MINUTES

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

QUARTERLY BOARD MEETING

JANUARY 19-21, 2016

SILVER REEF CASINO RESORT
FERNDALE, WA

January 2016 Quarterly Board Meeting
Summary of Minutes

Issue	Summary	Action	Follow-Up
Tuesday January 2016			
Area Director Report – Dean Seyler	Renew and Strengthen Our Partnership with Tribes and Urban Indian Health Programs ❖ Special Diabetes Program for Indians (SPDI)- FY2016 ❖ Community-Directed Grants- $130,200,000 ($25,552,678 increase) ❖ Portland Area- $6,932,564 ($1,198,021 increase) ❖ National funding formula based on user population, tribal small-size adjustment, and disease burden (prevalence) ❖ Thirty-seven successful grantees were announced in December. ❖ Portland Area Funds Distribution Workgroup (FDWG) convened to recommend to the Area Director method for funds distribution. ❖ Recommendation ❖ 5% of Area funds set aside for NPAIHB Data Center ❖ "Hold Harmless" concept- All sites begin with a base of the same amount they received in FY2015. ❖ Remaining funds divided: 70% proportionally based on FY2014 user population and 30% equally divided among grantees. ❖ Status of FY 2016 Funding ❖ Continuing Resolution #1 (10/01 - 12/11) 19.67% (with .2108% reduction) ❖ Continuing Resolution #2 (12/12 - 12/16) 1.37% (with .2108% reduction) ❖ Continuing Resolution #3 (12/17) 0.27% (with .2108%		

reduction)
- ❖ Continuing Resolution #4 (12/18 – 1/16) 8.20% (no reduction)
  - ❖ The final budget for IHS is pending OMB review and approval.

To Improve the Quality of and Access to Care

- ❖ IPC 2.0
  Nov 2015 -New Curriculum to IST
- ❖ Dec 2015-Feb 2016 -Site On-Boarding
- ❖ Mar-Dec 2016 -IPC 2.0 Implementation
- ❖ Site that are interested should contact one of the following Area Office Staff:
  - ❖ Jonathan Merrell Jonathan.merrell@ihs.gov
  - ❖ Tom Weiser – Thomas.Weiser@ihs.gov or tweiser@npaihb.org

To Improve the Quality of and Access to Care

- ❖ **RPMS Network On-Boarding**
  - ❖ RPMS DIRECT Messaging, IHS Personal Health Record (PHR), Master Patient Index (MPI), and Health Information Exchange (HIE)
    - ❖ All 6 Federal Service Units have completed the full on-boarding process and are now eligible to begin
    - ❖ No Tribal/Urban facilities have started the on-boarding process yet
    - ❖ Information and requirements have been distributed to all Portland Area Clinical Applications Coordinators
    - ❖ Any site that is interested in on-boarding to the IHS RPMS Network should contact CDR Roney Won (roney.won@ihs.gov | 503-414-5579)
- ❖ **Regional Specialty Referral Network Demonstration Project**
  - ❖ The PAFAC Found Both Proposed Sites Acceptable and

Provided the Following Recommendation for Locating the First of Three Facilities:
- Recommendation 1 – Fife, WA
- Recommendation 2 – Grand Mound, WA
- Recommendation Based on Three Factors
- Area Master Plan Alignment
- User Access
- Specialty Provider Recruitment and Retention
- Recommendation Conditioned Upon Identifying a Site Meeting Planning Criteria (i.e. Construction Feasibility and Expansion)
- PAO Staff Accelerating Project Planning Activities.
- PAFAC Will Continue Developing Recommendations to Maximize Benefits for all Portland Area Tribes

- **Anticipated FY 2016 Tribal Medical Equipment Funds**
  - Purpose:
    - Purchase Medical Equipment for New Tribally Constructed Healthcare Facilities.
  - Application:
    - Apply Online: https://facilops.ihs.gov/erds/
    - Due February 26, 2016
    -
  - Requirements:
    - Design Contract Signed Before Application Deadline.
    - Construction Contract Signed Between October 1, 2014 and September 30, 2017.
    - Project Funded in Part or in Total with Non-IHS Funds.
    - The Applicant Has Not Received Prior Tribal Equipment Funding for the Respective Facility.
  - Questions: Jonathan McNamara, Biomedical Equipment Program Specialist at (503) 414-7770 or Email at

	jonathan.mcnamara@ihs.gov ❖ **Active SFC Construction Underway in First Quarter FY2016** ❖ Spokane Tribe – Martha Boardman And Ford Water System Improvements For 105 homes. $710,097.92 Budget. Construction Is Over 2/3 Complete Since October. Project Completion Is Expected In Spring 2016. ❖ Makah – Sooes Valley Water Extension For 26 homes. $505,200 Budget. Work Was Inspected In December And Complete. ❖ Makah – Sewer Outfall Repairs Emergency Project For 517 Homes. $822,000 Budget Funded By IHS Emergency Funds And HUD ONAP Imminent Threat Grant. Construction Is Nearing Completion. ❖ Tulalip – Mission Beach Wastewater Treatment Plant For 394 Homes: $1.4 Million Construction Contract. Work Is Nearly Complete, And Wastewater Treatment Has Been Reported To Be Improving. Completion Expected By February. ❖ Swinomish – Water System Improvements For 200 Homes: A 300,000 Gallon Water Tank Has Been Constructed And Is Nearly Ready To Be Placed Online. Total Project Budget Is $1.2 Million, Cooperatively Funded By The Tribe And EPA . Completion Is Expected By February. Renew and Strengthen Our Partnership With Tribes and Urban Health Programs ❖ **The Department of Health and Human Services (HHS) Secretary's Tribal Advisory Committee (STAC)** ❖ A primary delegate and an alternate from each ❖ W. Ron Allen and Cheryl Kennedy ❖ One National At-Large Alternate vacancy ❖ February 5, 2016 Deadline ❖ Albuquerque - Bemidji – California ❖ Nashville - Oklahoma - Portland		

- National At-Large Primary Delegate (3)
- National At-Large Alternate

To Improve the Quality of and Access to Cure

- **Government Performance and Results Act (GPRA)**
  - **GY 2016- 24 measures**
  - **Four new measures:**
    - Statin Therapy to Reduce CVD Risk with Diabetes
    - Influenza vaccination Rates Among Children (6 mo-17 yrs)
    - Influenza Vaccination Rates Among Adults (18 and older)
    - HIV Screening Ever (13-64 years old)
  - **Two revised indicators:**
    - FAS Prevention (alcohol screening)- Age range expanded to females 14-46 years.
    - DV/IPV Screening- Age range expanded to females14-46 years.
- **<u>Naloxone: IHS-BIA MOU</u>**
  - The 7 Federal Pharmacy clinics have begun ordering small quantities of Naloxone Rescue Kits in preparation for full implementation in early 2016 when given the "go-ahead" from IHS HQ
    - Prior to this time, the pharmacies will be providing Naloxone to Tribal Police upon request
    - Available formulations:
      - VA Naloxone Rescue Kit (2 doses) – (off-label use) $39.20
      - Evzio® (Naloxone HCl) 0.4mg Auto-Injector (2 doses) - $379.20
      - Narcan® Nasal Spray – only FDA-approved intranasal formulation

	❖ Projected cost ~$70 | expected to be available in mid-January 2016 Portland Area Federal Sites Flu Vaccine Coverage Graphics		
Executive Directors Report – Joe Finkbonner	Personnel • Promotions: Lisa Griggs, ProgOps & Executive Assistant • Resignations: Jim Roberts, Policy Analyst • Temp: Cathy Ann Ballew, TOTS2T Tween Site Coordinator Events November 2015 • PHAB Accreditations, Alexandria, VA • University of Arizona Advisory Committee • Staff Retreat December 2015 • Dental Therapy Convening, Portland, OR • NPAIHB Staff Holiday Party • PHAB Board Meeting, Alexandria, VA • Hot Dog Feed…raised $$ January 2016 • Swinomish DHAT kickoff event Upcoming • ATNI Winter Conference, Suquamish – Feb 2-4 • CDC/TCAC, Atlanta, GA – Feb. 9-11 • NCAI Winter Session, Washington, DC Feb 22-26 • NWIC Foundation Board Meeting – Feb 26 • State of Oregon Rules Committee – Mar 8 Oregon Tribes DHAT Pilot Project Update Pilot Project Application • First Pilot Project submitted to the state: Project 100! • It was deemed “complete” and has gone through a 30 day review by a		

	Technical Review Board. • 10 days ago we received a "Notice of Intent to Approve" the application from OHA. It is now in the final few days of a public comment period. • OHA Dental Director will have up to 30 days to make final decision Next Steps • Once approved, we'll create an evaluation plan with a research contractor to measure the outcomes outlined in the application. Access to care, quality of care, and cost of services are all things we will be measuring. • One student from CTCLUSI started her DHAT training this past summer. CTCLUSI will start recruiting 2nd DHAT student and Coquille will be recruiting their 1st DHAT student from for July 2017 start of training • We are working with CTCLUSI to recruit an experienced DHAT to begin providing services at dental clinic in mid-2016 • Explore DHAT programs at other Tribes in OR Building Update		
Legislative & Policy Update – Jim Roberts	FY2016 Omnibus • FY 2016 President Request $460 million increase – House bill is $315 less than President's Request – 3.1% – Senate bill is $324 million less than President's Request – 2.9% – $8.6 million difference with House mark higher • FY 2016 Omnibus passed December 18, 2015 • Provides $4.8 billion for IHS programs, $295 million less than President's Request • $165 million increase over FY 2015 level, a 3.6% increase FY2016 IHS Budget Highlights • Very modest budget increases for H&C and Prevention accounts with exception of A&SA funding		

	• No funding for medical inflation or population growth • $19.4 million is included for pay act increases • Across the board H&C and Prevention receive less than 1.5% increase • Alcohol & Substance Abuse receive additional $14 million, a 7.5% increase over FY 2015 • CHS Program is flat line funded at $914 million • CSC receives $55 million increase, a 8.3% increase • Facilities accounts receive very good increases of $20 million for M&I, Sanitation, Construction Facilities Programs receive good increases • Maintenance & Improvement additional $20 million after 2-3 years of flat line funding 37% increases • Sanitation Facilities $20 million increase, 25% increase • Health Facilities Construction $20 million increase—President requested $100 million increase • California YRTC facilities funding is included • Contract Support Cost • FY 2016 final appropriation includes indefinite appropriation for CSC • IHS continues to meet with CSC Workgroup & initiated Tribal Consultation on its Policy – Tribal Redline with IHS responses prepared • Denver meeting nearly imploded over developing letter on duplication and pass through issues—speaks to the relationship with Tribes & IHS • Outstanding issues: – Cost incurred approach for reconciliation – Pass through and exclusions – Types of CSC reviewed for Duplication/Reconciliation – IHS marks to Tribal redline change some current practice – IHS CSC Practice and Impact on Health Programs • The costs incurred approach may impact Tribes that allocate CSC to their general fund		

	• IHS reconciliation process requires program to spend all health funding • If you do not spend 100% of your funding, there is a requirement to pay back CSC funds on unspent program dollars • This could pose accounting issues for Tribes that do not reserve CSC for health programs • In carry over situations, CSC could have been spent by Tribe, and now poses an accounting issue for where the funds to pay back IHS will come from? • Tribes may want to consider adopting accounting practice to deal with this issue. CMS 100% FMAP Update • CMS is still reviewing comments on its proposed 100% FMAP White Paper • January 11, 2016, CMS letter to South Dakota reveals framework of new policy and CMS anticipates issuing SMD letter the construct of the SD letter – CMS intends to allow 100% FMAP by non-I/T providers when a "written care coordination arrangement" are met – Non- I/T provider must be enrolled as participating Medicaid Provider – Established relationship patient and qualified practitioner at I/T facility (in person visit or telehealth) – Patient records retained by facility – 100% FMAP will be made on a permanent basis for such services • Next steps for CMS – Issue SMD letter outlining South Dakota framework – Develop minimum standards for "care coordination arrangement" (caution policy about referred services vs. authorized services) – Defining arrangements between IHS/Tribal facilities and		

Medicaid Providers
  - Defining the scope of Medicaid services
  - Defining billing and payment arrangements (I/T makes referrals and Medicaid provider bills, will require agreements)
  - CMS indicates technical assistance available to the states and to the Tribes

Accountable Health Communities Model Grants

- CMMI announced 5 year funding opportunity for up to $157 million to test screening for health related social needs
- Community based, non-profits, hospitals, and tribal organizations are eligible
- Program will require health personnel to screen patients for social issues like hunger, housing, domestic violence which can affect health care
  - Housing instability
  - Food insecurity
  - Utility needs
  - Interpersonal violence
  - Transportation needs /employment
- Funds are not for direct services but rather linkage types of activities
- CMS will award 44 cooperative agreements; **Letter of intent is due February 8, 2016**

Medicaid Access Rule Published

- November 10, 2015, CMS issued IFR for "Methods for Assuring Access to Covered Medicaid Services"
- Rule requires States to document access to care standards and provider payment rates
- Intent of the rule to ensure that payment rates are sufficient to attract providers on a geographic basis across a state
- Rule establishes standards for access to care and payment rates

- This can assist Tribes that are unable to get patient in for specialty care if clients are not enrolled in managed care
- States are required to complete access monitoring review by July 1, 2016—Tribes should ask to be part of this process
- Medicaid managed care rule pending...good language for Indian health programs

Veterans Choice Act Final Rule Issued

- October 29th NFR to implement Section 101, which established the Veterans Choice Program
- VCP expands access to non-VA care for veterans who qualified based on either wait time or distance from a VA facility
- IHS programs are eligible to participate in this program as participating providers, criteria include:
  - Wait times exceed 30 days
  - Live over 40 miles from VA facility or excessive burden to travel by ferry, air, boat to reach facility
- VA Tribal affairs staff will be here at QBM to answer questions

STAC Meeting Update

- CMS report of 100% FMAP was front and center
- ACA Updates and referrals, call center, Medicaid expansion with FFM
- ACA Employer Mandate fix
- Veteran Administration and IHS interoperability around services and MOA reimbursement agreements
- SAMHSA block grant funding and suicide in Indian Country
- IHS employee union settlement and worksheet of settled amounts by Area – None in Portland Area
- IHS discussed changes to SDPI funding
- Idaho 1915(b) Waiver for behavioral health services

Legislative Issues for 2nd Session of the 114th Congress

	• Employer Mandate • Advance Appropriations • SDPI Reauthorization • IHCIA Technical Amendments • Medicare-like Rates for outpatient services • Contract Support Costs mandatory funding and reconciliation language Indian Legislative Bills in 114th Congress • S. 286 – Department of Interior Tribal Self-Governance Act of 2015 – Introduced by Sen. John Barasso; Co-sponsors include Senators Tester, Murkowski, Crapo, Schatz, Franken – Amends Title IV of of ISDEAA to make it consistent with Title VI, the Self-Governance Program for HHS – Creates the same administrative efficiencies for DOI that have been in place for HHS programs. – Sen. McCain Amendments cause alarm going to mark-up but were withdrawn and had to do with *"OIG Alert to Tribes on the use of ISDEAA and 3rd Party Funds"* – S. 286 passed Senate by Unanimous Consent and has now been sent to the House for consideration – Title IV Task Force is trying to find a primary sponsor in the House • Senate bill Exempts Tribal Programs from Sequestration – S. 1497 would exempt IHS, BIA, HUD and other Indian programs from sequestration required under the Budget Control Act of 2011 – Introduced by Sen. Tester (MT); only one cosponsor Sen. Udall (NM) • House bill Exempts Tribal Programs from Sequestration – H.R. 3063 same companion bill to S. 1497 – Introduced by Rep. Young (AK); Co-sponsors include		

	Representatives Cole (OK), Ruiz (CA), McCollum (MN) • Both bills referred to Budget Committees • Likely to die in Committee • Likely best chance to avoid sequester for Indian programs is language in specific appropriations (Interior, HUD, Labor-HHS) • Exemption from ACA Employer Mandate (Shared Responsibility) – Tribal Jobs Employment and Protection Act – S. 1771 Introduced by Sen. Daines (MT); Co-sponsors Senators Crapo (ID) and Thune (SD) – H.R. 3080 introduced by Rep. Noem (SD); Co-sponsors Representatives Cole (OK) and Zinke (SD) – Senate bill referred to Finance; House bill referred to Ways & Means • Cadillac Tax amendment? • If passed what will the President do? • S. 1964 Family Stability and Family Kinship Act of 2015 – Introduced by Sen. Wyden; Co-sponsors Sen. Bennett, Brown, Cantwell, Casey, Gillbrand, Menendez, Schumer, Stabenow, Warner – Reforms the federal finance system supporting state and child welfare services – Funds preventive services and kinship placements for children at risk of foster placement – Current law creates incentives to place Indian children outside of families in order to receive federal funding – Encourages child welfare system to forego alternatives to prevent breakup of families like parent training, mental health counseling, trauma recovery, etc.		
Region X Update – Susan Johnson	See Minutes		
Hepatitis C – Jessica	See attached PPT		

Leston			
Accountable Communities of Health – Jessie Dean	See attached PPT		
Wednesday January 20, 2016			
WEAVE-NW – Nanette Star Yandell	See attached PPT		
Health Sovereignty and DHATS	See attached PPT		
Veteran's Administration Updates – Terry Bentley	See attached PPT		
Tribal Updates	See attached PPTs		
Tribes and Cannabis – Lael Echo-Hawk	See attached PPT		
Casey Eye Institute On the Road – Joan Randall	See attached PPT		
IDEA NW Registry & Data Sharing Agreements	See attached PPT		
21st Na-ha-shee Health Science Institute & New WSU Medical School	See attached PPT		
Tobacco Presentation	See attached PPT		
Election of Officers	**Chairman- Nomination Andy Joseph, Jr. by Greg Abrahamson, 2nd by Rhonda Metcalf closed and nominated by acclimation**		

	Closed by Cheryl Sanders		
	Secretary – Nominations Greg Abrahamson by Ronda Metcalf, 2nd by Kim Closed by Janice Clements, 2nd by Sean, nominated by acclimation		
Thursday January 21, 2016			
Chair's Report	See minutes		
Financial Report	See attached spreadsheets **Approve Finance Report, Motion, made by Greg Abrahamson, 2nd by Rhonda Metcalf, voted and passed**	**Motion Passed**	
Committee Meeting	Elders – Report Attached		
	Veteran's – Report Attached		
	Public Health – Report Attached		
	Behavioral Health – Report Attached		
	Personnel – Report Attached **Approval of Personnel report, Motion by Cheryl Raser, 2nd by Cheryle Kennedy motion passed**	**Motion Passed**	
	Legislative/Resolution – Report Attached		
	Federal Marijuana Policy & State Legalization – Presentation Attached		
Resolutions			
Resolution16-02-01 We R Native: Text 4 Sex Ed Resolution **Motion, Andy Joseph, 2nd by Rhonda Metcalf motion voted and passed**		**Motion Passed**	
Strategic Plan	**Motion, Leslie Wosnig, 2nd Greg Abrahamson voted and passed 1 abstention**	**Motion Passed**	
Approval of Minutes	**July 2015 motion, Greg Abrahamson 2nd by Cheryle Raser, motion voted and passed**	**Motion Passed**	
	October 2015, motion Greg Abrahamson, 2nd by Bonnie Sanchez, motion voted and passed	**Motion Passed**	
Future Board Meetings	**January 2017 - Chehalis motion to support by majority in agreement**	**Motion Passed**	
MOTION ADJURN	**Adjourn: motion by Greg Abrahamson, 2nd by Kim Zillyett-Harris motion voted and passed**	**Motion Passed**	

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

JANUARY 2016 QUARTERLY BOARD MEETING

Silver Reef Casino Resort, Ferndale, WA

MINUTES

Tuesday, January 19, 2016

Posting of Flags: Tribe Veterans posted the flags.

Roll Call: Shawna Gavin, Secretary, called roll: Thank you, Andy

Burns Paiute Tribe – **Present**	Nisqually Tribe – **Not Present**
Chehalis Tribe – **Present**	Nooksack Tribe – **Not Present**
Coeur d'Alene Tribe – **Absent**	NW Band of Shoshone – **Present**
Colville Tribe – **Present**	Port Gamble Tribe – **Present**
Grand Ronde Tribe – **Present**	Puyallup Tribe – **Not Present**
Siletz Tribe – **Present**	Quileute Tribe – **Present**
Umatilla Tribe – **Present**	Quinault Nation – **Present**
Warm Springs Tribe – **Present**	Samish Nation – **Present**
Coos, Lower Umpqua & Siuslaw Tribes – **Present**	Sauk Suiattle Tribe – **Present**
Coquille Tribe – **Present**	Shoalwater Bay Tribe – **Present**
Cow Creek Tribe – **Present**	Shoshone-Bannock Tribe – **Present**
Cowlitz Tribe – **Present**	Skokomish Tribe – **Not Present**
Hoh Tribe – **Absent**	Snoqualmie Tribe – **Present**
Jamestown S'Klallam Tribe – **Absent**	Spokane Tribe – **Present**
Kalispel Tribe – **Present**	Squaxin Island Tribe – **Present**
Klamath Tribe – **Present**	Stillaguamish Tribe – **Present**
Kootenai Tribe – **Absent**	Suquamish Tribe – **Present**

MINUTES

Lower Elwha Tribe – **Absent**	Swinomish Tribe – **Present**
Lummi Nation – **Present**	Tulalip Tribe – **Present**
Makah Tribe – **Present**	Upper Skagit Tribe – **Present**
Muckleshoot Tribe – **Absent**	Yakama Nation – **Absent**
Nez Perce Tribe – **Present**	

Mr. Chairman, we have a quorum. [There were 29 delegates present, a quorum is established]

AREA DIRECTORS REPORT

Dean Seyler: All right. Good morning everyone. Let's start off by sharing an update on the Special Diabetes Program funds that will change this fiscal year. Trying to work via 0:29:38.7 [INAUDIBLE.] I think Sharon gave an update during the last QBM. So what I wanted to do was just to make sure that this information was in your packet, that you had access to it. The big things they look at is that for the Portland Area, we did see an increase of 1.1 million for the area. And that the fund distributable workgroup did the, or did make a recommendation to hold harmless concept, that all sites with a baseof the same amount they received in FY2015 And then the main funds were divided as it's noted there, 70% proportionally based on user pop, and 30% equally divided among grantees.

An update on the 5% recommendation that they gave. Agree with that. Right now, I've got a call into headquarters. Hopefully I can catch them today. But to get more details as to how that changes up for this year. Because there's no 5% that has been constituted to help for us. With that technical grant, what they require now is that they have to follow the Federal Acquisition Regulations, (FAR). And they jointly put it out to bid. And all that process. I know that they were close, and Dr. Rudd has given an update on their own 0:31:20.8 [INAUDIBLE.] And then as soon as we get that information, we'll make sure and get it to the Health Board that work with the staff as much as we can. We're pretty limited as far as our involvement with the FAR as Federal employees. We have to walk that fine line and make sure that we don't get 0:31:41.7 [INAUDIBLE] in the eyes of the regulations 0:31:44.9 [INAUDIBLE.] So I hope to hear soon from Dr. Wallace down at headquarters and roll with that. But it's both for the Portland area and the Alaska area, or the Olympia area. The area offices themselves didn't operate Medical Support Center. It was the forms and both areas.

So we don't have the remaining fiscal year 16 money yet. I wanted to share this with

you, the 3/4 team Resolutions that we did work our way through at the beginning of the fiscal year as listed here. So far, as of January 14th, we had distributed $43 million to the Tribes. So the finance folks and our folks and everything you saw in Oregon. Very quickly, get all the paper work done and to get the money shipped over to the Tribes as soon as possible. For the calendar year Tribes, those were processed on January 7th and sent to the President on January 8th. So you should see you should have seen the money from the accounts already. If you haven't, make sure and let Terry know to follow up on.

The fiscal year a couple payments, we entered into our financial management system and it reopened on December 22nd, so they're in the process of getting those completed as we speak.

With the IPC 2.0 that's rolling out, there is a new curriculum coming out, and both Dr. Rudd and I were at a meeting a couple weeks ago in Phoenix where we had a little meeting on it. But it's something that is open again to any Tribes who wish to take part it that. And the two contact folks are either Jonathan Merrill or Dr. Weiser. If you choose to join into that. So far, we have not received any notifications of any Tribes that I'm aware of. Is that correct, John? No Tribes?

John Merrell: We have six Tribes.

Dean Seyler: Oh, we have six now. Oh. RPMS network, onboarding for those tribal programs that are running RPMS, the direct messaging, the IHS personal health record, mass client index, that's been in the test phase. All six federal sites, as we see they have completed the full onboarding. We've been testing with select folks instead of opening it up to everybody yet to make sure we can work through any of the little bugs and kinks that come up. For example, Dr. Rudd had his set up as one of the guinea pigs there, and they worked through some issue. It was a good thing because we want to be able to roll that out to the communities this fall or as soon as possible, knowing that there will be little hiccups here and there, but try to reduce that as much as possible. And I think this is where I get confused when I'm talking about as far as the Tribal facilities have started, is this avocation that no tribe has started the onboarding process yet. And they, when they're ready to do that, then they can contact 0:35:30.0 Commander Roney Won who's our pharmacy consultant and he's are Clinical Applications coordinator at the Area office. And he's got that information.

So the Regional Referral Center, network demonstration project, you guys know that's been helping share here for quite a while. The previous area Director here was Doni Wilder was the one who started up the committee and they've done a lot of work on it. It's finally gotten to the point where things start kind of moving and change back East, and also things changed here in the Northwest. And long story short, we had two

MINUTES

Tribes that offered land up to be considered for Phase 1 of the first of the three facilities. We did get an outside contractor, the Manola Group to pull in the data, to take a look at everything and provide an update to PAFAC who I had a long expedited meeting scheduled. And I'd like to thank those members who arrived, for taking the time to dial in and squeeze it into their schedules. But as it turns out, at the end of the day, it turns out the committee recommended and I accepted their recommendation to go with a Fife, Puyallup location with all the Tribe's land that was offered. And both sites were acceptable, but the Fife location they showed that they're 100,000 more users within a 120 mile radius. So it's the right location. And five offers more transportation options. The special need provider recruitment and retention, five was in a larger claim market. And should be easy to recruit and try to retain specialty providers.

So time is of essence. We're already working with headquarters to identify additional funding to go to the next step and get a PJD in place, a task which to move it along quickly, and that's what we're gonna do. There are conditions that Puyallup must meet, that we're gonna explore more with them, and if they don't, if they can't meet those within a timely fashion, then we'll go back and take a look at how we can make this work with Chehalis. So that's an update regarding this.

FYI, regarding the 2016 tribal Medical Equipment Improvement funds, they're there, and tribal facilities are starting up. They need to get their applications together. They have approximately $5 million available this month, but there's a cap of $300,000 that a tribe can request. As we see, the due date is February 26th and there is a website link there that you can go and apply online.

Quick update, much more detail each one, but just to show you the impact that the Sanitation and Facilities Construction Division OEE Environmental Engineer is working on. You know, I meant to count out the total number of homes that are being impacted in a positive way this coming fiscal year. Just doing a quick look at that, you're looking at probably around 1,000 homes, tribal homes throughout the Portland Area that are gonna see an improved service, whether it's water or removal of wastewater. One of the things that really, really -- not tasking, but been a little bit of a challenge is the Makah Sewer outfall repairs where it kind of looked like a Loch Ness Monster was out there in the bay and some of the fishermen we showed where the anchors gave way. But that's been moving along quite well. So we don't anticipate any further problems with that.

The STAC, the letter that came out from Secretary Burwell asking for nominations in the listed areas, Portland's in there. And the reason why Portland was listed is that the two members there, their term limit is coming up. So I did email both Ron Allen and Cheryle Kennedy and I haven't heard back from Cheryle, but Ron said that he'd want to put his name in again. So you should expect to see that, and I was hoping to catch Cheryle

here today and find out if she got that information, but anybody can put their name in for it, but just FYI, Ron's gonna put his name in.

So before I turn this over to Dr. Rudd, I just wanted to give a quick update. I didn't have information on a slide at the last board meeting. I mentioned that we had filled the area Dental Offices position, but there was a process of offering the job The person's name Dr. Sixkiller. She is currently a practicing dentist at the Warm Springs Service Unit. I'm not sure her tribal affiliation. She is a member of a tribe. She won't come on full time until June. She's got obligations that she needs to complete. So she is dealing with some Area programs, but she will be physically located in Portland this coming summer. And I anticipate that she will be spending a lot of time focusing and working closely with the Tribal Dental Support Center. At the Health Board that oversees. So at this time, I'm gonna turn it over to Dr. Rudd for him to go over the next slide.

Pearl Capoeman-Baller: Dean? I just have a really quick question on the SFC construction underway for the area's water and environmental issues. Is there any new funds at all that hasn't been locked down for Tribes that have situations that need to be addressed? Like you're talking about Makah's situation and all those new homes, the homes that will be connected through this -- are there any monies in the project area at all?

Dean Seyler: Maybe I'll ask Rich for a little more detail. I think it's a little difficult.

Pearl Capoeman-Baller: I can talk with Rich afterwards. I'm just interested.

Dean Seyler: quick two minutes with you. Maybe other Tribes want to hear too. But I know when I ask questions like that, it's a complicated response he gives.

Pearl Capoeman-Baller: Okay.

Rich Truitt: I'll change it to a simple response. This year's appropriation, 2016 does have $20 million additional money for SFC projects. As Dean has indicated, the money has not been distributed yet. But there is a hold on the regional project with some of that money.

Dean Seyler: What does that do in the Makah situation, since that was an emergency that the SFC planned well for. We were able to secure some money down at Headquarters out of the Directors' Emergency Fund. And I'm not sure whether the department the money or be able to give that fully funded together.

Ed Fox: I have a question that maybe Rich can answer too. So my question, on the medical equipment, is there a simple requirement for medical equipment on facilities?

MINUTES

We don't have any new facilities around here, but we do remodel facilities. And at Port Gamble S'Klallam put a lot into the dental facility. We need a digital X-ray, and we're expanding our equipment by a few feet is at Port Gamble S'Klallam medical equipment. If a remodel Dental and add about 20 square feet to the facility.

Rich Truitt: The simple answer is no. The money is intended for newly constructed facilities. But on follow-up, I'm happy to work with you and see if there's any possibility.

Dr. Rudd: PPT

EXECUTIVE DIRECTOS REPORT – PPT

Joe Finkbonner:

Personnel

- Promotions: Lisa Griggs, ProgOps & Executive Assistant
- Resignations: Jim Roberts, Policy Analyst
- Temp: Cathy Ann Ballew, TOTS2T Tween Site Coordinator

Events

November 2015

- PHAB Accreditations, Alexandria, VA
- University of Arizona Advisory Committee
- Staff Retreat

December 2015

- Dental Therapy Convening, Portland, OR
- NPAIHB Staff Holiday Party
- PHAB Board Meeting, Alexandria, VA
- Hot Dog Feed…raised $$

January 2016

- Swinomish DHAT kickoff event

Upcoming

- ATNI Winter Conference, Suquamish – Feb 2-4
- CDC/TCAC, Atlanta, GA – Feb. 9-11
- NCAI Winter Session, Washington, DC Feb 22-26
- NWIC Foundation Board Meeting – Feb 26
- State of Oregon Rules Committee – Mar 8

Oregon Tribes DHAT Pilot Project Update

Pilot Project Application

- First Pilot Project submitted to the state: Project 100!
- It was deemed "complete" and has gone through a 30 day review by a Technical Review Board.
- 10 days ago we received a "Notice of Intent to Approve" the application from OHA.

MINUTES

It is now in the final few days of a public comment period.
- OHA Dental Director will have up to 30 days to make final decision

Next Steps
- Once approved, we'll create an evaluation plan with a research contractor to measure the outcomes outlined in the application. Access to care, quality of care, and cost of services are all things we will be measuring.
- One student from CTCLUSI started her DHAT training this past summer. CTCLUSI will start recruiting 2nd DHAT student and Coquille will be recruiting their 1st DHAT student from for July 2017 start of training
- We are working with CTCLUSI to recruit an experienced DHAT to begin providing services at dental clinic in mid-2016
- Explore DHAT programs at other Tribes in OR

Building Update

POLICY & LEGISLATIVE REPORT

Jim Roberts: Thank you Andy. If I could get my hands on that money, that CSC money put it on the Broncos to win the Super Bowl, I'd be rich in a couple months! I've been rooting for the Seahawks for the last couple years because I want the rematch, but Kay, my wife says, "Why are you rooting for them? They kicked our butt in the Super Bowl." Well, we've got to have some redemption here.

So I just got an email from the Indian Affairs Committee, and there's a hearing next week to look at, I forget the title at the hearing she used, but to look at the ineffective or quality of care provided in IHS areas or IHS managed facilities in the Aberdeen area. And in the course of that, she reached out to me, and I think this is directed for the Direct Service Tribes, this is directed to you. If there are quality care issues at your locations, the Indian Affairs Committee would like to know about them. So if you could see me after the presentation, I can get you in touch with the folks if there's any issues that you want to bring up. And this has to do with the, about 6-9 months ago, the Winnebago Service Unit lost its certification, Medicare certification. And when you lose your Medicare certification, you can't bill Medicaid or Medicare. And so you lose your third party ability to bill Medicare, and it's automatic. It's like death rule. So once you lose your Medicare certification, it applies automatically to Medicaid as well. So you lose your ability to bill Medicaid, and it's very difficult. Usually when this happens in the private sector, what's required is a change in management or ownership or the board of advisory that governs and upholds that facility. Well, it's a little different with Federally operated facilities. You really can't change the ownership. It's still owned by the federal government and managed by the Federal government. So it's a little complicated. And so they're dealing with this issue in Aberdeen, and my understanding is there's another cert review that was done on one of the other facilities, and they're in danger of losing

their certification as well. So another facility in the Aberdeen area.

So there's a hearing on this next week. So if you're from one of the Direct Service Tribe let me know and I'll get you in touch with the AI people.

So which one is it? There we go. Okay. So just kind of going with you on the issues I have to talk about. IHS appropriations Omnibus we have a final bill now. Dean talked about the allocations going up to you, and they're trying to expedite that, get that off to programs. Some Contracts Support Cost updates. Andy was at a Contract Support meeting earlier, or last week. We were also in one in Denver last year in December. So some interesting developments in CSC that are starting to play out. At least three programs in the Portland area dealing with carryover issues and having to pay back Contract Support Costs, and I'll talk a little bit about what the implications for your health programs might be on that.

An update on the 100% FMAP policy. Whether consent from South Dakota outlining kind of the framework for how this is going to work. And then the pending legislation.

But before I get in, did you see the Broncos on Sunday? Yeah. So we take on New England in Denver, so I'm a little worried about that because they're gonna be in full force. We beat New England, Greg, earlier this year. Pearl and I did. Our team. But they'll have a lot of their players back so hopefully it's gonna be a good game. And I really was rooting for the Seahawks. Last week I was taking Kay to the airport, and I about drove off the road when that guy missed the field goal. Wasn't that crazy? That was good.

Okay. I'm gonna come around here.

So just to kind of recap, the president's request included a really sizable, good increase. It was a big increase for the Indian Health Service budget. Probably the second or maybe the best request. The big one was in 2010 when we received I think it was a $450 million increase. But this was just as good. But I think there's a lot of political grandstanding, because the likelihood of a Republican-controlled Congress approving the President's request was not very good, and we knew that at the time. So when the House bill came back, their bill was $315 million less than the President's request, and then the Senate bill was $324. And the Omnibus was passed in December. It included $4.8 million for IHS, but it was $290 million less than the President's request, so not as bad as the initial marks. The overall increase for the FY2016 budget is $165 million over the FY15 amount, so it's about a 3.5% increase.

So given some of the appropriations process right now, other agencies within the HHS were flatlining. It's a pretty good request I guess, given the sign of the times. Never

enough money.

So some of the highlights, there's very modest budget increases over the, for the agency and prevention accounts, with the Alcohol / Substance Abuse line item. In money for medical inflation and population growth, despite the fact that the President's request included planning for those items. There's $19 million for pay act increases. So the appropriation does fund Tribal and federal pay act increases. Across the board, the agency line items for the Preventions received probably about 1.5% increase. The Alcohol / Substance abuse line item received a $14 million increase which is about $8 million and 108% increase over the 2015 amount. So good increase for Alcohol / Substance Abuse.

Details, you know, weren't clear in the language about how that's going to be allocated. I haven't seen a detailed change scale. The President's request did include an additional $10 million for this Youth Suicide Initiative. So I think that proportion of the money is going to go into that suicide initiative. It's one of the things that was authorized in the Indian Health Care Improvement Act. So a portion of the money could go into that. I don't know if it's going to include the full $10 million.

The CHS program Unfortunately, was flatlining, funded at $914 million. So there's no additional funding for the Contract Health Service program. Not good for us in the Portland area.

The CSC received a $55 million increase, about an 8% increase over the 2015 amount. And of course as Dean or Rich already stated, Facility accounts received very good increases of $20 million for each line item. So the M&I fund was increased $20 million. Sanitation as well as Facilities Construction.

So and then I just want to mention, M&I since ARRA has been flatlined budget for the most part, because if you remember I think we received about $100 million for M&I that lasted it to the areas, and then since that time, the line item has been, you know, hasn't received increases, and then along comes the sequestration, and the M&I line item has actually been eroded after that line item was cut following the sequester in 2011, 2012, whenever that happened.

Sanitation, Facilities, the same thing. There was a large increase in sanitation projects in ARRA, and then we also received transfer from the EPA during that same year. So a lot of money was put into IHS Sanitation programs, and again, money was not gonna be flush during the appropriation process, and when ARRA eroded the base budget again. So sanitation M&I actually lost money since 2010.

The Health Facilities Construction program received an additional $20 million. So I

think the construction program is about $108 million. The President requested $100 million for the facilities account. And then California YRTC facilities have received money both for staffing package, for this other facility, and new construction money for the northern facility that was started. So we don't mind, you know, why YRTC is in California since our sister area in Elkhorn, we see money for their facilities. But we did so again this year in the Budget Formulation process.

Contract Support Costs. So the 2016 requests included indefinite line item funding, or funding, legislative language for Contract Support Costs, making the kind of, what we vote to be permanent appropriation. IHS continues to meet with the Contract Support Cost workgroup on a number of different issues. There was a Dear Tribal Leader letter that was included in your Dropbox that IHS sent out a week or so ago, initiating tribal consultation on current policies. The policy that's on the IHS website, although there is a Tribal red line graph that's being prepared for the workgroup and for IHS, and IHS then took that and responded back to that Contract Support Costs red line that we drafted, with what their position was on our recommendations, and also pointing toward additional changes or recommendations to the policy, and some of which kind of are different than pending or current CSC practice. So the agency is actually proposing changes to its current practice that they've adopted in light of a lot of the CSC litigation and changes that are going on with whole funding.

There was a very interesting meeting a month ago in Denver, and I think it speaks to the tenor of kind of the issues and the relationship that Tribes continue to have with IHS around some issues. There was a meeting in Denver where initially the Tribes went into a caucus about whether it was even worth our while to continue a dialogue about CSC issues with the agency. There's a new political appointee for IHS, Mary Smith. And a couple of the areas on the workgroup have taken the position that to continue to have a conversation with IHS on some of these things isn't going to be effective because the agency is kind of developing policy from a legal, or to support litigation that's going on with the agency, and that's not the best position to be developing policy from. So they're proposing policy that supports the litigation position that they have. And the Oklahoma area particularly was outspoken about that issue. They felt that that kind of position hadn't changed. So there was a long conversation before we started the meeting on addressing any of the issues about whether the agency could have an effective conversation with Tribes, consultation with Tribes about what needed to be done in this whole funding environment.

So it was decided that we would continue to work any issues, that there were positions or recommendations that were proffered by the Tribal Technicians and Workgroup members on several issues. And the agency continued to have a conversation as if those were in negotiation and hadn't been decided. And later on in the afternoon, there was a letter that was sent by Mr. McSwain in response to some issues that were raised,

the same issues that we were addressing or negotiating over in the morning. And the letter was sent to self-governance. Lynn Malerba Chairperson and Ron Allen, that they had already made a decision on those issues. In the meantime, they had engaged us in a dialogue or conversation about those issues, leading us to believe that they were still up for negotiation, and pulled the rug out completely from the Workgroup members, and it didn't go over very well in the meeting. It pretty much imploded. The Tribes went into a Tribal caucus to talk about that issue and how it was disingenuous to the process they have for discussion and negotiation on those issues, and that it kind of just underscored the position that the Tribes had started the meeting with, was this is just a waste of time. IHS is not serious about this, and they continue to negotiate policy changes with respect to Contract Support Costs and support litigation. And you know, Mary Smith said -- and I really like her, I think she's very -- primarily worked on two issues: some of the ACA fixes, the tribal appointment issue, the Indian definition issue, and this Contract Support Cost issues in the wake of whole funding. But they agreed to continue to negotiate at the workgroup meeting, and I think we're starting to see some progress, a little bit at least. We still have a ways to go, but I think Mary's participation has really helped to inspire some kind of commitment to the process on behalf of the agency. And I think the Tribes trust the process now, with her involvement. They won't meet with any of the IHS technical folks unless a political person is there. Mary's there. I think the feeling is that there's no trust between the IHS CSC folks and the OBC folks who are in the room around the CSC issue. But as long as Mary's involved and Bob McSwain's involved, I think they'll continue to engage in the process.

So some of the issues that continue to be outstanding are the cost incurred quotient reconciliation, pass exclusions in terms of determining CSC, types of CSC review duplication during the reconciliation process, IHS marks to kind of redline changes, some are current practice, and I already talked a little bit about that.

But I think this is one of the important things, and I had a conversation over the last month with several Tribal Health Directors about this. But the IHS practice of cost incurred to reconcile the past year's CSC I think is changing a little bit about some of the tribal kind of practices in terms of how you view utilize or how your CFC is used within the tribe. So the IHS process requires you to spend all of your program dollars. And if you don't spend all of your program dollars and you get a Contract Support Cost on top of that, and you have to carry forward your program dollars into a new year, you have to pay back some of your Contract Support Costs. And the Tribe organization is that over kind of a statistical timeline, that evens and levels itself out. So at some point, the agency, even though you have to pay back the CSC, what you do spend in other money that you carry over, they're gonna have to provide you Contract Support Costs again on top of that. So it just kind of defies the logic to have to pay it back, and over the long run, that process will smooth itself out. But the agency has continued to take this position that unless you spend all your program dollars, you have to return dollars back

to the agency.

For those Tribes that may not put your Contract Support Costs back into your health program, in other words it may go into like your GMA fund at the tribe, and that money is spent, by the time you've reconciled and closed out your fiscal year, your process with IHS, that money may be gone. So I've talked with a couple Tribal Health Directors over the last month about what to do about that and how you manage that. And so I just bring it up to your attention so you're aware of it. I don't know how many of you have that situation. But it potentially, carrying over a lot of the program dollars from year to year, this could potentially implicate your program if you're not spending all your dollars. Because a lot of times, I can see a Tribal Administrator or a CFO saying "that's not my fault. That money's gone. How come you carried over and didn't spend all your money?" So you know, there could be a rub that's created between the administration and programs with your administrative approach, your CFO's and your GM's and that type of stuff. We're looking at this at the Board. I think we'll have a couple carryover years for some money. But some of it, we don't get Contract Support Costs like Meth / Suicide / Domestic Violence money, that type of stuff.

Any questions about that? Because I know that's a real kind of technical issue.

So another thing on the 100% FMAP, so just to kind of remind you, CMS is reconsidering its policy on 100% FMAP to provide 100% FMAP for CHS rebirth services, so services that are provided outside of the four walls of your facility. They initiated consultation on that, to which the board provided comment. And last week, they issued a letter to South Dakota that kind of provides a glimpse of what the claim part of this new policy will be. So I think it looks pretty good so far, but I think there's some kind of potential steps in this process where if we leave it to CMS to develop the policy, the brain work of it, they may kind of do some things, and I'll talk about those here in a moment, that could be potentially dangerous for us.

So the first one is that it extends intents of 100% FMAP by non-I/T/U Indian Tribes. Urbans are not included, where written care coordination agreement is developed. So maybe like a contractor agreement of some type. And the letter's actually included in your Dropbox too. It's a South Dakota letter, if you want to look at it later. CMS has indicated that they're gonna put brain work for additional requirements about what this care coordination arrangement will be. The non-I/T/U provider must be enrolled as a participating Medicaid provider, which I think most of them are. There must be an established relationship between the patient and qualified practitioner at the tribal facility. And this arrangement can be done through an in-person patient visit or through a telephone visit of some type. So there's got to be an existing provider relationship between that patient and the facility. The patient records must be retained by the facility, the IHS facility. The Tribal Facility. And 100% FMAP will be made on a

permanent basis. So they intend to make this a permanent part of the process.

So the next steps that were outlined in the South Dakota letter is that they plan to issue a state Medicaid director letter, and this was explained on a TTAG teleconference call last Wednesday. So CMS is going to issue state guidance to the state Medicaid directors about this. They're going to write developer minimum care standards for care coordination arrangements. So I caution about the policy about how this is going to be developed. We know a little bit about this with referrals for QHP's and with referrals for authorizations for Medicare-like late payments. So you know, referred services is what I hope they use. But I caution about CMS developing some type of care coordination arrangement where authorized services are used, because if you use referred services, you cast the net to I think potentially cover more people. Where referrals is just a referral of care, whereas an authorization is actually a commitment to pay for that service. And that's the word that's used in Medicare-like rates where the CHS authorization is used, and the word used in QHP for no cost sharing or copayments, is a referral.

Binding arrangements between the IHS tribal facilities, Medicare providers, so we talked about that. The final scope of Medicaid services, I think that's pretty clear. It's going to be what's ever in the state's Medicaid plan.

Defining billing and payment arrangements. So the IHS or the tribe makes referrals, and the Medicaid provider bills CMS for the service, or the state for the service. So this will require some type of arrangement. So if you make a referral, rather than you working out the billing arrangement, you will just negotiate with the provider to bill for that service and pay for it. I don't know that any providers want to do that. I think they would prefer to get paid from the Tribe. But this is the part that kind of -- this is the rub that made the costs for the Urban programs. If they can do this, and allow the provider to bill on behalf of the tribe, why not just allow referred services or then 100% FMAP for the urban programs? Because I can see incidences where Tribal Urban programs might be located in close proximity to a Tribes program, and if they got a member from that tribe under the program, they could just coordinate with that tribe and make the referral or the authorized service to get that person care on 100% FMAP. We're not costing the Urban program money, we're not costing the tribe any money.

And then CMS indicates that they'll provide technical assistance to the States and Tribes who work out this policy. This is very good change. It's going to change the landscape of the way things are done in the States with Tribes over the next couple of years.

Any questions about any of this? On the 100% FMAP referral, referred services? Ed, you look like you have one.

MINUTES

Ed Fox: I wanted to add one thing. And in that letter it said also, it looks like they're definitely regulating 100% FMAP for non-transportation, which would really change things where we could work with the state to have a different way to get paid for all the service we're providing and adding to a real complicated process to get reimbursed for transportation. So it kind of opens that. But I think 1:42:52.3 [INAUDIBLE.] But it's something. What I think is a big thing that we need to use our imaginations now, I'm just saying, let's say the state put some money to build some facilities like they do in Alaska. Then one thing I'd be looking to do for an 1:43:09.9 [INAUDIBLE] program in Alaska, is how do they build that beautiful new facility in both Bethel and Anchorage for mothers to come prior to delivering babies. They get state funding for that. They built I think two bunker care facilities, so they get 100% FMAP. So I think our Tribes need to be asking the State to put up some of their money, because this will stay in Washington, not that much. A lot less than I thought originally. But between $25 million a year or more will go to the state of Washington because of this change. What are they going to do with that money? Isn't that a good time to say, "We need some facilities construction money, and by the way, services provided in those facilities like the PAFAC are going to be neighbors at 100%, so you need to combine that." I also think to expand, I hate to live with the state planned services. I'd like to go beyond that to include chiropractic, massage therapy, acupuncture, that the state doesn't provide in Washington. Why is it we have to be limited to that? So that's one comment for CMS. Why do we have to stay within the state plan? Anyway.

Jim Roberts: It's just going to change the landscape. I mean, I could see a virtual CCO in Oregon where you have some contract with a CCO to provide those services, and the CCO's takes all of their Indian enrollees and roll them into this vertical CCO. And then the tribe manages, what do they call it? Care coordinate. You do all the care coordination and make a referral. And this is completely budget neutral to this State. So there's a lot of potential here. Also there could be an intersection on what you just talked about, Ed, with the uncompensated care waiver and the Tribes, because the Tribes have the ability to bill for all the services that are included in the same plan. They're not tied to just, you know, what's allowed on the prioritized list of services, at least in Oregon. So really, this really dose change the landscape of things and the relationships that can evolve out of this.

In that facility Ed was talking about, South Central and ANTHC have each built patient housing facilities across the street, at least in Anchorage, for the patients that are being seen at the facility, so usually mothers that are giving birth and people that are going through different treatment there. It's pretty nice facilities.

So I'm gonna wrap up here pretty soon, because I think we're coming up on time. But just go through these real quickly. There's an announcement called Accountable Health Communities Model Grants from CMMI. So this is a 5-year opportunity that's going to

award up to $157 million a year to community based nonprofits, hospitals, and tribal organizations are eligible. The program will require personnel to screen patients for social issues, not necessarily direct health care issues like hunger, housing, domestic violence, which can affect health outcomes. So things like housing instability, food insecurity, utility needs, interpersonal violence, transportation needs, employment needs, funds are not through direct services but are rather through linkage types of activities so that you can coordinate with that patient to get them into services and support around this area. So there is a letter of intent due February 8th, so if you're interested in this, or a consortium of Tribes are interested in this, I could see how this could be pulled off by the American Indian Health Commission. It kind of dovetails with what's going on with kind of the end relation projects and the Medicaid waiver that's going on, the big waiver, Health Care Washington Initiative where they're looking at providing housing support, and different kind of social service supports. There's a letter of intent due February 8th. It's non-binding, so just submit the letter and then interest, preserve your ability and the closing date. I forget the details on the closing date after that.

So Caroline, I see you nodding your head. So you might want to take a look at that.

The Medicaid Access Rule has been published. This is a rule that makes sure, to ensure that states comply with network advocacy standards and payments, so that payments are meeting the needs to attract enough providers into the Medicaid program, and that there's consistency across the state. The states have to provide CMS with some type of filing that ensures they've done evaluation on their process by July 1st . If you're in a, you know, some of us have been experiencing access to care challenges with Managed Care entities that are in our States. I would request that you ask the state to have Tribal involvement in the development of that plan that gets filed on July 1st with CMS, because otherwise the States could claim that the networks are adequate, but at the same time we're walking out on specialty care. This is a real issue with the CCO's in Oregon.

The IFR final rule was issued. This implements kind of like a CHS program through the Veterans Administration. So if there are wait times that exceed 30 days or they live, a veteran lives more than 40 miles away from a VA facility or needs kind of burden, you know excessive burden to travel by you know, boat, ferry, what-have-you, then the VA can provide resources for that person to go seek care at a specialty care provider outside of the VA system. IHS is included in this. Terry will be here tomorrow. Is she here today or tomorrow? Is Terry here? From the Veterans Administration, I'm sure she'll talk a little bit about this. And getting this kind of work included into your MOA reimbursement agreement for you guys that have negotiated those with the VA.

STAC meeting update. I think Dean may have talked a little bit about this. Somebody

talked about this. But you know, these are some of the issues, a sampling of some of the issues that we talked about at the STAC meeting. That CMS should be put on 100% FMAP was a big deal three or four months ago. ACA updates and referrals, call center issues, Medicaid expansion, that's an interesting one. So you know, potentially that could have an impact on Idaho if they ever decide to expand Medicaid. But Alaska where they have decided to expand Medicaid about four or five months ago, you've got a lot of people that are under 138% FMAP that are enrolled in QHP plans. There's a real technical challenge in getting them unenrolled from the QHP plan and enrolled in the Medicaid. So it's resulting in sponsorship programs up in Alaska having to cover those folks for additional months until they get off of that insurance product and enrolled into Medicaid. So watch for that in Idaho if Idaho does decide to expand Medicaid.

The ACA Employer Mandate fix, some discussion about that. Mary Smith's been involved in some of that. We've been involved in some of those conversations at the board. We put more white paper on kind of developing a policy linking it to some aspect of policy or legal kind of authority for IRS to exempt employers from having to comply with the large employer mandate.

VA and IHS interoperablility around services and MOA reimbursement agreements. I guess there are some problems coming up across the country around that. This kind of talks a little about, speaks back to the issue about IHS and the behavioral health money for youth suicide, but SAMSA block grant funding issues and suicide in Indian Country continues to be a prevailing issue at the STAC meetings.

IHS employee union settlement and a worksheet to settle amounts by area. So at the staff meeting, Bob McSwain provided a worksheet of where the money is at in different areas. We included it, in our weekly mail out when I came back from the staff meeting. So it's on the website under the weekly updates, that we sat down to report, but there's not any that have come out of the Portland area as of yet. So, is that's the case Dean told us a year or so ago when this first came up.

IHS discussed changes to the SDPI and STAC meeting, and then the 1915 (b) waiver for behavioral health services came up. Idaho tried to make very good progress on 1915(b) waivers on auto assignment issues and care coordination issues with these waivers. I think their tribe was having a meeting at CMS in Washington DC either today or tomorrow. Because I can't be there, they've got Elliott Milholin from Hobbs, Strause, Dean & Walker who's going to provide technical support to the tribe on some of these issues that people kept going on the 1915b waiver. You know, I'm happy to report that Idaho has pushed this thing. The Tribes in Idaho, further than anybody in the United States has gotten on the 1915b waiver. We've made similar types of progress on these issues for 1115 waivers. But in terms of this behavioral health waiver, this is really good to see that CMS is responding to the Tribes in Idaho in a positive, favorable way. And I

know that the 1915b waiver is in the process of renewal in Washington state too. So we've done, we've got a lot of good correspondence on some of these issues that will be helpful on the 1915b waiver in Washington state.

So these are kind of just issues that we've identified in the second session. We'll update these into the legislative plan. So the Employer Mandate continues to be important for tribal leaders getting an exemption for Tribes from that. Advanced appropriations, SDPI reauthorization. We've got a two-year extension right now. Indian Health Care Improvement Act Technical Amendments, I think it's time, and I talked about this earlier and talked about the self-governance a couple months back, that we need to start putting together kind of our wish list of technical amendments, things that we need to fix in the Indian Health Care Improvement Act, the implementation of the ACA.

Medicare-like rates for outpatient services. I understand that the regulation is being reviewed by OMB and IHS but that announcement we kept the IHS regulation should be issued sometime soon.

Contract Support Cost mandatory funding money and reconciliation language. So the mandatory recently I think was accomplished with the 2016 appropriation money, which includes a requirement that it be permanent funding. So I don't know if it accomplishes the same thing as mandatory rules. I'll take a look at that to make sure that it is. I'll be coordinating with Joe and new policy analysts to make sure that these things get updated and reviewed to the legislative plan.

So I'm going to stop there. The rest of this was stuff that I've gone through before at past meetings. I kept it in the presentation so that you have it. These are bills that are currently before the Indian Affairs Committee.

Any questions about anything that I presented on? Sharon looks like she's got a question. Okay. Andy, I'll turn it back to you. Thank you, and look forward to the recession time. And the Broncos winning next Sunday. I'm serious.

[Applause.]

Eric Metcalf: I stopped at the Nike Outlet Store on the way up, and there was a bunch of NFL shirts, and the only one they had in stock was for the Broncos. All the rest were sold out.

Jim Roberts: But you know the Seahawk jerseys, you can get those on fire sale right now.

MINUTES

Andy Joseph: All right. We're scheduled for a break now, so we'll come back from that at 11:15.

Break

2:20:49.2. **Region X Update, Susan Johnson**: Thank you Mr. Chairman and thanks to all of you for being able to spend some time with you, and to the Lummi Nation. It's my first time up here. So I appreciate this opportunity. I'll also be here through the evening to celebrate with Jim and through tomorrow noon. So I hope to have individual time if there are issues which I can help with.

Again, it's just a pleasure to be with you. I want to just touch on a few large areas of issues. First, the secretary would slap my hand if I didn't mention the enrollment period we're in, knowing that American Indians and Alaska Natives can enroll in Affordable Care Act coverage at any time, but it was a significant effort during this enrollment period that she declared, she hoped, 10 million people would sign up for coverage in the three months starting in November, and I'm happy to say that as of last week, 11.3 million people have signed up for coverage. So she is good on her promise for this administration, and we're still going to focus on improving health and saving lives, which this number represents.

In Region 10, I'm happy to say also that all of our states are over 100% of the enrollment numbers from last enrollment period from last year, with Oregon leading the way. And Joe, you can help them 2:22:20.3 [INAUDIBLE] numbers. They're up to 120% of last year's enrollment, and that's great given the trouble that was mentioned with Cover Oregon. So they've rebounded well at 120% of Washington to 102% right now of last year's enrollment. Idaho holds right at 100%, and Alaska as well at 102%. So I think things are going well, and we know that all of your efforts, I think there were several tribal days of action, of enrollment in the past several months. Those also have been noted by administration, and the activities that you've engaged with.

The second significant area I want to mention is significant information, detailed information will be coming out to you probably in the next 10 days. We just reached a tentative agreement for this for our next tribal consultation last week. And it will be May 12-14, in May. May 12-14. And you'll notice it's three days this year, at the request of folks in DC. Ours will be at the Snoqualmie Clearwater Casino Resort in Washington state, and the three days will be similar to last year but different for the additional day. The first day, as in the past, will be one-on-one sessions devoted to Tribes who want to send in requests to meet with representatives largely at the regional operating division, CMS, all –

[END OF RECORDING]

MINUTES

HEPATITIC C – Jessica Leston – PPT

Background

- Hepatitis C virus (HCV) infection is a substantial and largely unrecognized health problem.
- An estimated 3.5 million persons in the US are currently living with HCV, most of whom are unaware of their infection.
    - ¾ of persons living with HCV were born between 1945-1965.
- HCV is a major cause of liver disease, cirrhosis, hepatocellular carcinoma.

God and Bad News

- The good news
    - Hepatitis C can be cured
    - Curing HCV reduces mortality and morbidity
    - Curing HCV reduces the risk of transmission
- The bad news
    - The HCV epidemic still remains ***invisible***
        - Public/Medical providers/Policy makers
    - It is the infectious diseases with the highest mortality[1]
    - Access to treatment is complicated
- Good news again
    - WE CAN CHANGE THIS

Hepatitis C Paneling

Purpose: To provide sites with a list of current HCV+ patients and begin cascade of care

- Started with 6 Federal Sites (open to all)
- Remote access to iCare
- Paneled patients according to ICD9/10 codes

HCV Panel Results

- 635 unique patients with an HCV diagnosis were identified
- The median age was 53 (range 10-86)
- The proportion that were boomers was 61% (387/635)

Cross-site Breakdown: APRI

- 635 unique patients with an HCV diagnosis were identified
- 360 (57%) RNA test documented
    - 43% need follow up
- 174 (48%) RNA+ (chronic HCV infection)
    - This implies a 52% clearance
- 138 (80%) had enough information to calculate APRI
- 28 (20%) had an acute APRI (stage 3 or 4 fibrosis)

MINUTES

- 20 (71%) were born between 1945-1965
- Most common genotype GT1 (60%)

Consider

- HCV cirrhosis risk 20% over 20 years =
- HCC risk in HCV cirrhosis 17% over 5 years
- So, when you CURE 25 patients with HCV
- (in 8-24 weeks of treatment) you will prevent:
- 5 cases of cirrhosis
- 1 case of HCC
- Compare, if you treat 104 patients with statins, you will prevent 1 first time heart attack and ¾ of a stroke.
- Review Dr. David Newman July 2015

Access to Medication

- If patient has insurance – insurance will mostly cover
  - Assistance with co-pay https://www.panfoundation.org/
- If patient is eligible for Medicaid – apply for Medicaid
  - WA, ID, OR will treat stages 3 or 4
  - For exact rules, https://www.ohsu.edu/xd/research/centers-institutes/evidence-based-policy-center/evidence/med/upload/02b-HCV-Medicaid-Policy-SenFin-2015.pdf
- If patient is not eligible or denied – apply for patient assistance

Breaking down the cost

One case manager = $50,000 salary

- 50 courses of 8 weeks of Harvoni obtained via patient assistance = 1.9 million dollars of meds into the system
- 50 patients treated = 10 cirrhosis cases avoided and 2 cases of liver cancer avoided
- $17,000 /year HCV no cirrhosis
- $23,000 /year HCV comp cirrhosis
- $60,000 / year HCV decomp cirrhosis

Syringe Access: Partial Lift of Congressional Ban

- A simple adjustment to congressional policy to help stop the spread of HIV and HCV and lower healthcare cost – without costing extra money.
- What is it –
  - A syringe access program provides free syringes and ensures safe disposal of used syringes. Most programs also offer other services, such as HIV/HCV/HBV screenings, referrals, vaccinations and on-site medical care.
  - Public safety –
  - In Portland, OR, the number of improperly discarded syringes dropped by almost 2/3 after implementation of an access program.

MINUTES

- Wide-spread support for Syringe Access
  Syringe access policies are supported by:
    - American Academy of Pediatrics
    - American Bar Association
    - American Medical Association
    - American Nurses Association
    - American Psychological Association
    - American Public Health Association
    - National Academy of Sciences
    - National Police Association
    - U.S. Conference of Mayors
    - U.S. Surgeon General
    - World Health Organization

WORKING LUNCH – Committee Meetings

ACCOUNTABLE COMMUNITY OF HEALTH – Jessie Dean – PPT

Presentation Agenda

- **1:45** – Introductions
    - North Sound ACH partners in attendance
- **1:50** – Accountable Communities of Health (ACH)
    - Background / Timeline
    - ACH Function/Designation Requirements
    - ACH-Tribal Engagement
- **2:00** – Upcoming work with AIHC and ACHs
- **2:05** – Questions
    - FAQ Document
    - ACH Contact Information
- **2:15** – HCA Contact Information

ACH Functions

- 2015/early 2016: ACH Designation
- Requirements for Designation:
    - Balanced representation
    - Community engagement activities
    - Financial and administrative functions
    - Identify regional health needs, resources and priorities
    - Operating budget and sustainability planning

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- Ongoing ACH work (SIM and beyond)

ACH – Tribal Engagement

- Guidance Sent to ACHs in 2014
  - Tribal engagement by ACHs continues to be a priority
  - ACHs should reach out to each Tribe and allow each Tribe to decide whether or not they will participate and how they will coordinate their participation
  - State maintains government-to-government relations with the Tribes; ACHs need to respect this
  - HCA is developing a Tribal coordination plan
- Experience since then:
  - ACHs at various stages of engagement with Tribes
  - HCA has contracted with the American Indian Health Commission for Washington State for assistance in developing a Tribal coordination plan
- ACH-Tribal Engagement: AIHC Project

  Goals for 2016:
  - To inform ACHs on the government-government relationship
  - To inform Tribes/UIHOs on the function/role of ACHs in WA
  - To gather information on what the Tribes/UIHOs want for ACH engagement
- Report and recommendations due January 31, 2017
- Potential parallel model for Tribes/UIHOs:
  - Tribal Coordinating Entity
- ACH FAQ
- ACH Contact Information
- For the most up-to-date information: http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx

STRATEGIC PLANNING- Joe Finkbonner and Stephanie Craig-Rushing – PPT

Recess

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Wednesday, January 20, 2016

Call to order by Cheryle Kennedy

WEAVE-NW – Nanette Star Yandell, PPT
WEAVE-NW
Comprehensive approach to good health and Wellness in Indian Country Awards
Why Policy, Systems, and Environment Focus:

- ENVIRONMENTS where we **live, learn, work, and play** shape health outcomes.
- Policy decisions made by "non-health" agencies play a major role in shaping environments.
- Upstream Approach = Prevention

Policy Change

- Laws, ordinance, resolution, protocols, MOUs, regulation, inclusion of language in mission or value statements, or rule designed to guide or influence behavior

Systems Change

- Changes made in organizational processes (such as personnel, resource allocation, protocols)
- Systems & policy change often work hand-in-hand

Environment Change

- Physical, observable changes in the built, economic and/or social environment.

Programs vs. PSEs

Health Promotion Programs

- Often one-time events
- One person
- Short term
- Non-sustaining

PSE Strategies

- Ongoing
- Population
- Long term
- Sustaining

What this means for your tribe!

WEAVE NW Resources & Technical Assistance

- ✓Public health surveillance
- ✓Tribe specific data collection and analysis
- ✓Program evaluation
- ✓Strategic action planning
- ✓Commercial tobacco prevention and intervention
- ✓Capacity development and sustainability
- ✓Best-practices in prevention and management of chronic disease

Monthly Webinars

- Fourth Tuesday of each month 1-2pm
- Topics vary based on requests and activities
- PSE On-line Library

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- Launch in 2016
- Requesting copies of any tribal policies you are willing to share anonymously or with your Tribe association
- PSE Survey
- Survey Monkey link sent out Wednesday January 13th
- https://www.surveymonkey.com/r/EpiCenter2016

TRIBAL UPDATE – Confederated Tribes of Grand Ronde, PPT
Confederated Tribes of Siletz, PPT

BREAK

HEALTH SOVEREIGNTY AND DHATS – Chairman Brian Cladoosby, Swinomish Tribe and Stephen LeCuyer, PPT

Building a 21st Century Dental Team at Swinomish Indian Tribal Community

Swinomish Dental Clinic

- Part of the Indian Health Service system of dental clinics
  - There are 29 I/T/U Dental Clinics in the State of Washington. In 2012, only 55% of Native Americans have access or are accessing these Clinics
  - Clinics are operated directly by the Indian Health Service or by the Tribes or Urban Indian organizations through Contracts or Self Governance Compacts
  - Indian Health Service provides only 22% of current program funding from Dental Program funds –balance comes from the Tribal general fund and 3rd Party billing, mainly Medicaid
- The SITC Dental Clinic is operated by the Swinomish Indian Tribal Community through a Self Governance Compact
- Typical 2015 staffing consisted of 1 Full time Dentist, 1 Part time Dentist, 1 Dental Hygienist, 3 Dental Assistants, 1 Support staff

Indian Health Service Overview

- General U.S. Population has an average of 1,000 Patients per Provider/Dentist
- Typical I.H.S Provider/Dentist availability is 2,800 Patients per Provider

Typical I.H.S Provider is expected to service 86% more patients than the U.S. Dental average

Medical Care System in the 1970's

- Imagine when Primary Care could only be provided by an MD, i.e. no Physicians Assistants or Nurse Practitioners
- In the 21st Century, the Primary Care System is reliant on Mid-Level Providers

MINUTES

- Dental Practices are operating under the similar model that Medical was under in the 1970's
- Swinomish Medical Clinic has operated with Mid-Levels for 37 years!

Dental Health Aide Therapists provide:

- Cultural awareness and understanding of community needs
- Routine and preventive care – dentists can now prioritize more complex cases
- Improved pediatric care
- Cost savings to tribal health systems
- Relief to overburdened IHS system
- A new educational/employment field for AI/AN students

Alaska DHAT Scope of Practice

- **Dental Health Aid Therapist (DHAT)**

[----]----------

<50 Billable Procedures

- **DDS**

[----------]

>500 Billable Procedures

Why a 2 Year DHAT Program

- Competency reached with 2 years for the <50 Billable Procedures
- Curriculum fits a 2 year structure
- Training costs lower
- Graduates return to their Communities sooner
- Cost of social commitments for trainees lower
- Procedure review for FY 2012, 2013 and 2014 for Swinomish Clinic showed that over 50% of procedures and services could have been provided by trained dental therapist under the Alaska model
- Analysis shows that the same procedures could have been covered with 50% personnel cost savings by replacing dentist time with dental therapist time
- Analysis shows that dentist time could have been significantly re-oriented to more complex dentist-only procedures, i.e. such as prosthodontic, advanced restorative and surgical procedures, etc.

ADA attempts to stop Alaska's success

Litigation against Alaska Native Tribal Health Consortium (ANTHC), individual DHATs, and the State of Alaska

- Alaska Attorney General Opinion supported IHS certification of DHATs for use in Native Villages
- Favorable State Court ruling upholding the right of IHS to certify DHATs to practice in Native Villages without a license from the State of Alaska

MINUTES

After losing its court battle in Alaska to prevent DHATs from providing services to Native Villages, the following language was inserted in the re-authorization of the Indian Health Care Improvement Act (as part of the Affordable Care Act):
Expansion of the Indian Health Service Community Health Aide Program "*shall exclude dental health aide therapist services from services covered under the program…"*

- Unless requested by *"an Indian tribe or tribal organization located in a State (other than Alaska) in which the use of dental health aide therapist services or midlevel dental health provider services is authorized under State law to supply such services in accordance with State law."*

Political Road to Sovereignty Solution

- Swinomish worked for 5 years with the Northwest Portland Area Indian Health Board and a coalition of community advocates, public health organizations and dental professionals to pass a bill in the Washington Legislature authorizing dental therapists to practice in Washington in order to meet the requirement of the IHCIA limiting language
- Swinomish worked for the past 2 years to pass a **Tribal Specific DHAT Authorization Bill**
- Neither bills got out of House or Senate Committees in Washington State for the past 5 years, blocked by legislators working on behalf of the Washington State Dental Association
- **Swinomish determined it has the power and obligation to address oral health systems change by exercising its Tribal Sovereignty**

Sovereignty in Action: Step 1
Invest in our new workforce model

- Swinomish has entered into an Agreement with the Alaska Native Tribal Health Consortium to provide DHAT Training to Swinomish members
- Swinomish has funded a Tribal Member to attend the DHAT 2 Year Training program in Alaska. Aiyana Guzman started her program in July 2015, and will graduate June 2017
- Swinomish is recruiting a second trainee to start this summer

Sovereignty in Action: Step 2
<u>Build Tribal Regulatory Framework</u>

- Swinomish created a Division of Licensing, bringing together existing Tribal licensing and regulatory functions:
    - including licensing/regulating child care services and on-Reservation businesses
    - Swinomish also self-certifies its mental health providers and regulates admission to practice in Swinomish Tribal Court
- Swinomish adopted the first Tribal Dental Health Provider Licensing Code to license and regulate Dentists, Hygienists and Dental Therapists

MINUTES

- This is a quintessential exercise of Tribal sovereignty: regulating Tribal providers who are employed by the Tribe, paid with Tribal funds, working in a Tribal clinic built on Tribal land, and improving the health of Tribal community members

Overview of Swinomish Dental Licensing Code

- Establishes Dental Health Licensing Board of five members, with five year terms:
  - Chair of Swinomish Senate's Health, Education and Social Services (HESS) Committee
  - Member of HESS Committee
  - Dentist or other individual with experience in oral health education and training
  - In dividual with education, experience, interest in and commitment to improvement in oral health among Native Americans
  - Swinomish Chief Dental Officer
- **Licensing Board duties**:
  - Consult with and advise Swinomish Senate and Division of Licensing on technical and policy matters, and recommend Licensing Code amendments
  - Review and approve Division of Licensing procedures and forms
  - Conduct hearings and appeals from license or sanctions decisions
- **Division of Licensing duties**
  - Investigate license application and
  - Issue license,
  - impose conditions on license,
  - or deny application
  - Investigate complaints
  - Take action to protect public or sanction licensees
- License requirements include:
  - Must meet Tribal minimum standards of character for contact with Indian children or elders
  - Employed by Tribe or eligible for employment when licensed
  - Completed required training and education
  - Satisfied continuing education requirements
  - Demonstrate formal education, training and/or personal or professional experience that would reasonably be expected to result in cultural competence
  - If a Dentist, have experience supervising Dental Therapists or complete an acceptable course on supervision
- Robust investigative and appeal provisions to:
  - protect public safety
  - provide due process to license applicants or holders
- Division of Licensing authority to impose range of sanctions:

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- Probation, with regular reporting, limited practice, continued education
- Reprimand
- License suspension
- License revocation

Sovereignty in Action: Step 3

Provide services now!

On January 4, 2016, Daniel Kennedy, an experienced DHAT, joined the Swinomish Dental Team in making history by becoming the first Tribally licensed Dental Therapist providing services in the lower 48 states

Sovereignty in Action: Step 4

Secure dental therapy model for all Tribes who want it:

- Continue to build support for legislation in Washington State to allow all Tribes to use their IHS resources towards dental therapy model in their clinics
- Build support in Washington DC to repeal the limitation in the Indian Health Care Improvement Act on expansion of DHATs by IHS outside Alaska, or to amend IHCIA to recognize and respect Tribal as well as State authority to license Dental Health Providers
- Successfully defend any legal, political, or public relations battle that Sovereignty in Action may inspire
- Demonstrate success of program using a regional and national dental therapy evaluation plan being coordinated by the Northwest Portland Area Indian Health Board

VETERAN'S ADMINSITRATION UPDATES –Terry R. Bentley, PPT

National Focus on Access

- **Secretary McDonald's main focus areas:**
  - Access
  - Backlog
  - Homelessness
- **Dr. Shulkin's (new Under Secretary for Health) Five Priorities:**
  - Improved Access
  - Increased Employee Engagement
  - Consistency of Best Practice
  - Rebuilding the Trust of American Public
  - Building a High-Performing Network

Access to Care:

- Increase timely access to care for Veterans patients

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- Decrease the number of Veterans patients on the electronic wait list (EWL) and waiting greater than 30 days for their care
- Standardize the process and tools for ongoing monitoring and access management at VA facilities

Choice – FY 16 Changes to Choice

- **Operational Enhancements**
  - **Choice First Phase 2:** NVCC staff will contact eligible Veterans from the 30-day wait group to explain the Veterans Choice Program and offer it as an option to receive care when their wait time for a VA appointment is greater than 30 days (Go Live 10/1)
  - **Outbound Calls:** Eliminate the requirement for an inbound call from Veteran; require Contractor to make outbound calls to eligible Veterans to facilitate care (Go Live Nov 2015)
- **Legislative Changes**
  - **Removal of 8/1 enrollment and combat status requirements**; Veteran must be VA-eligible and enrolled (In process – target completion 10/1)
  - **VA Appointment Beyond Clinically Indicated Date -** To have outreach by VA Care Coordination staff to Veteran offering Choice as an option to receive care when their wait time for a VA appointment is beyond the clinically indicated date (Go Live Nov 2015)
  - **Removal of 60 day authorization limit** - Move to Episode of Care with maximum length of 12 months (Go Live 12/2015)
  - **Expansion of Provider Base** - Expand provider eligibility beyond those providers expressly listed in current Contract eg. Dental (Go Live 11/2015)
  - **40 Mile Expansion** - For Veterans seeking care and the nearest medical facility is a CBOC with Primary Care Physician below 0.9 FTEE (Go Live 10/2015)

VISN 20 Focus on Access:

Progress Toward Achieving Goals

- Electronic Wait List (EWL) for Primary Care in VISN 20 reduced from **3,003** on 9/1/14 to **1,702** pm 9/21/15 and currently at **1,542** on 12/21/15.

Challenges

- Lack of supply in community
- Difficulty in recruiting providers in rural areas

Accelerating Access to Care Initiative – Implementation

- Systematically reviewed clinic capacity to maximize ability to provide Veterans timely appointments
- Identified the resources required to provide timely care
- VA increased the use of care in the community through the non-VA care program (FEE)
- Each facility reached out to Veterans to coordinate the acceleration of their care – either to fee out or reschedule with VA at patients preference

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Improving Access for American Indian and Alaska Native Veterans through Reimbursement Agreements

- VA recognizes and values our relationships with Tribes
- