PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Annual Tribal Health Convening

October 7, 2024

ACCREDITED NCQA HEALTH PLAN

Land Acknowledgment

- Tribal land of the Nisenan people
- Gathering place for many local Tribes
  - Southern Maidu people to the North
  - Valley and Plains Miwok/ Me-Wuk Peoples to the South
  - Patwin Wintun Peoples to the West
- Wilton Rancheria, in Sacramento County.

Sacramento River

Introductions

Partners in health: *The illustration above, as described by the artist, honors the heritage of the Tribal communities served by Partnership. The use of watercolor reflects a deep respect for the earth and its healing properties. Baskets represent the foundation of many tribal cultures. The woven basket design symbolizes unity among tribes; the hands show care and assistance; and the four feathers stand for the four corners of the earth.*

– Design by Loren Lavine (Hoopa)

- Name
- Any Tribal Affiliations
- Organization
- Position

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Partnership Updates

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About Us

Partnership is a County Organized Health Systems (COHS) Plan

Non-Profit Public Plan

Low administrative costs allows for Partnership to have a higher provider reimbursement rate and support community initiatives

Local Control and Autonomy

A local governance that is sensitive and responsive to the area's healthcare needs

Community Involvement

Advisory boards that participate in collective decision making regarding the direction of the plan.

About Us

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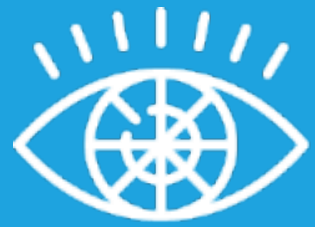
MISSION

To help our members, and the communities we serve, be healthy



VISION

To be the most highly regarded managed care plan in California

MEMBERS

897,543

(As of Aug. 2024)

POPULATION

28% of all residents in our 24-county service area are Partnership members

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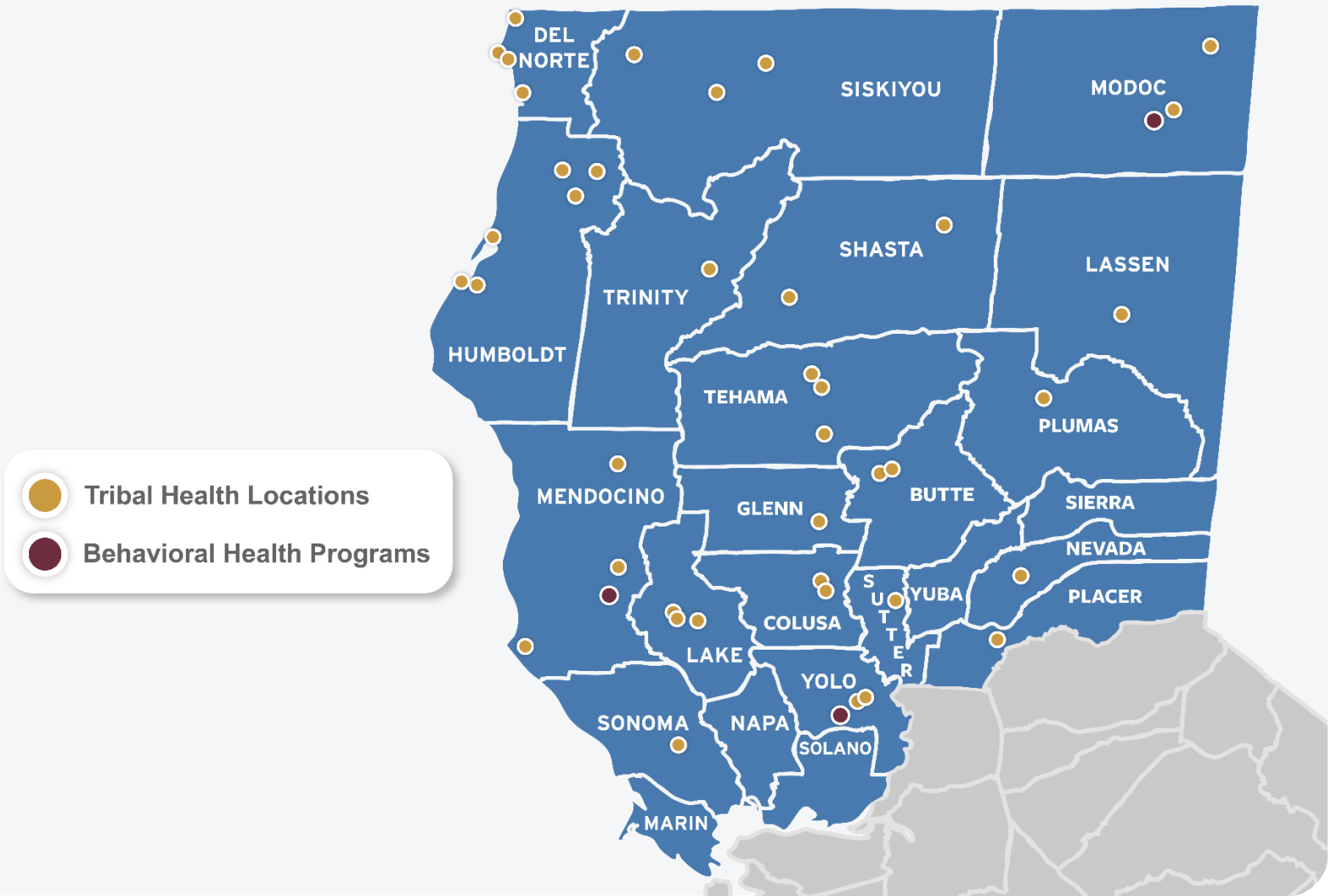
Tribal Health Centers

Partnership Service Area – Tribal Health



Tribal Health Centers

- 21 Organizations
- 50 sites

Tribes

- 51 Federally recognized
- 8 Non-federally recognized

Tribal Involvement with CalAIM

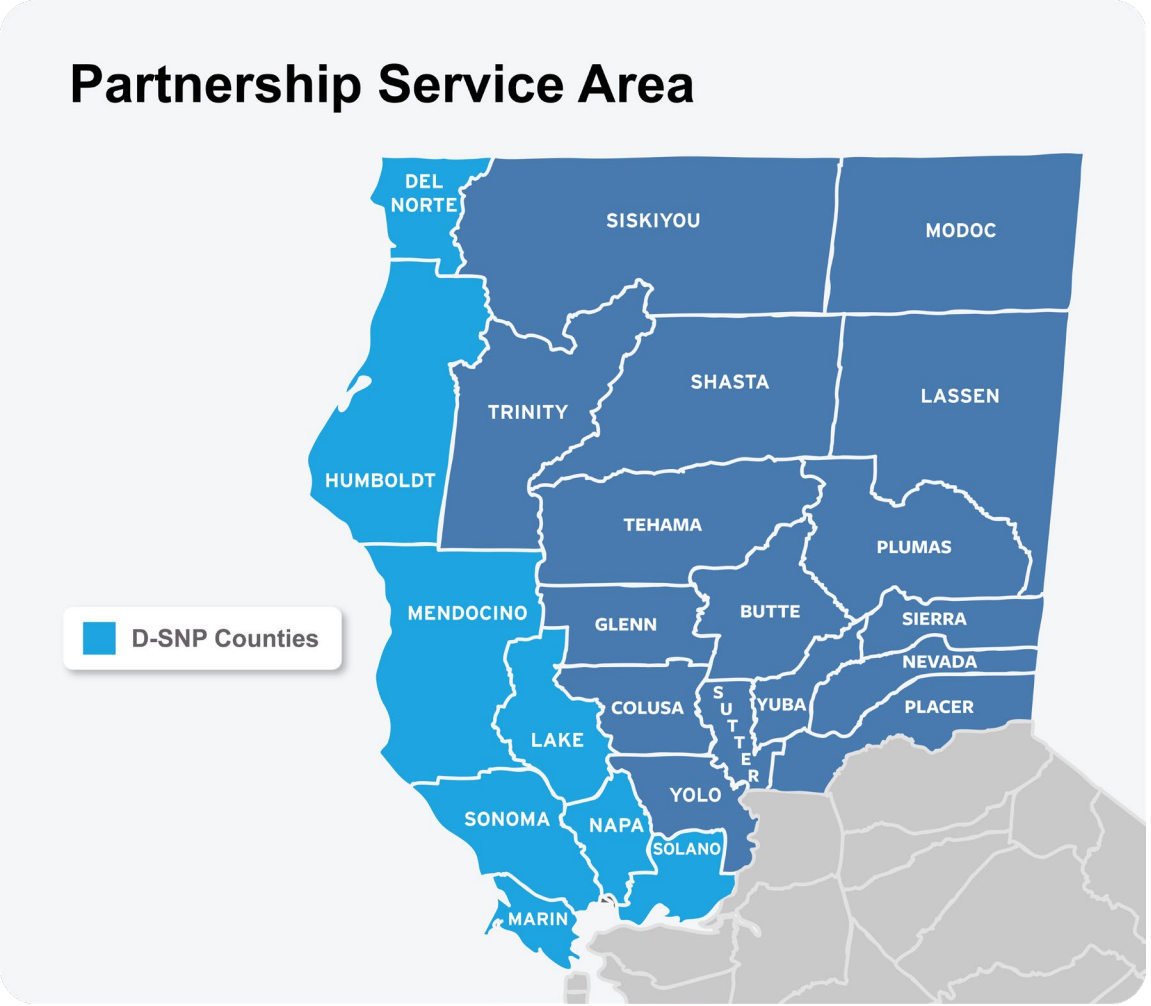
- Enhanced Care Management
  - Fully contracted, pending start: three Tribal health centers and one community based organization (CBO)
    - Chapa De Indian Health
    - Northern Valley Indian Health
    - Pit River Health Service
    - Indigenous Wellness Alliance, Inc.(IWA)
  - Contracting pending: One Tribal health center and two tribes
    - Sonoma County Indian Health
    - Karuk Tribe
    - Blue Lake Rancheria
- Community Supports
  - Contracted: Kee-Cha-E-Nar (Yurok), Indigenous Wellness Alliance (also ECM)
  - Contracted, pending start: Northern Circle Indian Housing Authority, IWA,
  - Groups expressing interest: Lake County Tribal Health, Greenville Rancheria, Hoopa Tribe, Cahto Tribe
- *Information as of September 6, 2024.* We encourage additional Tribes and Tribal health centers to join.

Equity Practice Transformation Program

- Eight tribal health centers in the Partnership region applied; all were selected.
- The funding was cut by DHCS due to the state budget shortfall, but it was designed to mitigate the effect on smaller health centers, like tribal health centers.
- The funding available is between $250,000 and $570,000, depending on the size of the health center.
- A total of $2,623,620 is available for all eight Tribal health centers.
- The first check/payment is delayed into 2025.
- Partnership Performance Improvement staff and Indigenous Pact will work with these eight sites to help meet the goals.
- Trainings on Practice Transformation topics has started; attendance is mandatory for some trainings

(For details see handout in packet.)

Medicare: Partnership Advantage



Phase 1: January 1, 2026

- Partnership Advantage is a Dual Special Needs Plan (D-SNP) that will allow Partnership to cover Medi-Cal and Medicare services for members who are eligible for both programs.
- Initial phase will go live in eight counties on January 1, 2024. Other counties will follow in 2026 and beyond.
- Having one insurance combining these two coverages will result in better efficiency and better coordination of care.
- Partnership is hosting a roundtable for the eight Tribal Health Centers in phase 1 on October 22, 2024.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Tribal Liaison Remarks
Yolanda Latham, MBA
Hupa, Chilula
Partnership Tribal Liaison

Partnership Tribal Liaison

Reduce tribal community fatigue by aligning with other similar initiatives, assessments and community lead interventions.

Deepen the relationship between Partnership, tribal public health and other tribal partners.

PARTNERSHIP TRIBAL LIAISON

Promote a deeper understanding of tribal needs and indigenous social determinants of health

Support tribal health's response to emerging trends, especially in areas where Partnership can intervene by providing coverage, education and outreach.

