change has been announced since that challenge in September and brought up a lot of questions about next steps with regards to the development of the mental health system.

**Doug Porter** – I don't know where the responsibility for mental health services will end up. I'm going to act as if it will be my responsibility. I to keep moving forward with this.

**Bob Brisbois** – 1) if we're moving forward, do you have any money to throw into the pool to the tribes, AIHC, and IPAC to assist with this, 2) how much, 3) when, 4) who would you recommend as the lead agency to employ the individual?

**Doug Porter** – Roger told me this might come up – \$65,000 is the amount of money we have to put on the table. Who gets hired, or if it's a contract person – that would be up to you. You tell me who I should get the money to in order to get this thing going. When? As soon as possible.

**Steve Kutz** – as the tribes sit here and start looking at their options, say something magically came up in 4-5 months that looked promising that the tribes were ready to move forward with – how much lead time would the state need to be responsive to move forward

**Doug Porter** - By November we should have a pretty firm idea of what the plan ought to be, we can put place holders in place until then.

**Colleen Anderson** – I guess I feel really strongly that we want to move forward with our initiative to have DTMHP to hospitalize. Our culture isn't going to go away, it's not going to change much, and I don't see people leaving our reservations. I think we need to keep the DTMHP in our sights.

**Bob Bribois** – Just wanted to follow up on the 65K that we have access to. Has there been a position description created yet? (NO) So Liz and Marilyn, how can we partner with other agencies to get this position to work for us – to start working on the short and long term goals that this meeting has identified?

**Liz Mueller** – I would think that one of the things that we could offer with IPAC and the Health board is to talk about what would be important to us and then relay that to Doug so that a job description can be developed from that.

**Helen Fenrich** – is this a one time fund? Or is going to be ongoing?

**Roger Gantz** – This is a one time fund that isn't continuing.

**Kimberly Miller (Skokomish)** – the idea of this position is to keep the momentum moving forward to keep us on track, correct? Yes.

**Colleen Anderson** – is there anything we can do to lobby for the waiver?

**Doug Porter** - You all have some pretty good connections back East that we could probably leverage. Let's make sure we coordinate that.

**Roger Gantz** – the concept of having some resources, e.g. the \$65K came from our workgroup meetings when tribal leaders that we need to do an assessment of the resources available today – need to understand the current layout. The dollars were planned to be used for that. Also, to have tribal leaders provide key attributes they would like to see in the improved and revised TMH system. If the need to move forward with certain issues – strong about TMHP and needing to develop strategies to make admissions to inpatient psychiatric facility and equally important to have strong discharge plans. Those two concepts are the ones that we feel we should go forward with now, and after we've had a chance to have more dialogue.

**Marilyn Scott** – one of the other things as a next step is looking at our list of short term and long-term goals. I think some of those short-term items that were identified yesterday were immediate assessment of appeals. That is one of the items that David said we have planned as a presentation at the May meeting. So it falls right in long with the short term –

we need to look at that immediately. That needs to be part of our agenda for the May 18 meeting. Also when Port Gamble talked about the contract obligations that are in the RSN contracts – Port Gamble had been asked to waive their sovereign immunity to enter a contract with the RSN. There are ways that the state can hold the RSNs accountable and that is not something that is allowable. Those are two of the short-term items that I had noted – but I think it is imperative that we review that list and discuss what we want to look at next. We want to also start the process with getting the funds (\$65K) mobilized to keep this ball rolling.

**Liz Mueller** – I'd really like to take some time today to identify what are our next steps – what are we looking for with that \$65K

**Steve Kutz (Cowlitz)** – as we're having a meeting on the 18<sup>th</sup> and we're going to discuss this hospitalization and not all of the tribes are here today. Have all of the tribes been getting this information, had a chance to review and provide input? **We need to assess whether or not the information is getting to everyone it needs to.**

**Liz Mueller** – This is where it's really critical where we as IPAC and AIHC delegates that when we get the information, we make sure it's getting out to everyone also because I know that sometimes I get so many emails that I see them but I don't necessarily always pass them on. I know between Debra Sousa and Cheryl and Colleen and many more that we get a lot of that information out. If people in the room are NOT getting enough information, let your AIHC and IPAC delegate know – that would be very helpful.

**Jim Sherrill (Cowlitz)** – how do we move ahead, establish a position, and get that \$65K moving forward. I see two entities in the room that can do that – contract with DSHS and AIHC that seem like the two most obvious options.

**Bob Bribois** – I'm not sure if it's important for an entity to bring forward a motion. I think what we need to do – we need to find a partner that could match, so that we have money for travel and everything else that will be needed. But the first thing I would ask our two honorable chairwomen to do is appoint a work group to develop a draft Position Description to give to Doug Porter so that we can start moving forward (even tonight if possible) Tomorrow I'd like AIHC and IPAC decide who they want to lead this project. I think together we could develop a vision for this and ask for a timeline and start preparing deliverables.

**Liz Mueller** – when I was talking with Secretary Dreyfuss we were talking about this and the AIHC would be the entity working directly with the HCA. That doesn't mean that IPAC is out but this is really in the arena with what the AIHC does. It can get confusing with too many agencies. You in the room are the ones that can comment on that.

**Jim Roberts** – the board has been approached by the Commission r.e. whether we would be willing to participate in this – we will. Whatever the mechanism, we will bring out expertise. We do have resources – so we'd be willing to match the \$65K for this new position. I just wanted to put that out there. I myself think it's going to take at least \$100K to get this done. And I don't think it's just going to fund a PD – I see this as being a coordinated approach of several types of deliverables, tasks – i.e. the inventory. Looking at the system we are trying to develop – and seeing how it relates to the Indian Health Care

Improvement Act. There are a lot of pieces that need to be put together – through the use of several different consultants with expertise in different areas.

**Carleen Anderson** - I think it would be incumbent upon us to have the expertise of the NPAIHB for this endeavor.

**Marilyn Scott** -NW Portland Area Indian Health Board works for the tribes of the NW – the NWIPHB has expertise and the contacts to be able to identify resources as well as the tribal leadership that regularly lobbies at the national level for the federal dollars for money to come to Indian communities in the states. We need to keep in mind what is going on at the national level and hold the state accountable for what the federal government sets in place. When I had a meeting with secretary Dreyfus last week, one of the things we talked about was how the continued work for DSHS with the new health cabinet is going to look different. I don't want to deny the work that the Indian policy, AIHC and NPAIHB are doing – we are all working towards the same goal. The capacity of the AIHC – I have one staff, the director. We have been continually trying to get new funding to continue the policy work we are attempting to do in WA State. We do not have the funding to do a major project like this. So it was when I talked with Secretary Dreyfus about eh new cabinet and Medicare moving over to the HCA. But the division of mental health is going to remain in DSHS. I felt that the potential for matching the supp we not only need a facilitator – we also need a legal advisor. We would also need the technical assistance support that I think the NPAIHB can provide to look at this new way of doing business. The tribes of WA have been working with the state on Medicaid administrative match for I don't know how many years. We aren't willing to let it go – we still are going forward as if we do have that approval – the plan has not been approved, we continue to revise it. If the tribes agree – the NPAIHB could be the entity that could help us move forward with this work.

**Liz Mueller** – I think that tomorrow the IPAC and AIHC delegates can vote on this tomorrow. We will probably hold more joint meetings over the next couple of years as it is important that we are working together. We've had a great couple of days and thanks to all of you for that.

Jim Sijhon – how many tribal leaders do we have in this room right now? (6-7). This is what I'd like to say to you ladies. I think tomorrow morning the Tribal leaders should have a quick discussion about what we've been talking about for the past 20 minutes. Tribal leaders will convene at 8am after breakfast for 20 minutes and then the IPAC meeting will begin.