Major Activities (Past Year)

- Tribal Perinatal Program
  - Three roundtables
- Other roundtables
  - Tribal health equity data
  - Electronic health records
- Participation in state and national meetings related to tribal health policy
- Internal Partnership Activities
  - Partnership Education
    - Day-long training of Partnership managers and leaders on American Indian history, policy and health policy (conducted by Indigenous Pact)
    - Keynote speech for leadership retreat
  - Several departmental trainings

Theme for today and year to come

Partnering with Tribes to Support Public Health

Pillars:

1. Building a strong Native health workforce
2. Supporting wellness and addressing behavioral health needs
3. Improving access to helpful data

Listening Session I

Facilitator:
Yolanda Latham, MBA
Partnership's Tribal Liaison

Tribal Health Center Updates

- Major updates in the past year (new sites, major leadership changes)
- Focus for the year to come
- One major unmet need that you would like help with

American River in the Autumn

Break

- Break for 15 minutes

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Data Integrity and Sovereignty

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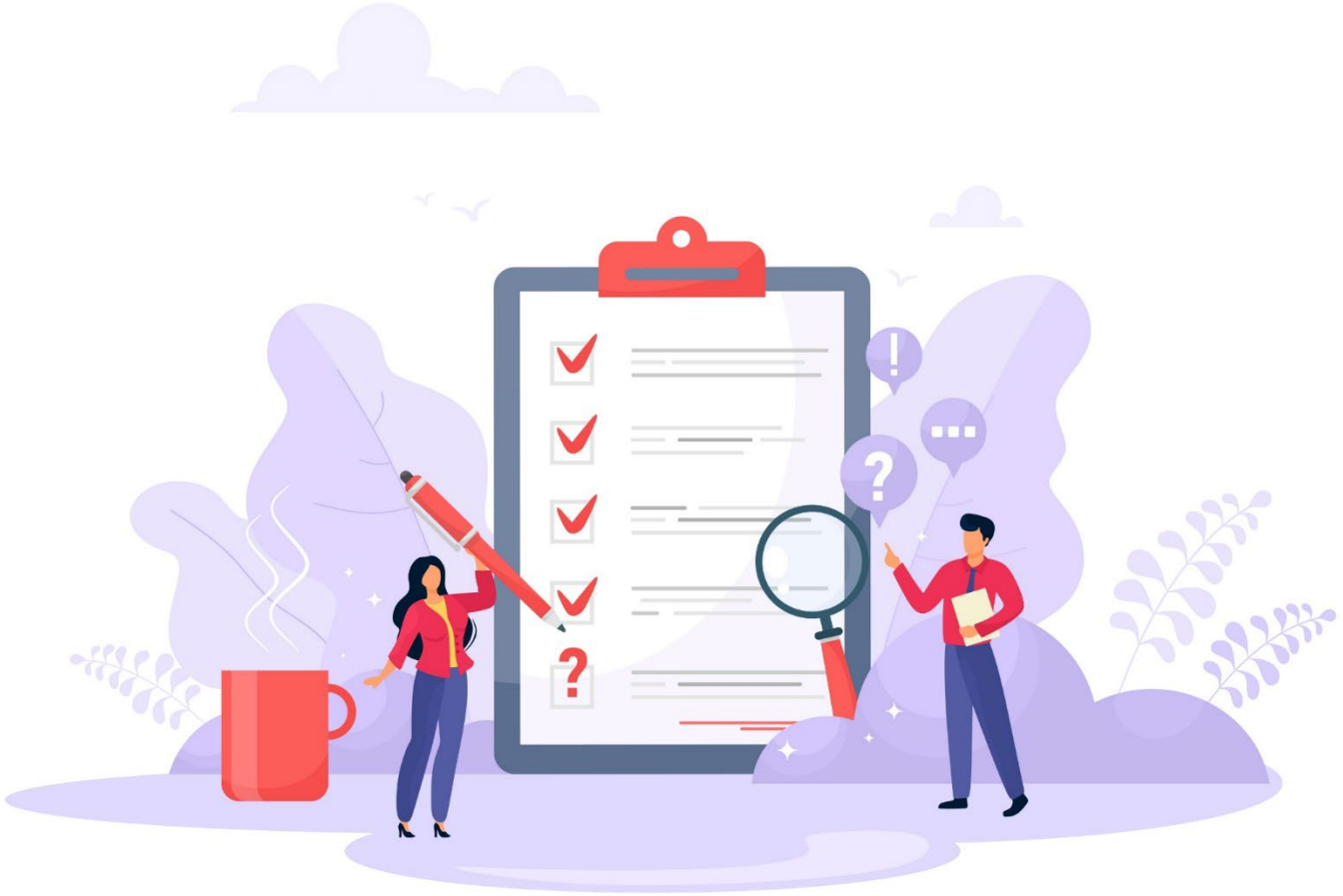
Topics

- Medi-Cal Undercounting of American Indian/Alaska Natives
- Data Sovereignty
- Public Health Data Sharing

Handouts



Partnership's Commitment to Health Equity

- We acknowledge the historic and systemic forms of erasure that our Tribal communities have endured. Partnership is committed to creating lasting bonds between our health plan and the Tribal communities we serve. By working to address and confront health inequities and disparities, our goal is to create more seamless access to care for our Tribal members and communities.

Systematic Undercounting of AI/AN

- In July, 2024 DHCS reported that, as of April 2024, there were:
- 14,981,547 Californians with Medi-Cal, but only 50,996 of them were classified as being Native American or Alaska Native:

Race/Ethnicity	Number of Certified Eligibles	Percentage of Total
African-American	1,022,292	6.8%
American Indian/Alaskan Native	50,996	0.3%
Asian/Pacific Islander	1,393,671	9.3%
Hispanic	7,710,166	51.5%
Not Reported	2,408,724	16.1%
White	2,395,698	16.0%
Total	14,981,547	100.0%

Department of Health Care Services, July 2024. Medi-Cal at a Glance, April 2024 as of the MEDS Cut-off for July 2024. California Department of Health Care Services

https://www.dhcs.ca.gov/dataandstats/statistics/Documents/Medi-Cal-at-a-Glance-Apr2024.pdf

Census Data Not Consistent with DHCS data

- 2020 Census of the California population
  - 1.6% identified as AI/AN alone
  - Additional 2.0% identified as AI/AN in combination with some other race.
  - Total **3.6%**
- If we assume the proportion of AI/AN with Medi-Cal is about the same as the population as a whole, then about **3.6%** of the Medi-Cal population should be identified as AI/AN, not **0.3%.**
- **This represents a 12-fold undercounting. Put another way, the true number of AI/AN with Medi-Cal is 1200% higher that that presented by DHCS.**
- This means the number of individuals state-wide with Medi-Cal who identify as fully or partly AI/AN is approximately **600,000** instead of **50,000.**

Impact of Undercounting AI/AN

- Erroneous framing in Native and non-Native populations
- Insufficient prioritization of policies
- Inequitable resource allocation
- Incorrect conclusions drawn from invalid data

- The current method of conveying racial data was implemented before the current DHCS tribal consultation process (2009 and 2011).

https://www.dhcs.ca.gov/Documents/Tribal-Engagement-Plan.pdf

Why is the DHCS Number So Low?

Better data is collected on the Medi-Cal application:

Page 4 of the Medi-Cal application:

Tell us about your race *This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide what health insurance you qualify for.*

What is your race? *(optional; check all that apply)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other _____

Are you of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No

If yes, check which ones:

- ☐ Mexican, Mexican American, Chicano
- ☐ Salvadoran ☐ Guatemalan
- ☐ Cuban ☐ Puerto Rican
- ☐ Other Hispanic, Latino, or Spanish origin: _____

★ ☐ Check here if you are an American Indian or Alaska Native, and fill out Attachment A on pages 20 and 21.

Page 20 of the Medi-Cal application

Is this person a member of a federally recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

If yes, *write the name of the tribe:* _____ *and the state of the tribe:* _____

But . . . DHCS **Chooses** One Race

- The membership file (834) DHCS sends to health plans associates just **one** race with each Medi-Cal enrollee. Of note, Hispanic ethnicity is reclassified as a race.
- Here are the options:
  - White
  - Black
  - Hispanic (No subgroups included)
  - Asian Pacific Islander (specific subgroup is identified in membership file from 12 options)
  - Native American/Alaska Native
  - Unknown/Missing
  - Other

But . . . DHCS **Chooses** One Race

- The algorithm used by DHCS to determine which race is chosen is not transparent, but can be inferred.

2100A	DMG05-3	Industry Code	2106-3 2135-2 2054-5 2028-9 1002-5 2036-2 2034-7 2033-9 2039-6 2040-4 2080-0 2029-7 2076-8 2087-5 2041-2 2047-9 2131-1	If DMG05-2 is populated, the RET codes correspond as follows to the FAME Ethnic codes "2106-3" = 1 – White "2135-2" = 2 – Hispanic "2054-5" = 3 – Black "2028-9" = 4 – Asian or Pacific Islander "1002-5" = 5 – Alaskan Native or American Indian "2036-2" = 7 – Filipino "2034-7" = C – Chinese "2033-9" = H – Cambodian "2039-6" = J – Japanese "2040-4" = K – Korean "2080-0" = M – Samoan "2029-7" = N – Asian Indian

DHCS
California Department of HealthCareServices

5010 834 COMPANION GUIDE

Control Segment or Loop ID	Reference	Name	Codes	Comments
				"2076-8" = P – Hawaiian "2087-5" = R – Guamanian "2041-2" = T – Laotian "2047-9" = V – Vietnamese "2131-1" = Z – Other

Race and Ethnicity in 2020 Census

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➜ **NOTE: Please answer BOTH Question 6 about Hispanic origin and Question 7 about race. For this census, Hispanic origins are not races.**

6. Is this person of Hispanic, Latino, or Spanish origin?

- ☐ **No**, not of Hispanic, Latino, or Spanish origin
- ☐ Yes, Mexican, Mexican Am., Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino, or Spanish origin – *Print, for example, Salvadoran, Dominican, Colombian, Guatemalan, Spaniard, Ecuadorian, etc.*

Figure 2.
2020 Census Race Question

7. What is this person's race?

Mark ☒ one or more boxes AND print origins.

- ☐ White – *Print, for example, German, Irish, English, Italian, Lebanese, Egyptian, etc.*
- ☐ Black or African Am. – *Print, for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.*
- ☐ American Indian or Alaska Native – *Print name of enrolled or principal tribe(s), for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, etc.*
- ☐ Chinese
- ☐ Filipino
- ☐ Asian Indian
- ☐ Vietnamese
- ☐ Korean
- ☐ Japanese
- ☐ Other Asian – *Print, for example, Pakistani, Cambodian, Hmong, etc.*
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Chamorro
- ☐ Other Pacific Islander – *Print, for example, Tongan, Fijian, Marshallese, etc.*
- ☐ Some other race – *Print race or origin.*

Multi-generation white Americans will write "American" instead of one or more groups from Europe/Middle East

Sixteen-letter maximum in text fields prevent describing more than one or two descriptions.

Indigenous individuals from outside the United States are encouraged to select a tribe, which classifies them in the American Indian category.

Many Hispanic individuals don't want to choose one of the race options, and so will write "Hispanic" under "Some other race."

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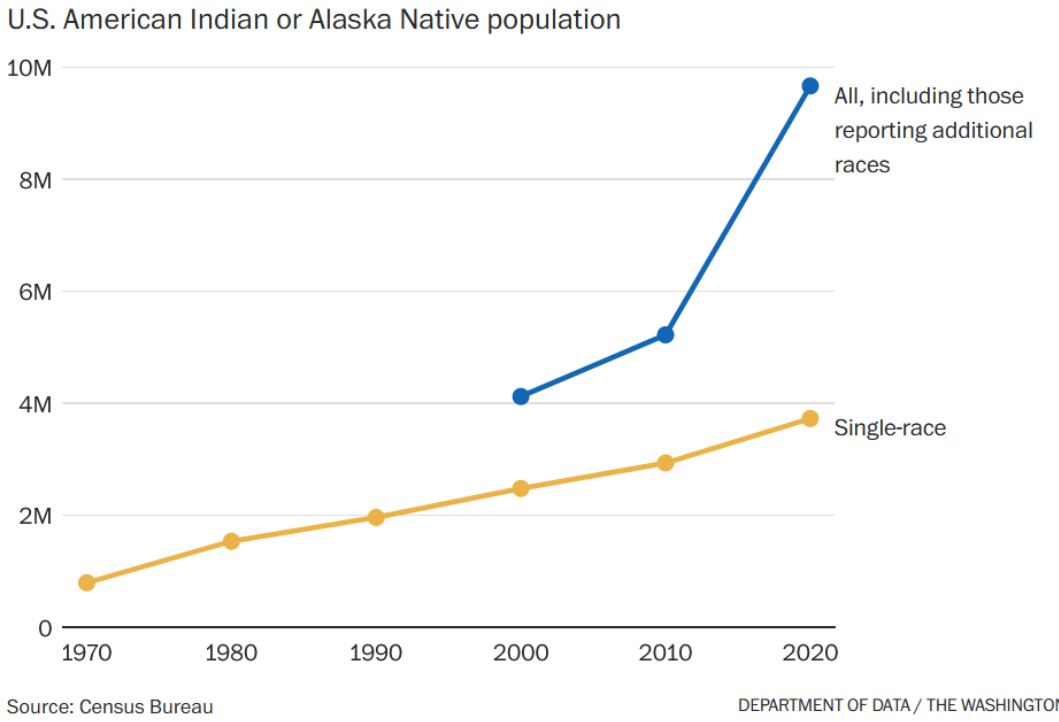
Examples:

Medi-Cal Application	Census	DHCS Membership File
Race: AI/AN Ethnicity: non-Hispanic Enrolled in Federally Recognized Tribe: Yurok	Race: AI/AN and lists under tribes: "Yurok Karuk Hupa" Ethnicity: non-Hispanic	Single Race: AI/AN Principle: Non-Hispanic ethnicity with only one race chosen.
Race: Other: Mexican Ethnicity: Hispanic: Mexican	Race: AI/AN: Aztec tribe Ethnicity: Hispanic: Mexican	Single Race: Hispanic Principle: Hispanic Status trumps any race choice
Race: White and AI/AN selected Ethnicity: non-Hispanic Enrolled in Federally Recognized Tribe: Round Valley	Race: White: German and AI/AN: Concow, Pomo (runs out of room so cannot include others) Ethnicity: non-Hispanic	Single Race: Other/Missing Principle: Non-Hispanic ethnicity with more than one race.

2020 U.S. Census

- Aztec and Maya added as specific Options in 2020



Slighly muddled counts of Native American origins

U.S. Native Americans, by self-reported origin, 2020

Search in table

Page 1 of 118

TRIBE OR ENTITY	SINGLE-ORIGIN	ALL
Aztec	387,122	583,981
Navajo Nation	315,086	423,412
Cherokee	214,940	1,513,326
Maya	180,359	300,519
Choctaw	69,454	255,557

Source: US Census 2020

Dividing up the AI/AN Category

American Indian and Alaska Native Alone and Alone or in Any Combination Regional Groups: 2010 and 2020

Regional group	Alone			Alone or in any combination		
	2010	2020	Percent change	2010	2020	Percent change
Alaska Native	120,260	133,311	10.9	166,120	241,797	45.6
American Indian	1,935,910	2,159,802	11.6	3,232,465	6,363,796	96.9
Canadian Indian	6,435	7,723	20.0	14,825	72,701	390.4
Latin American Indian	172,280	766,112	344.7	269,050	1,319,523	390.4

- Census category of AI/AN might more properly be called Indigenous people of the Americas
- Offering Aztec and Maya choices increased number of Indigenous individuals from Latin America
- Indigenous individuals from Latin America and Canada comprise 21%
- Increased self-identification of AI/AN mixed with other race

Source: US Census 2020

Another Estimate of Undercounting

- The 2021 American Community Survey (a random sample from across the country) framed the questions differently, not including Indigenous people from outside the United States. It calculated that 330,959 individuals have Medi-Cal, which is 660% higher than official estimates, but less than the 600,000 extrapolated from the U.S. Census.

https://www.census.gov/data/developers/data-sets/acs-5year.html

Resolving Overcounting

- New OMB 2024 standard for categorizing race/ethnicity
  - Must be implemented by 2029 at the latest
  - The Middle-eastern/north African population was carved out of the white category
  - Moves Latino/Hispanic to be a co-equal race/ethnicity category, instead of carved out ethnicity category
  - Anticipated result: Less Hispanic race, more of all other categories.

OMB 2024 Options for Reporting Race

- Official options for categorizing individuals who select more than one race
  1. **“Alone or in combination”**
     - Intermediate complexity, less granular analysis possible
     - Categories add to over 100%, because mixed race counted in all racial categories
  2. **“Most frequent multiple responses”**
     - Most complex to convey and analyze
     - Categories add to 100%
  3. **“Multiracial” categorized as “other” or “mixed”**
     - Simplest but least useful for analysis
     - Categories add to 100%

DHCS Remedies

- Since it has such a large impact on the Tribal member's data, formal Tribal Consultation is required before a decision is finalized.
- Partnership recommends:
  - DHCS should adopt the "alone or in combination" option for categorizing data
  - DHCS should share detailed race/ethnicity/tribal affiliation data with Managed Care plans
  - DHCS, health plans, and academic partners should develop a framework for analyzing racial disparities/inequities including the "alone or in combination" method
- Urgency:
  - New federal standards offer an opportunity to change the standard for sharing racial data.

Questions

Data Sovereignty: Definition

- “Indigenous Data Sovereignty is the right of Native nations to govern the collection, ownership, and application of its own data.”

THE UNIVERSITY OF ARIZONA
NATIVE NATIONS INSTITUTE
Founded by the Udall Foundation & the University of Arizona

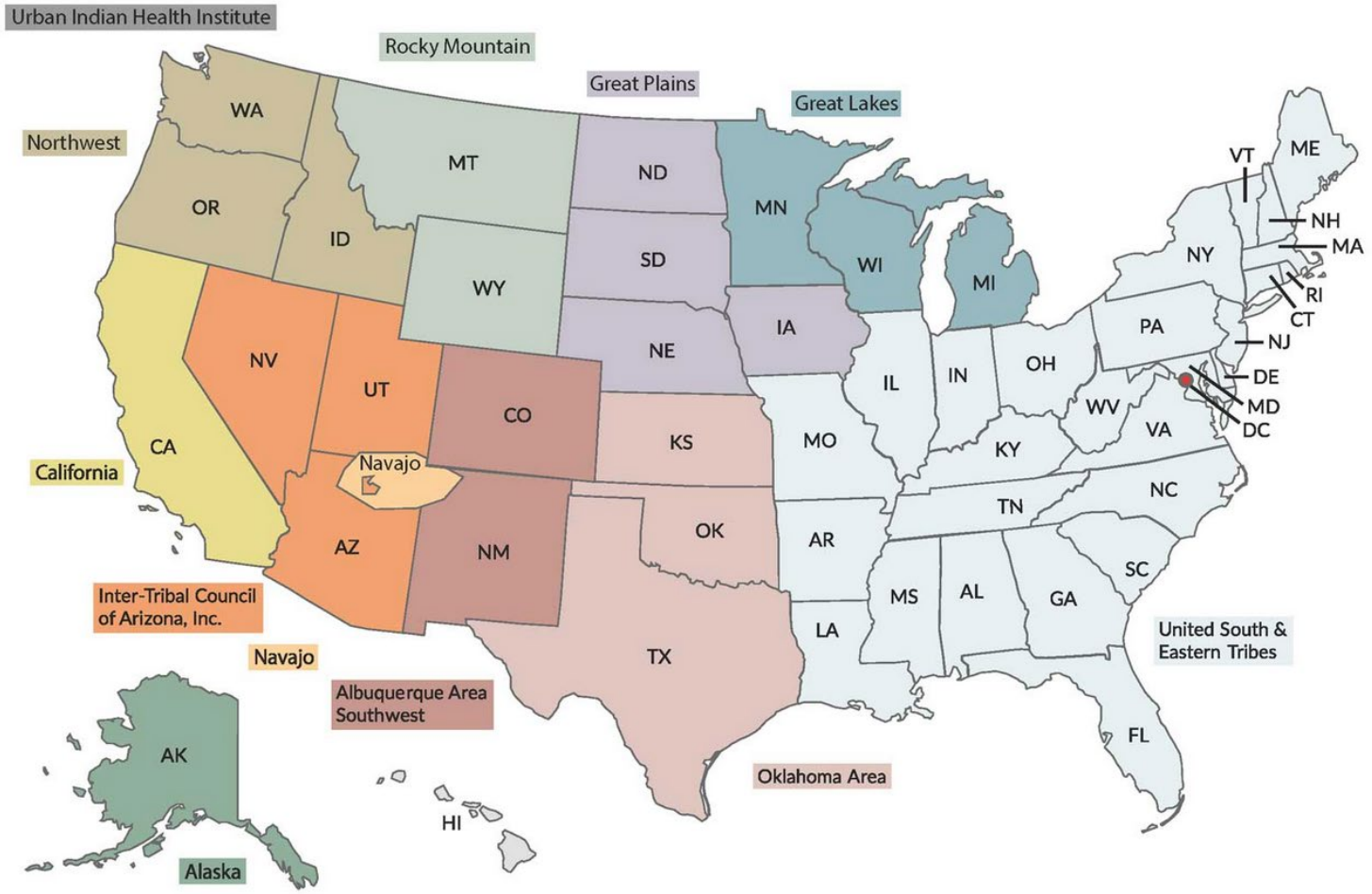
Strengthening Indigenous Governance

Data Sovereignty: Key Issues

- Consequences of Lack of Data Sovereignty
  - Existing Indigenous data are inconsistent, inaccurate or irrelevant to Tribal goals
  - External entities control the collection, ownership, and application of Indigenous data
  - Legacy of mistrust of data from history of exploitative research and policies
  - Lack of Indigenous data infrastructure and analytic capability

Data Sovereignty: 1996 Developments

- Creation of 12 Regional Tribal Epidemiology
  - Founded in 1996 as part of Indian Health Care Improvement Act
  - Permanently re-authorized in 2010
  - Legal status as Local Public Health Authority
  - Grant funded, largely by US Centers for Disease Control



California Tribal Epidemiology Center

The California Tribal Epidemiology Center (C-TEC)
associated with the California Rural Indian Health Board

Seven Goals of Tribal Epi Centers

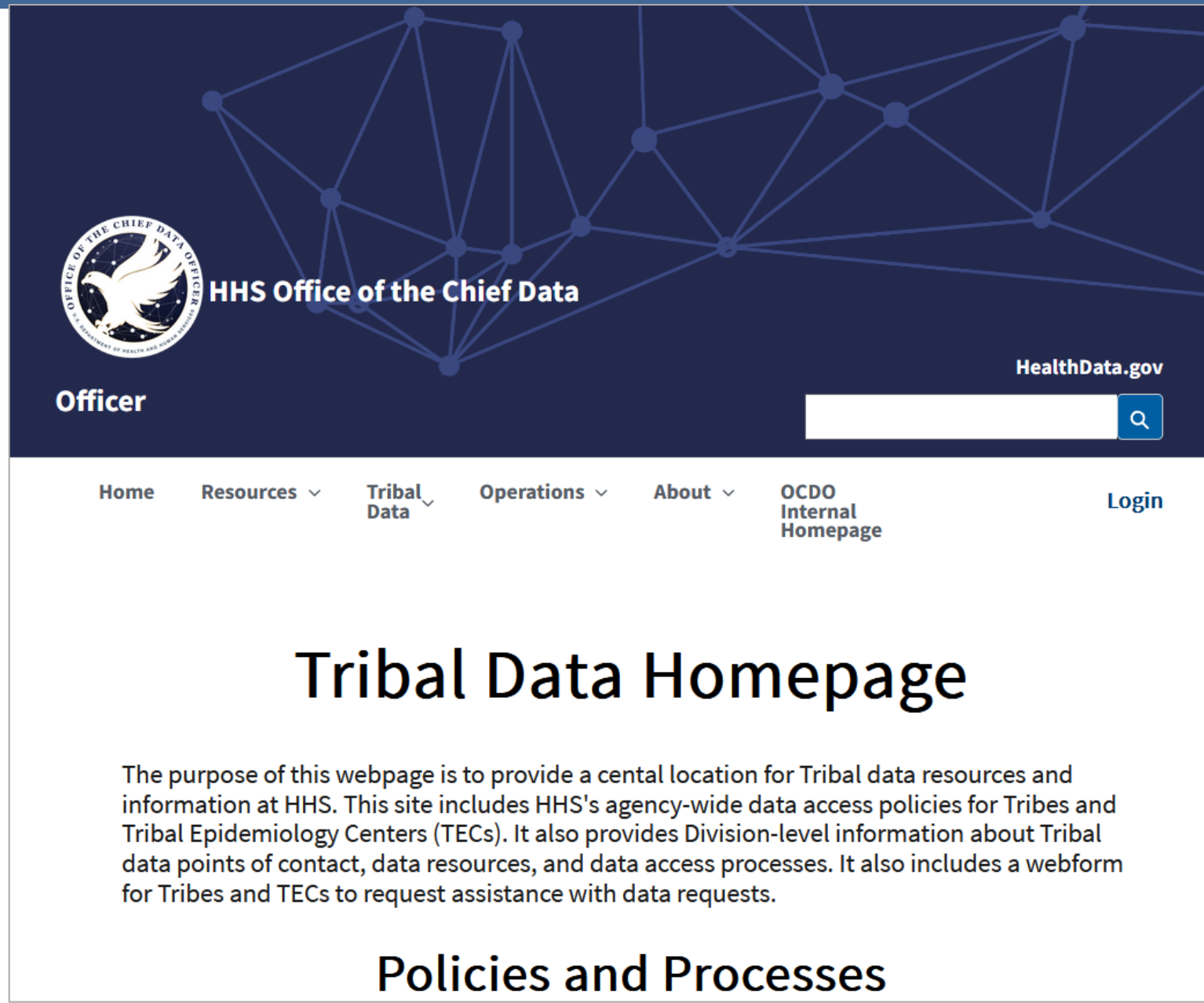
1. Collect data related to health status objectives of Tribal organizations
2. Evaluate existing delivery system and data systems
3. Assist with prioritization of health status objectives, based on data
4. Recommend targeted services needed
5. Recommend health care delivery system improvements
6. Provide technical assistance to tribal organizations
7. Disease surveillance and promotion of Tribal health

https://cdo.hhs.gov/s/tribal-data

Data Sovereignty: 2024 Developments

- Federal activities to share data
  - Tribal Data Homepage
  - Draft Tribal Data Access Policy
  - Draft TEC Data Access Policy

https://cdo.hhs.gov/s/tribal-data



Key Data Sovereignty Policies

- Tribal Data Homepage FAQs
  1. Tribes can establish many different types of public health authorities, including local health departments, epidemiological data collection and analysis agencies, regulatory bodies, and service providers, as well as developing public health infrastructure.
  2. HHS does not have the authority to compel states or local jurisdictions to share their data with the federal government, or with Tribes, TECs, or any other public health authority. Public health authorities seeking access to state data must work on voluntary data sharing agreements directly with states.

https://cdo.hhs.gov/s/tribal-data

Partnership Support: Data Sovereignty

Priority 1: Data Accuracy

- All race-based equity analysis done by Partnership is tainted by the undercounting of AI/AN race in our source data from DHCS
    1. Advocacy: Granular race data needed
    2. Analytic Framework for applying granular data
    3. Detailed re-analysis of health outcome data

Public Health Data Sharing

Priority 2: Share the data we have

Data Sharing Prototype

- Partnership data to help with Tribal Health Center decision-making and prioritization

Listening Session II

Facilitator:
Robert Moore, MD MPH MBA
Chief Medical Officer, Partnership HealthPlan of California

Listening Session II

1. What are your highest priorities for use of data that you do not have in your current electronic systems?
2. What other data from within the Tribal populations you serve would you like to have (regardless of source of data?
3. What are the major barriers to your health centers and the Tribes that you serve, to building an Indigenous capacity to analyze and use data for decision-making and public health activities? (e.g. training “Data Warriors”)

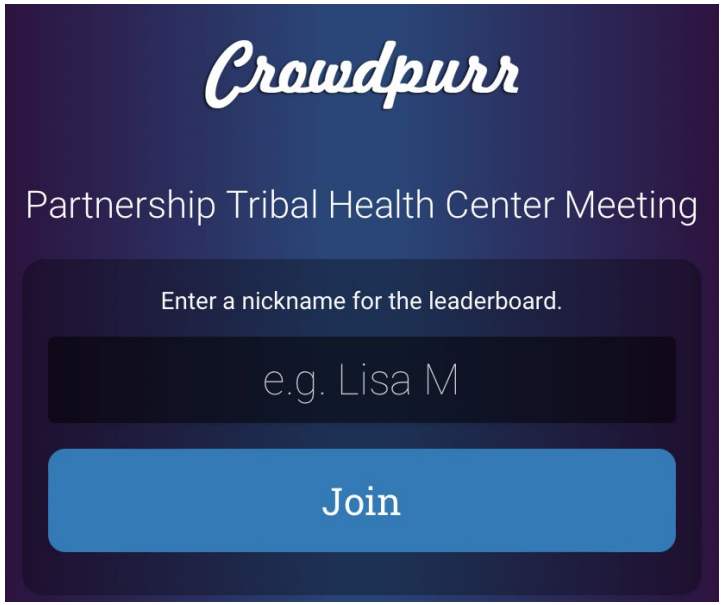
Lunch

Wahpepah's Kitchen
Native American Cuisine
Holistic Foods Catering in the Bay Area since 2012

Trivia Quiz

On your phone, visit:
https://www.crowd.live/

Or scan the QR code to access the trivia quiz.



Scan to join

Building a Tribal Health Care Workforce

- Panel Discussion

UC DAVIS HEALTH

Tribal Health and Workforce Initiatives

SCHOOL OF MEDICINE

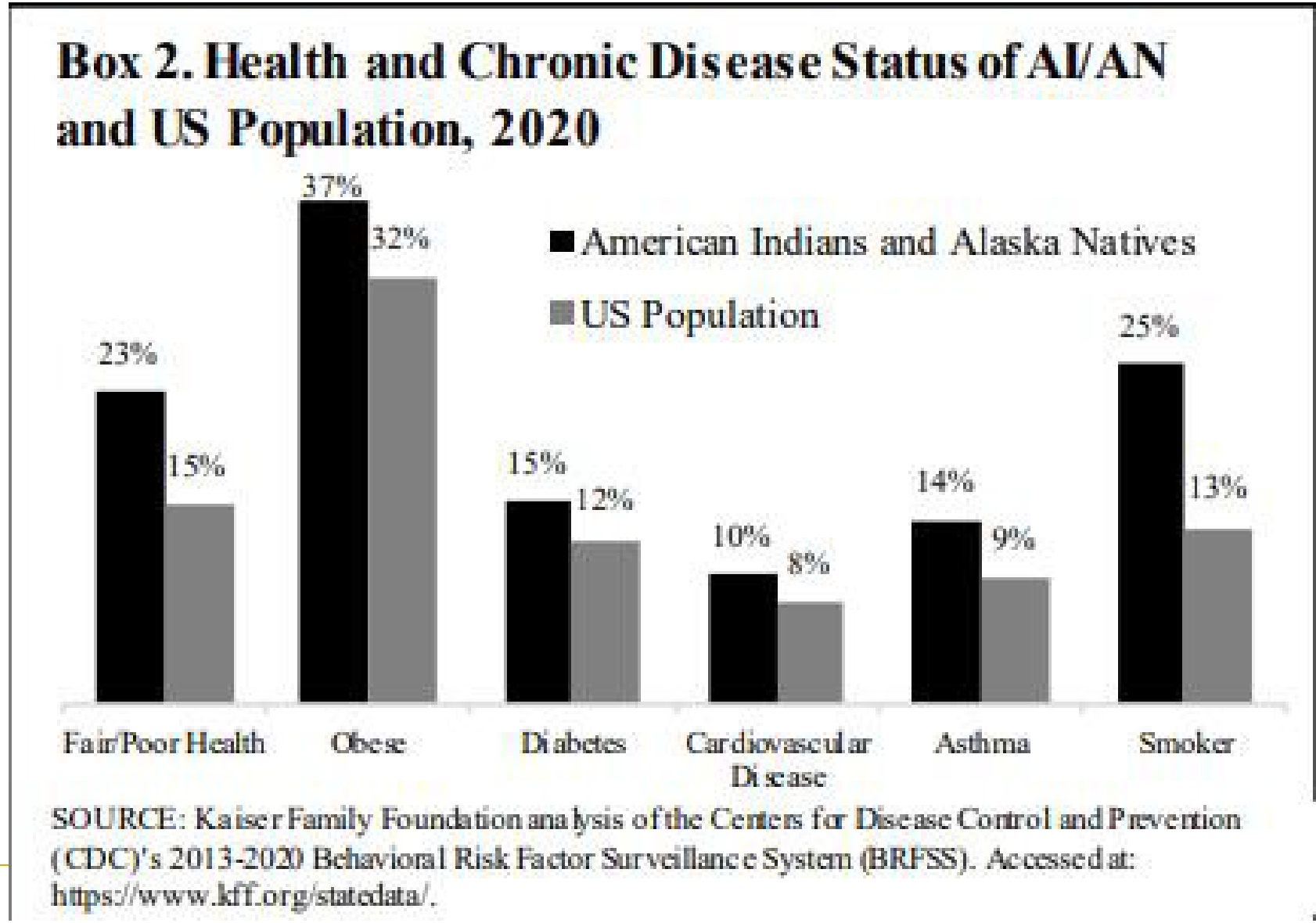
Eric Crossen, MD, MPH
Antoinette Martinez, MD
Melody Tran-Reina, MD

UC Davis School of Medicine Mission

*To provide excellent learner-centered education to a **diverse body of medical students** and graduate students; cultivating in them the passion to improve lives and **transform the health of the communities they will serve** as physicians, scientists and health care leaders.*

The challenge

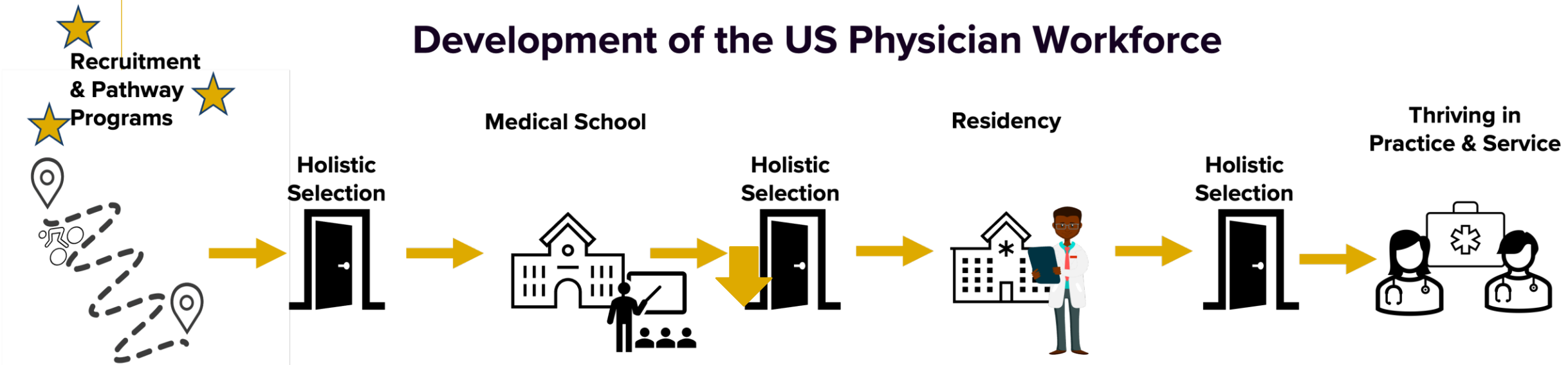
Health professions vacancies exacerbate burden of preventable disease morbidity/mortality in AIAN communities



The challenge

- Abysmal workforce shortages in tribal communities in the Western region
- AIAN students are underrepresented in health professions schools

How Medical Education Can Address Community Health



- Work within pathway programs that include mentorship (level the playing field)
- Build more inclusive learning environments e.g. peers, mentors
- More community-based training (e.g. tribal health centers, rural, FQHC) which helps diverse learners remain connected to people and communities they aim to serve

AVENUEM PATHWAY PROGRAM

AvenueM

Roadmap to Your Career in Medicine

California Medicine Scholars Program

AvenueM is a community college to medical school pathway program that aims to reduce barriers to entry to medical and other healthcare careers. Led by Dr. Charlene Green, the UC Davis School of Medicine team has partnered with UC Davis, Sac State, and Cal Poly Humboldt and a network of community colleges in the Northern California region.

AVENUEM PATHWAY PROGRAM

AvenueM
Roadmap to Your Career in Medicine

California Medicine Scholars Program

Map of Program Partners and Scale

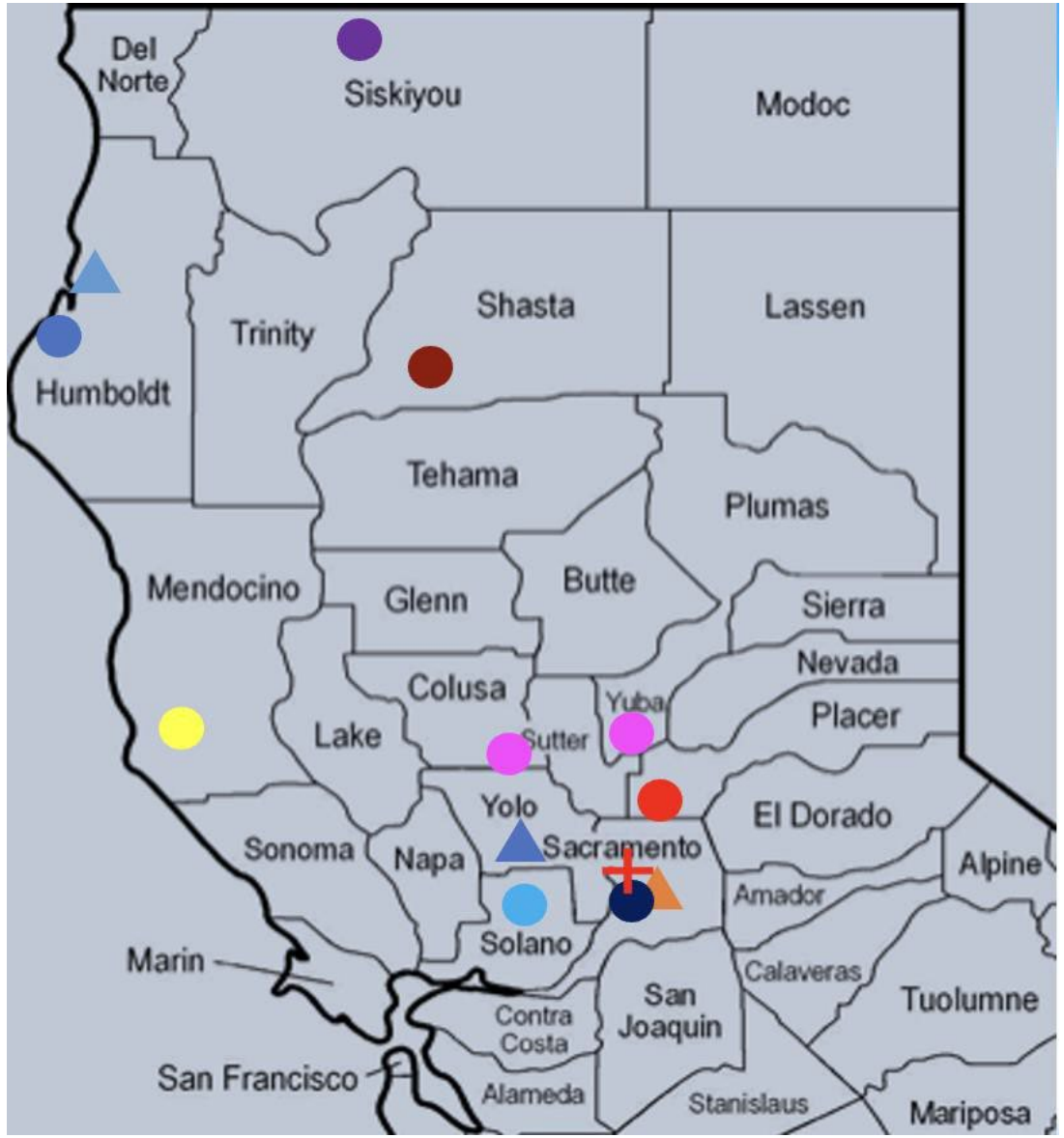
+ UCD School of Medicine

4-Year Institutions

- ▲ UC Davis
- ▲ Sac State
- ▲ Cal Poly Humboldt

Community College/Districts

- ● Los Rios
- ● Yuba/Woodland
- ● Solano
- ● Sierra
- ● College of Redwoods
- ● College of the Siskiyous
- ● Mendocino College
- ● Shasta College
- ● California Tribal College



Our Mission

In partnership with Cal Poly Humboldt, UC Davis School of Medicine launched Huwighurruk (hee-way-gou-duck), a postbaccalaureate pathway program for learners who are passionate about providing healthcare to AI/AN communities. Huwighurruk is designed to support participants on their journey to medicine.

Huwigurruk Postbaccalaureate Program at Cal Poly Humboldt with UC Davis

In the Wiyot language, ***huwighurruk*** means plants, grass, leaves, and medicine.

Huwighurruk scholars are immersed within a culturally-focused framework intertwined with courses at Cal Poly Humboldt.

Our mission is to successfully recruit, retain, and train prospective medical students focused on serving American Indian/Alaska Native tribes and communities in both rural and urban areas

UCDAVIS HEALTH

Huwigurruk PB assistance

Tuition and other costs (MCAT prep, MCAT)

Stipend

Housing

Conditional acceptance into Medical School with:

Completion of program with GPA of 3.7 or higher

MCAT score of 499 or higher

A letter of completion and recommendation from Program Co-Directors

QUESTIONS? Call or email us!

Email: tribalhealth@ucdavis.edu

Application: https://tinyurl.com/TribalHealthPB

Info Sessions: https://tinyurl.com/CAConsortInfo

Wy'east Postbaccalaureate Pathway

Wy’east is a tuition-free post-baccalaureate health education Pathway for American Indian and Alaska Native (AI/AN) learners who are passionate about becoming physicians. We recruit nationwide and our scholars receive a monthly stipend throughout the 10-month Pathway.

NNACOE
NORTHWEST NATIVE AMERICAN CENTER OF EXCELLENCE

WY’EAST MEDICINE

Community Health Scholars Programs

The mission of the Community Health Scholars Program is to nurture and train future physician leaders to transform the health of California's rural, urban, Native American, and Central valley communities.

Rural PRIME
Est 2007

Rural and Frontier communities

REACH
Est 2019
SJVPRIME Est 2011

Central Valley of California (Agricultural and Urban)

TEACH-MS
Est 2011

Urban Underserved Primary Care

Tribal Health PRIME
Est 2022

California's Urban and Rural Tribal communities

Partnership with Wy'East Post-Baccalaureate program, as well as COMPADRE

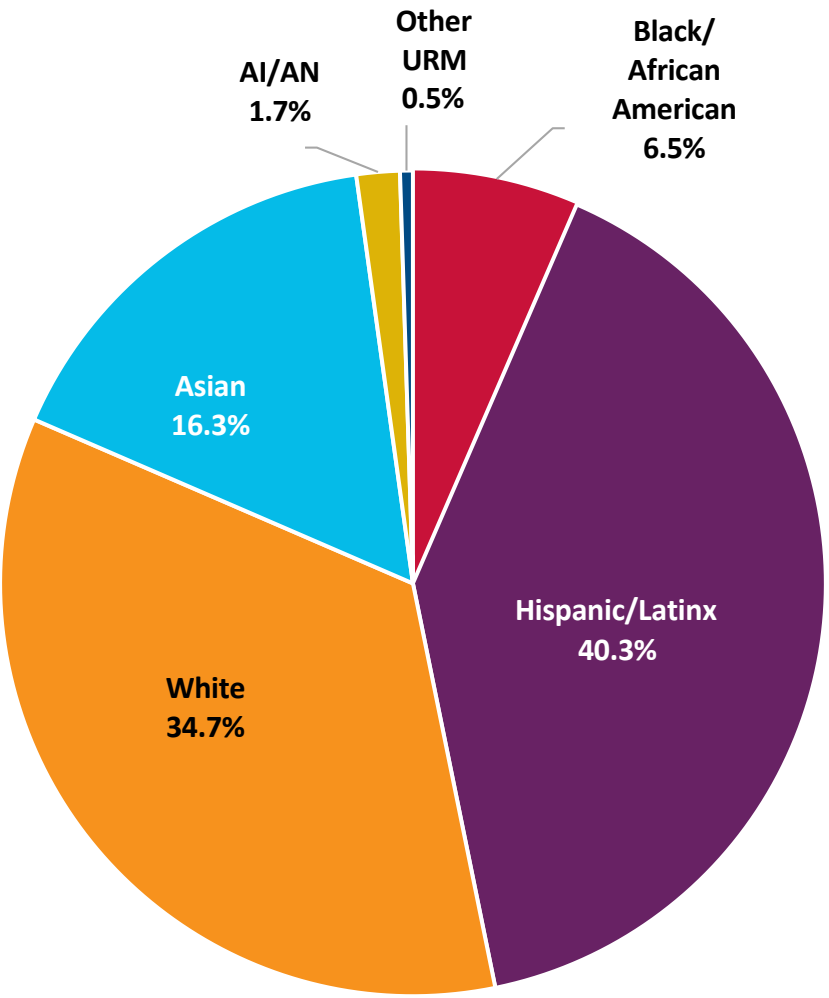
New Huwighurruk PB in Humboldt County

ACE-PC
Est 2014

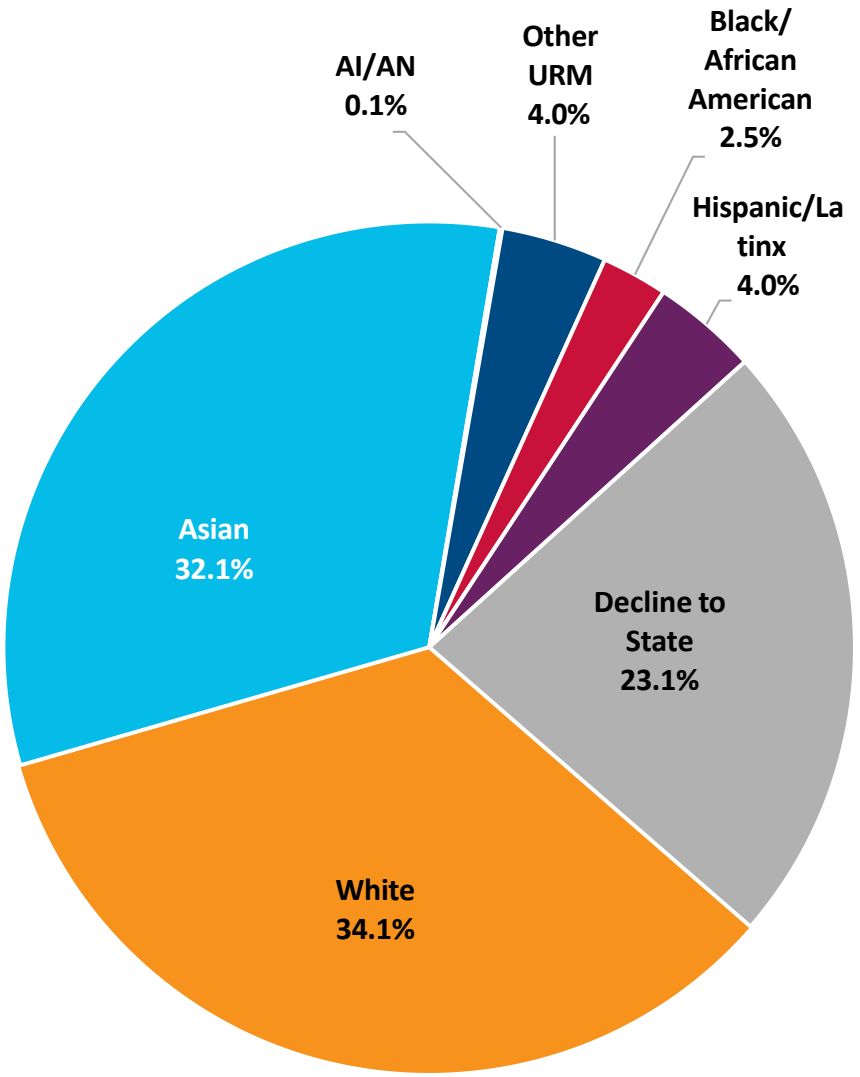
3-year accelerated track for primary care

CHS Curriculum

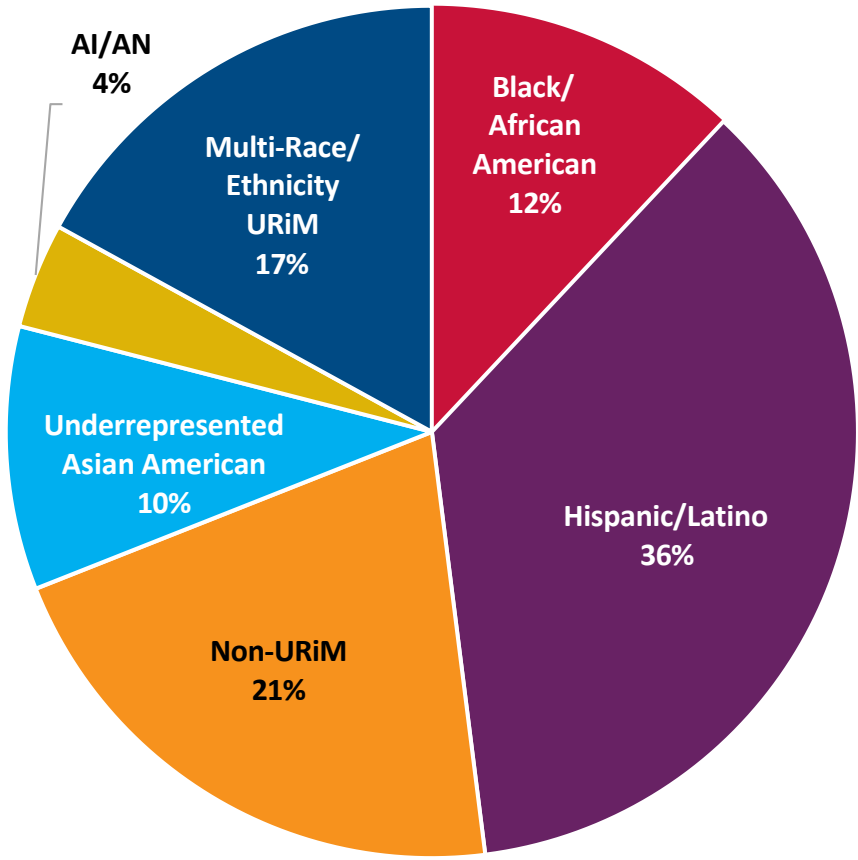
CA Population Race/Ethnicity (2022)



CA Physician Population Race/Ethnicity (2022)



CHS Student Ethnic/Racial Groups (as of Nov 2023)



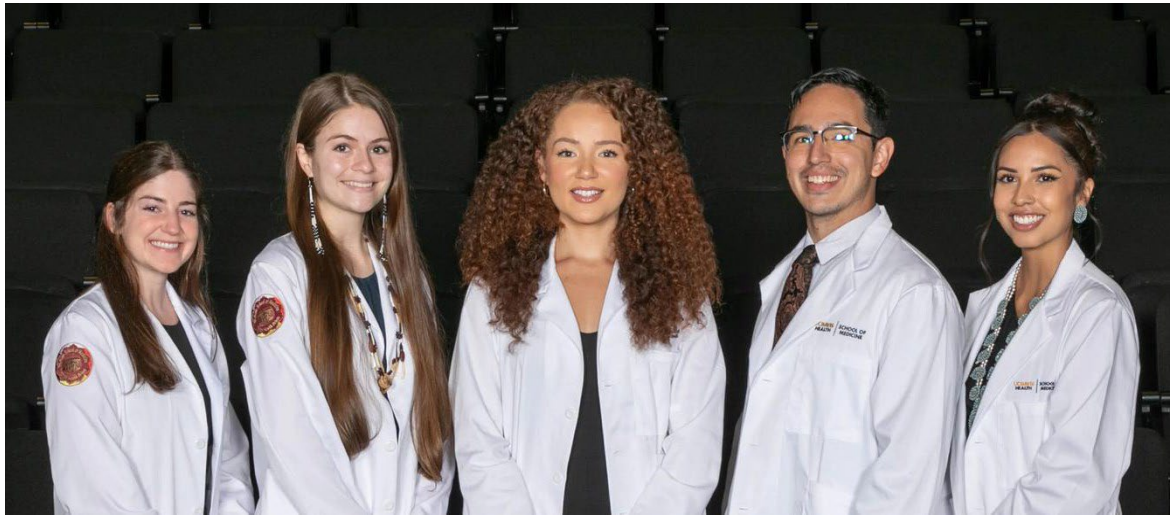
TRIBAL HEALTH INITIATIVES

Tribal Health PRIME

The UC Davis Tribal Health PRIME Community Health Scholars Program is designed to provide students with the appropriate knowledge and skills to practice medicine in California's urban and rural tribal communities

Program Goals

- Recruit new physicians to serve California's tribal, urban, and rural communities.
- Reduce health inequities within California's urban, rural, and tribal communities by increasing physicians in the healthcare workforce with additional training on cultural, historical, and social determinants of health.
- Understand how self-determination and health advocacy shape health services for tribal and urban communities.
- Work in partnership with AI/AN communities, clinics and physicians to enhance health care in the region.



Class of 2026

Alyssa Fowlds
Cheyenne River Sioux Tribe
Hometown: Sylmar, CA

Hannah Posey
Comanche Nation
Hometown: Sacramento, CA

Justin Rehwaldt
Karuk Tribe
Hometown: Crescent City, CA

Class of 2027

Temerity Bauer
Round Valley Indian Tribes
Hometown: Las Vegas, NV

Savannah Lukkes
Cheyenne River Sioux Tribe
Hometown: Rapid City, SD

Ashley Martinez
Navajo Nation
Hometown: Albuquerque, NM

Andres "Drew" Ramos
Big Valley Band of Pomo Indians
Hometown: Los Angeles, CA

Jennifer Tashjian
Citizen Potawatomi Nation
Hometown: San Jose, CA

Class of 2028

Leonard "Leo" Almero
Citizen Potawatomi Nation
Hometown: Anaheim, CA

Uriah Contreras
Oglala Lakota
Hometown: Rapid City, SD

Greg Gurrola
San Carlos Apache Tribe
Hometown: Phoenix, AZ

Viviana Vega
Cloverdale Rancheria of Pomo Indians
Hometown: Windsor, CA

Mia Wungnema
Nisqually Tribe
Hometown: Olympia, WA

Since THP initiation in 2022, UC Davis School of Medicine has matriculated 13 AI/AN students who:

- Have significant ties to tribal communities
- Are passionate about addressing AI/AN health disparities
- Wish to serve California tribes and other AI/AN communities

Tribal Representation among THP Students

Round Valley Indian Tribes

Big Valley Band of Pomo Indians

Karuk Tribe

Cloverdale Rancheria of Pomo Indians

Nisqually Indian Tribe

Oglala Lakota

San Carlos Apache Tribe

Cheyenne River Sioux Tribe

Comanche Nation

Navajo Nation

Citizen Potawatomi Nation

Develop THP Student Identity as a Native Person and Native Physician

- Didactics to focus on culture and tradition
- Self-explore what it means be Native
- Support students in their own individual development
- Change the framework for communities and for medical students by using approaches which are:
  - Strengths based
  - Culturally based public health approaches
  - Development of connection with communities and tribes

Place-Based Clinical Learning for THP Students

- Longitudinal Clinical Experience over first two years of med school
  - Partnerships with **NVIH (Woodland)** and **Chapa De (Auburn)**
  - Apply, practice and refine clinical skills in a real-world setting

- Clerkships in 3rd year of medical school
  - Partnerships with **UIHS, NVIH (Chico)**

- **Seeking partnership with Tribal Health Programs for LCE and clerkships!**

- Graduates more likely to return to work in settings where they learned, especially outside of academic centers (e.g., community health centers)

Timeline of Tribal Health Initiatives

2018-2019

Reimagine Indians into Medicine (RISE) – Partnership with OHSU and WSU to increase Native physicians in the Pacific NW

2019-2021

Partnerships to Address Tribal Health (PATH) Listening Sessions

UC Davis Wy'east Postbacc Program launch and recruitment

Dr. Antoinette Martinez (UIHS) and Dr. Eric Crossen recruited as Co-Directors

2021-2022

Launch of Tribal Health PRIME; Cohort 1 = 3 students

UCOP funding granted for Tribal Health PRIME and PRIME Tide

AvenueM $1.8M Community College to Med Grant – focus on AI/AN and other medically underserved communities

2022–2023

Northwest Native American Center of Excellence (NNACoE) funded to expand Wy'east program; UC Davis led postbac will be developed at CalPoly Humboldt

Tribal Health PRIME Cohort 2= 5 students

2023–2024

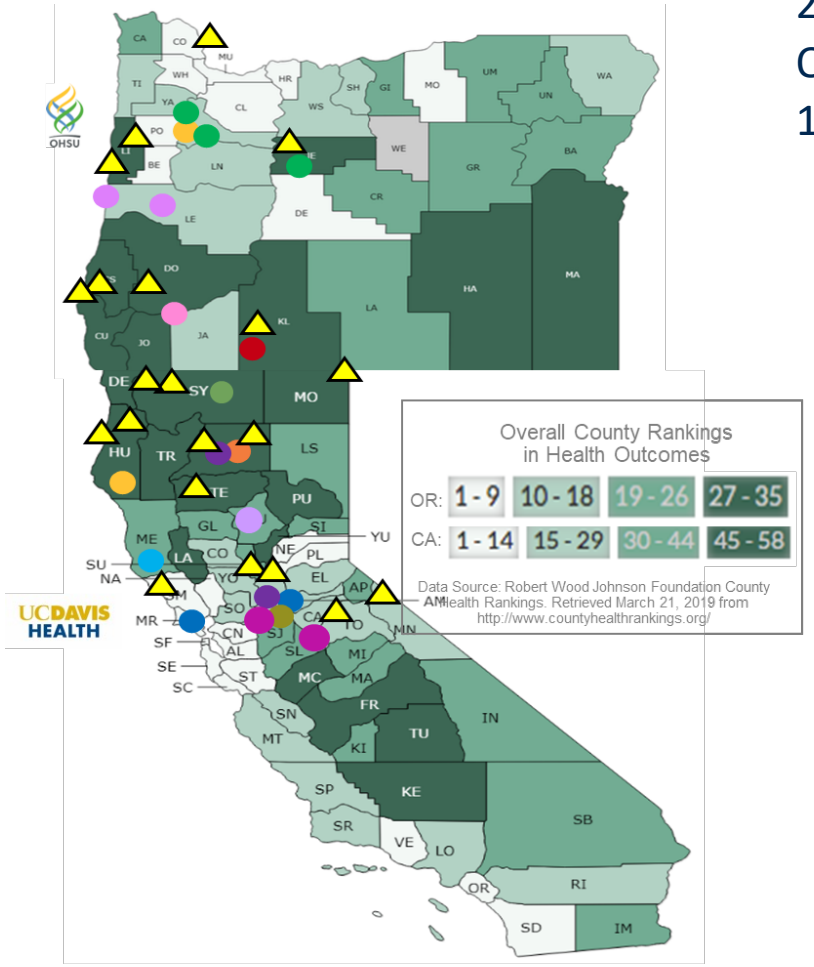
Planning Year/Recruitment for 1st AI/AN Postbacc Cohort at CalPoly Humboldt: Huwighurruk

2024–2025

Launch of AI/AN Postbaccalaureate Program: Huwighurruk - 4 students in Cohort 1

California Oregon Medical Partnership to Address Disparities in Rural Education and Health

COMPADRE
Oregon Health & Science University
UC Davis School of Medicine



2 Academic Medical Centers

Over 30 graduate medical education (GME) programs across 10 health care systems, 16 hospitals, and a network of FQHCs in Northern California and Oregon.

Tribal Communities
Confederated Tribes of Coos, Umpqua and Siuslaw
Confederated Tribes of Grand Ronde Community
The Klamath Tribes
Confederated Tribes of Siletz Indians
Cow Creek Band of Umpqua Tribe of Indians
Confederated Tribes of Warm Springs Reservation
Cowlitz Indian Tribe
Fort Bidwell Paiute Reservation
Redding Rancheria
Toiyabe
Greenville Rancheria
Karuk Tribe
Sonoma County Indian Health Project
Mathiesen Memorial Health Clinic
Pit River
United Indian Health Services, Inc.
Chapa-De Indian Health
Feather River Tribal Health
Hoopa Valley Tribe
Quartz Valley Indian Reservation
Coquille Indian Tribe

Health Centers and Hospitals

University of California, Davis
UC Davis Health Hospitals

Ukiah Valley
Mendocino Community Health Clinics FM

Kaiser Permanente Northern California
Sacramento FM, Psych
Santa Rosa FM

Oregon Health & Science University
Hillsboro Medical Center
OHSU Hospitals
Three Sisters FM RTP

Providence Health & Services
Providence St. Vincent Medical Center, Portland
St. Joseph's of Eureka

Healthy Rural CA
Chico FM
Butte County Psychiatry RTP

Fairchild Medical Center
Yreka FM

Samaritan Health
Good Samaritan Regional Medical Center
Newport FM RTP

Sky Lakes
Sky Lakes Medical Center FM

Catholic Health Initiatives Mercy Health
Mercy Medical Center Roseburg FM

Shasta-Redding
Shasta Community Health Center FM
Shasta Regional IM

Dignity Health
Mercy Medical Center Redding FM
Sierra Nevada Sacramento FM

Sutter Health
Amador FM RTP
Coastal FM
Sacramento FM

Hearing our stories, looking to the future. Thank you

Thank you!

Eric Crossen, MD, MPH
ecrossen@ucdavis.edu

Antoinette Martinez, MD
antoinette.martinez@uihs.org

Melody Tran-Reina, MD
mltran@ucdavise.edu


PARTNERSHIP
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A Public Agency
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NCQA
HEALTH PLAN
Tribal Perinatal Program/Tribal Birth Equity Initiative
Dr. Colleen Townsend
Asia Lum
Angelica Trejo

Partnership Perinatal Care Portfolio

- Perinatal Services
  - Shift in administration, oversight, and reimbursement of services to Partnership.
- Doula services
  - Non-clinical support during and after pregnancy and during labor and delivery
- Tribal Perinatal Program
  - Collaboration between tribes and Partnership build and reinforce perinatal services provided in tribal health

Partnership Perinatal Care Portfolio

- Obstetrics Access
  - Include obstetrics providers in recruitment and retention bonus programs
  - Improve process for non-physician pregnancy care providers (Licensed Midwives and Nurse Midwives) to become Partnership contracted and credentialed
  - Improve access to out of hospital birth birthing options
  - Support policy and local initiatives to maintain or increase regional Obstetrics care access

Partnership's Perinatal Services

- Core Services: 4 Domains of Services
  - Health education and care management
  - Behavioral health
  - Nutrition care
  - Prenatal medical care
- Innovations
  - Straightforward application: one per parent organization
  - Modular approach
  - Virtual services permissible
  - Monitoring through site reviews every 3 years

Applications for PHPS emailed to Perinatal providers and all practices that are current CPSP and prenatal practices and ECM Birth Equity due to be submitted to Partnership Dec 31, 2024

Doula Services

- Non-Clinical pregnancy support that is demonstrated to improve pregnancy outcomes and satisfaction with birthing experience
- Doula services are reimbursed in Fee For Service Model
- Requires that doulas become PAVE (MediCal) enrolled, and that they contract and credential with Managed Care Plans
- Partnership continues to explore with local/ regional doulas and groups to recruit current practicing doulas and to identify local/ culturally congruent training programs

Interested doulas can contact doulaservices@partnershiphealthplan.org

Partnership Perinatal Provider Training

- **Neonatal Airway Management**
  - Two hour hands on experiential training to learn updated techniques and tools for airway newborn management
  - Focusses on training labor and delivery, pediatric, emergency department and EMS teams
  - Training and Neonatal Airway Scope provided to rural hospitals
- **Basic Life Support/Obstetrics**
  - Day long experiential training to learn approaches to addressing obstetric urgencies
  - For non-medical professionals who work with pregnant individuals/ families - doulas, non-medical first responders, perinatal case managers
  - November 16, 2024 in Redding with Shasta Family Medicine Residency program
- **Advanced Life Support/Obstetrics**
  - Day long experiential, CME eligible training for clinicians to address obstetrical urgencies
  - Focus on clinicians who care for pregnant individuals: Family Medicine Providers, Midwives, Emergency Medicine providers, Nurses, EMTs
  - October 26, 2024 in Redding

Tribal Birth Equity Initiative Goal

Goal: To create the best possible outcomes for Native American children/babies

Core Curriculum/Trainings

- Case management of pregnant individuals
- California Indian Customized Curriculum

Capacity Building Funding

- IPP funding
- Grants provided to cover educational trainings
- Fund case manager recruitment support

Program Training Curriculum

GOAL: Enhance and strengthen the maternal care systems in the tribes with evidence based practices and culturally congruent information

- **Shared curriculum topics:**
  - Family Spirit Curriculum (32 hours)
  - Hear Her Campaign (1 hour)
  - Trauma Informed care
  - Mental health first aid
  - Motivational Interviewing (Basic training 4 days)
  - Supporting pregnant individuals with substance use disorder (2 hours)
  - Business support (1 hour)
  - Case Management Boundary Setting

- ECM Care Manager Core Training (2 hours)
  - reporting requirements, care plan components

- Doula Specific Training (16 hours)

- PHPS Case Manager Core Training

- Overview of other perinatal resources - CPSP, GTP, Sweet Success (1 hour)

Program Progress

Cohort 1

- Pit River Health Services
- Northern Valley Indian Health
- Lake County Tribal Health

Cohort 1.5

- Round Valley Indian Health
- United Indian Health Service

Cohort 2

- Chapa-De Indian Health Project
- Consolidated Tribal Health Center
- Feather River Tribal Health
- Greenville Tribal Health
- Karuk Tribal Health
- Lassen Indian Health Center
- Redding Rancheria Indian Health SVS
- Sonoma Indian Health

Cohort groups are dependent on when the Tribal health center starts the Tribal Perinatal Program
(Cohort 1 – April 2024
Cohort 1.5 – June 2024,
Cohort 2 – October/November 2024)

Program Trainings

MAY 2024:

- Family Spirit Training (May 6-9, 2024)

OCTOBER 2024:

- Mental Health First Aid Training (October 23, 2024)
- Motivational Interviewing Part 1 (October 24-25, 2024)

JANUARY 2025:

- Mental Health First Aid Training (January 8, 2025)
- Motivational Interviewing Part 2 (January 9-10, 2025)

Upcoming Trainings:

- Boundaries Training
- Doula Services Training
- Lactation Training
- Enhanced Care Management
- Case Management

Program/Training Testimonials

Birth Equity Webinars

Partnership Health Perinatal Services (PHPS)

Webinar from September 11, 2024

- If you would like to receive slides from the PHPS webinar, please let us know by emailing us at: TribalBirthEquity@partnershiphp.org

Perinatal Genetic Testing

Webinar on October 24, 2024 at Noon

- If you are interested in registering for the webinar, please let us know by emailing us at: TribalBirthEquity@partnershiphp.org

Contact Information

For any questions regarding doula/perinatal services

Dr. Colleen Townsend
Regional Medical Director
ctownsend@partnershiphp.org

For any questions regarding the Tribal Perinatal Program and grant

Asia Lum
Program Coordinator I
alum@partnershiphp.org

Angelica Trejo
Program Coordinator I
atrejo@partnershiphp.org

Please feel free to contact us at TribalBirthEquity@partnershiphp.org for any other questions.

Questions


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NCQA
HEALTH PLAN
Behavioral Health Updates
Mark Bontrager
Senior Director of Behavioral Health

Behavioral Health Updates

- Services for youth and children
- Coverage of traditional healers
- Substance use treatment overview
- Discussion

Partnership and Foster Youth

- New Requirement for MCPs to have a Child Welfare Liaison
  - **Child Welfare Liaison – Shahrukh Chishty**

    schishty@partnershiphp.org
- How do we serve foster youth:
  - Training for our staff re: special needs of Child Welfare Involved Youth
  - All foster youth are “Direct Members”
  - “Out of area providers”
  - MOU with County Child Welfare
  - Experience working with youth with more complex needs (CCS, CCM)
  - CalAIM – Enhanced Care Management (ECM) & Community Supports (CS)

CYBHI Work Streams (Direct Impact on Schools)

PARTNERSHIP HEALTHPLAN of CALIFORNIA
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Workforce Training and Capacity		Behavioral Health Ecosystem Infrastructure		Coverage Architecture	Public Awareness
Behavioral Health Counselor and Coach Workforce (HCAI)	CalHOPE Student Services (DHCS)	School-Linked Partnership and Capacity Grants (DHCS)	Behavioral Health Continuum Infrastructure Program (DHCS)	Enhanced Medi-Cal Benefits – Dyadic Services (DHCS)	Public Education and Change Campaigns (CDPH)
Broad Behavioral Health Workforce Capacity (HCAI)	Trauma-informed Training for Educators (OSG)	Student Behavioral Health Incentive Program (DHCS)		Statewide All-Payer Fee Schedule for School-Linked Behavioral Health Services (DHCS/DMHC)	ACEs and Toxic Stress Awareness Campaign (OSG)
Behavioral Health Virtual Services Platform (DHCS)					
Healthcare Provider Training and e-Consult (DHCS)					
Scaling Evidence-Based and Community-Defined Practices (DHCS)					

Student Behavioral Health Incentive Program (SBHIP)

- **SBHIP: Three-year project for MCPs to partner with schools**
  - Partnership legacy 14 counties
    - 14 County Offices of Education (COE)
    - 86 partner School Districts (LEAs)
    - Monthly ‘Learning Collaborative’
    - Over $22 million
  - Expansion counties
    - Completed transition plans along with exiting managed care plans ($2.3 million 2024)
    - 20 partner School Districts (LEAs)

Final Year 2024!

- **Multi-Payer Fee Schedule**
  - ***All*** health plans will reimburse for 'school-linked' behavioral health services beginning 2024
- **What is it?**
  - School sited or arranged for services by "school affiliated providers"
  - New, expanded provider types
  - No authorization requirements
  - Deductibles and Copays don't apply (generally)
- **How?**
  - State will use a third party administrator to receive claims and process credential providers.

***Schools can provide services with their own staff or through community providers**

Fee Schedule Services & Provider Types

Categories of service included in the fee schedule

Psychoeducation

Screening and Assessment

Treatment

Care Coordination

Eligible practitioners

- Alcohol and Other Drugs Counselor
- Associate Marriage and Family Therapist
- Associate Professional Clinical Counselor
- Associate Social Worker
- Educational Psychologist
- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- **Community Health Workers**
- Licensed Professional Clinical Counselor
- Medical Doctor (Physician or Psychiatrist)
- Nurse Practitioner
- Physician Assistant
- **PPS School Counselor**
- **PPS School Psychologist**
- **PPS School Social Worker**
- Psychologist
- Registered Nurse
- **Wellness Coaches**

Children & Youth Behavioral Health Initiative (CYBHI) and School Initiative

Cohort I: January 2024

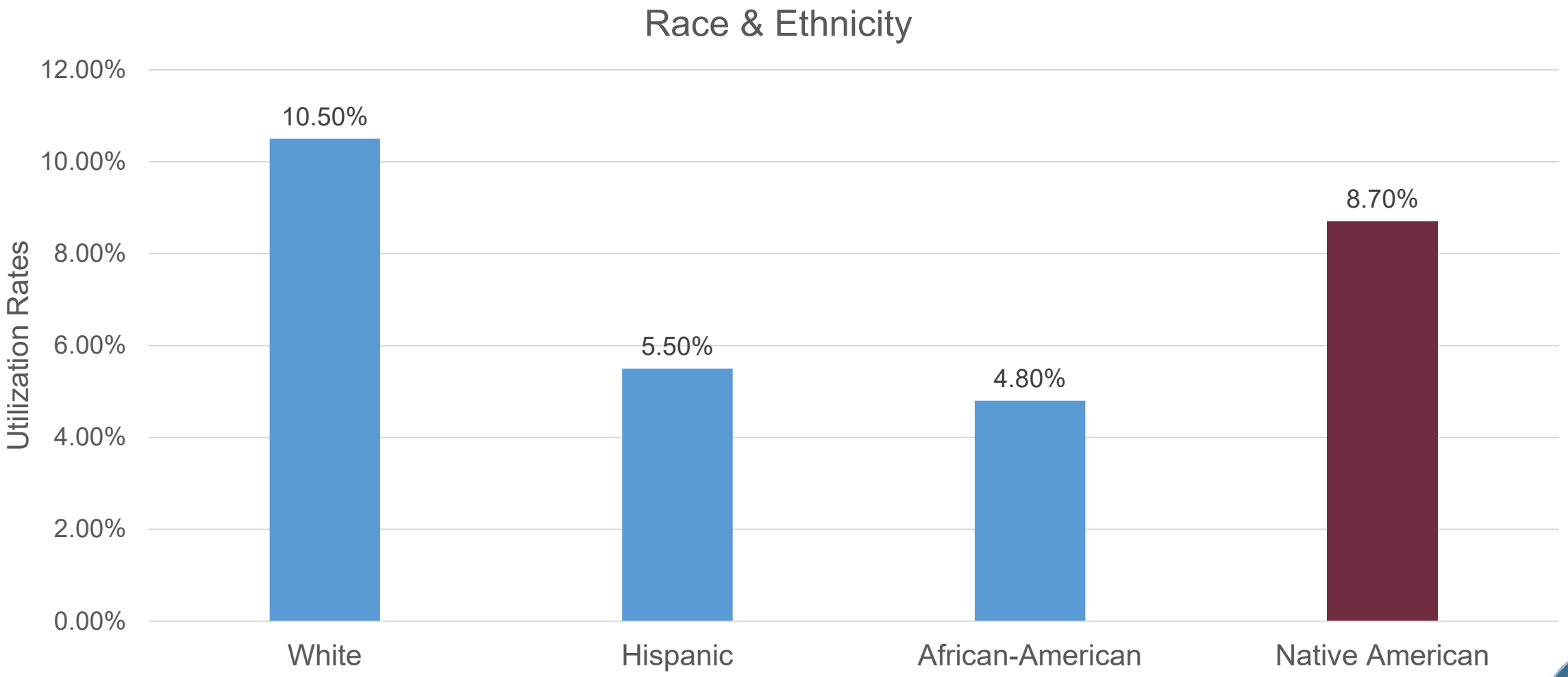
- Butte – Butte COE
- Humboldt – Humboldt Court & Community; Southern Humboldt USD
- Nevada – Nevada Joint USD
- Placer – Placer COE; Roseville Joint USD
- Shasta – Shasta COE
- Solano – Solano COE
- Tehama – Tehama COE; Red Bluff Union SD

Cohort III: January 2025

Cohort II: **July 2024**

- Butte – Core Charter School, Thermolito Union
- Del Norte – Del Norte COE
- Glenn – Orland School District, Glenn COE
- Humboldt – Eureka City Schools
- Marin – Marin COE
- Mendocino – Mendocino COE
- Modoc – Modoc COE
- Nevada – John Muir Charter
- Placer – Tahoe-Truckee Unified, Rocklin Unified
- Sonoma – Windsor Unified, Santa Rosa City Schools
- Trinity – Trinity COE
- Yolo – Esparto Unified, Winters Unified, Davis Unified
- Yuba – Wheatland Union, Yuba COE

Utilization of Mental Health Services CY 2023



What Do We Know About Our Utilizing Members?

Members utilizing non-specialty mental health services:

- Overall average of 10 visits per utilizer
- 32% telehealth visits
- 88% therapy
- 12% medication management
- Diagnoses:
  - 45% anxiety disorders
  - 25% depressive disorders

Mental Health: Member Outreach and Education Plan

SB1019 mandates that all managed care plans do the following every year:

- Conduct an assessment of mental health utilization
- Consult with stakeholders:
  - Consumer Advisory Committee
  - Tribal members
  - Racial and ethnic diverse stakeholders
  - Include input from the Population Needs Assessment
- Create a member outreach and education plan
  - Plan must include multiple means of communication
  - (examples: website, written materials, texts, etc.)
  - Use “stigma reduction” techniques
  - Meet cultural and linguistic standards

We need your help!

Tribal Health Roundtables in 2025

Traditional Healers and Natural Helpers

- CMS:
  - Approval expected this year! Effective date unknown, but likely in 2025
  - Would be a demonstration project, with an evaluation (to be designed)
  - Services provided by Tribal health centers
  - Any Medicaid beneficiary would be eligible
  - Healers would need to be employed by health center.
- DHCS 1115 Waiver Proposal:
  - Traditional healers and natural helper services for use in treatment of **Substance Use Disorder**, in **counties with a Drug Medi-Cal Organized Delivery System.**
  - Healers need two years of experience, recognized by their Tribe.
  - Credentialing process must be developed by the Tribal health center.

https://www.dhcs.ca.gov/services/rural/Documents/Tribal-Consultation-Meeting-07-22-24.pdf

Service Descriptions

- **Traditional Healers** may use an array of interventions including, music therapy (such as traditional music and songs, dancing, drumming), spirituality (such as ceremonies, rituals, herbal remedies) and other integrative approaches.

- **Natural Helpers** may assist with navigational support, psychosocial skill building, self-management, and trauma support to individuals that restore the health of those DMC-ODS beneficiaries receiving care at IHCP.

Substance Use Disorder Tx Services

Drug Medi-Cal – Organized Delivery System (DMC-ODS)

- ***Expanded*** substance use disorder treatment benefit under Medi-Cal
- Includes residential treatment
- Uses a tool from the American Society of Addiction Medicine (ASAM) objectively screens individuals to different levels of care
- Counties can opt in across the state

Substance Use Services Systems

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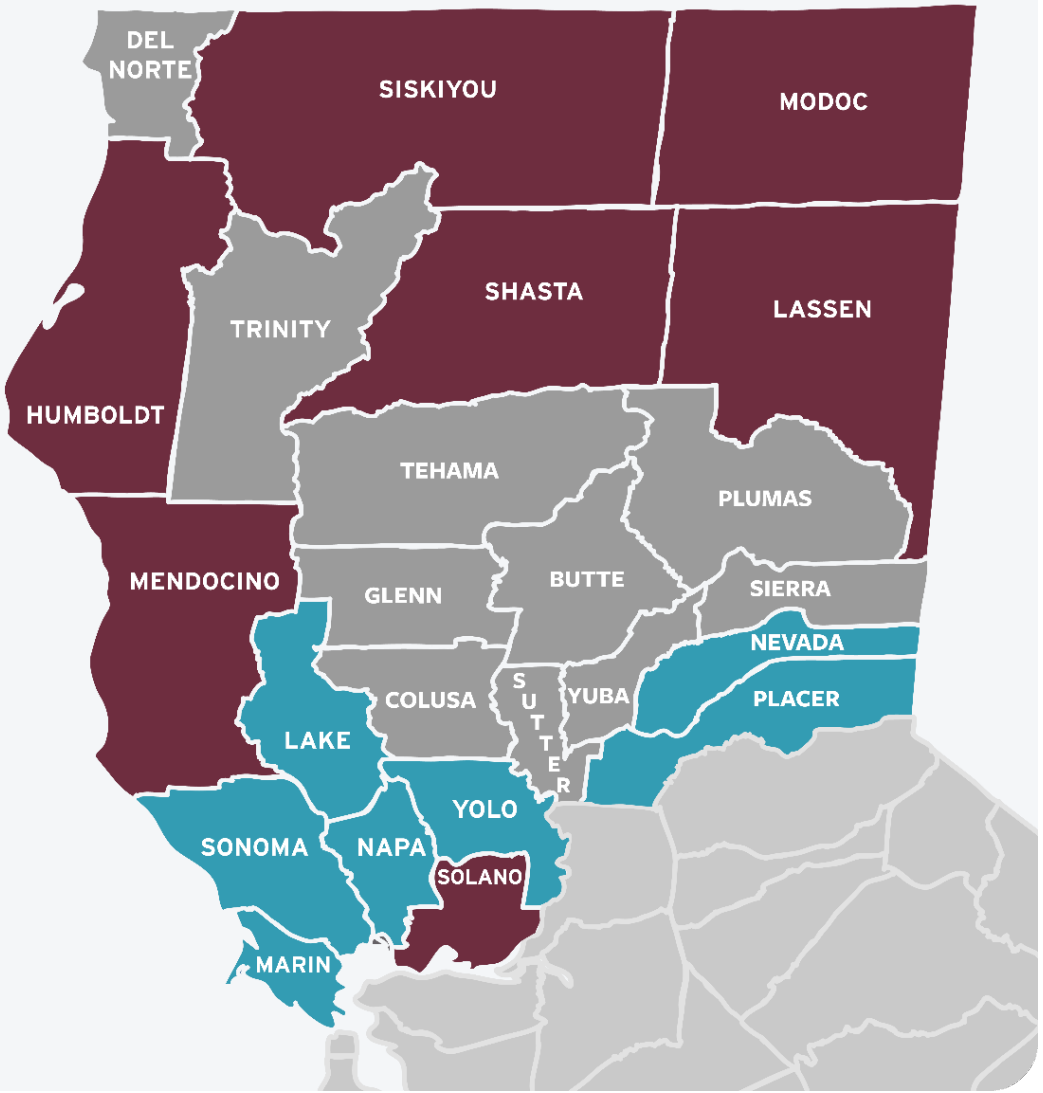
Organized Delivery System in Partnership Counties



- Partnership Wellness and Recovery Counties
- County-Run Drug Medi-Cal ODS
  Sonoma: January 1, 2025
- Counties without Drug Medi-Cal ODS

ACCREDITED NCQA HEALTH PLAN

SUD Regional Model Utilization Rates by Race/Ethnicity

Partnership / Regional Model				Statewide
Race/Ethnicity Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate
White	115,963	2,564	2.21%	1.93%
Latino/Hispanic	49,619	311	0.63%	0.69%
African-American	18,743	279	1.49%	1.33%
Asian/Pacific Islander	16,707	49	0.29%	0.17%
Native American	8,221	171	2.08%	2.02%
Other	33,751	417	1.24%	1.40%

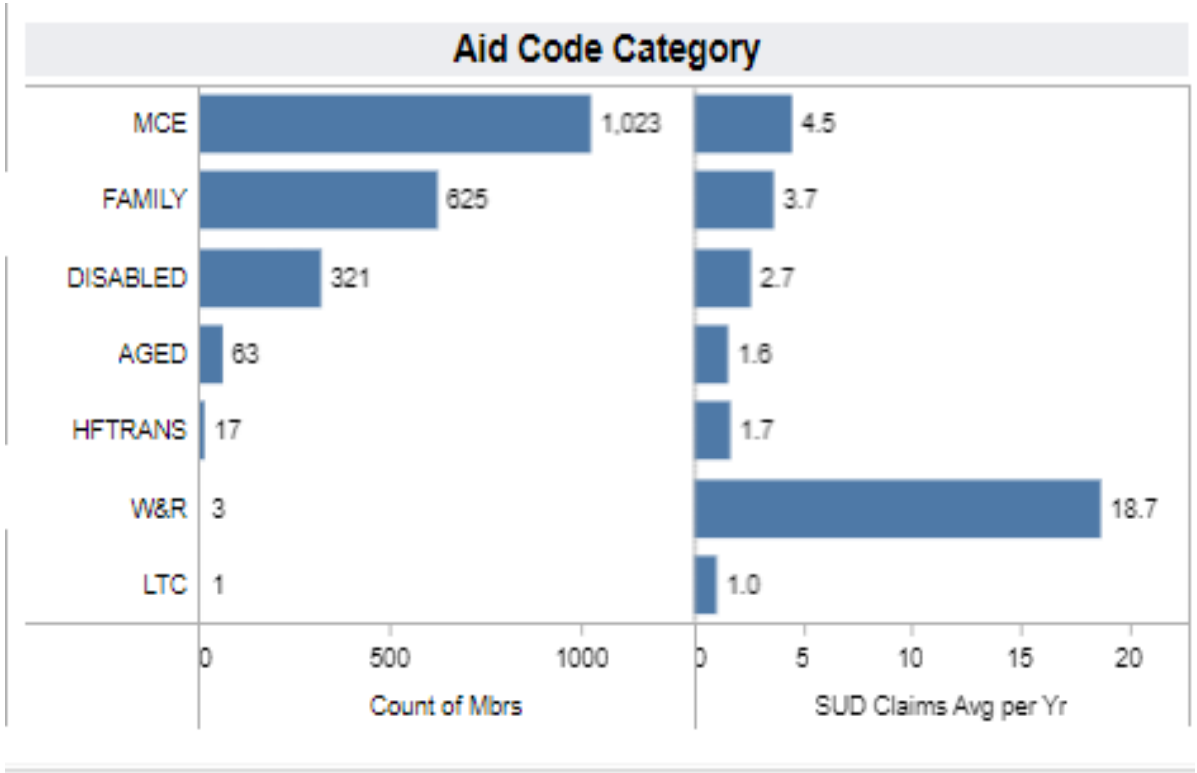
*As reported by BHC & UCLA through the 2022 Regional Model EQRO

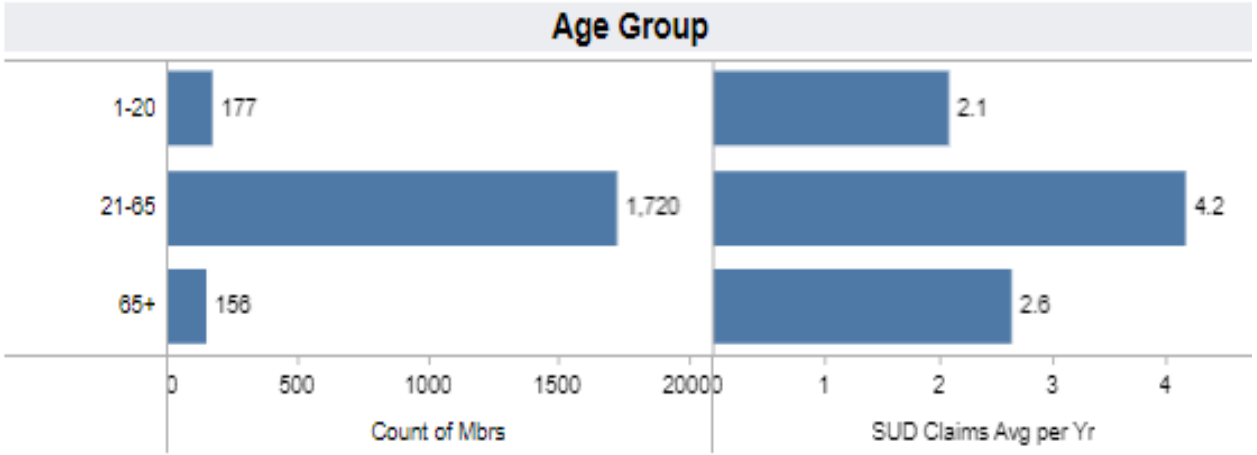
Substance Use Disorder Services (all settings)

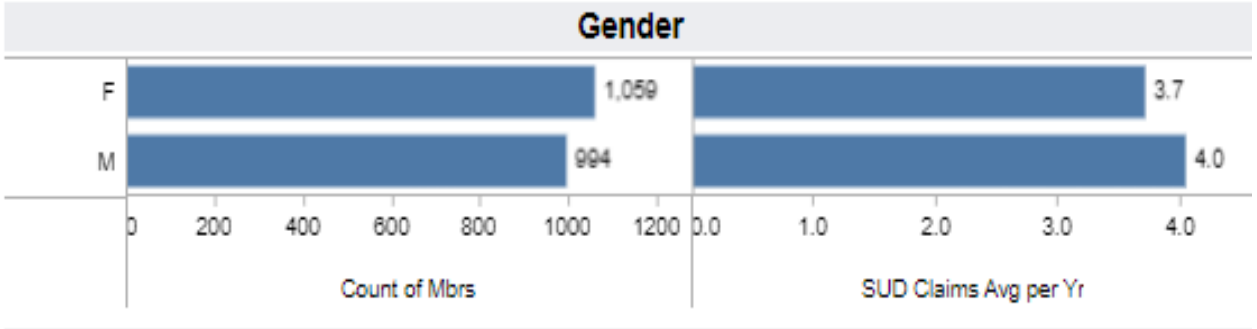
In 2023, SUD services were provided to 2053 Native American members with 8% rendered for youth

Native American members had an average of 3.9 claims as a result of their SUD diagnosis per year

21.4% of Native American members who received SUD services were unhoused







Best Practices in Supporting Youth

- What programs do you offer at your health center that support youth in building resilience, prevention, and early detection of depression?

Questions

See handouts for more information about mental health and substance use services.

Break

- Break for 10 minutes
- Raffle after break

Prizes

- Please take your seats

Keynote

Virginia Hedrick, Yurok Tribe

Questions

Wrap Up and Thanks!

- Thank you for attending!
- Acknowledgments
- Feedback: Survey coming – or you can email any of us!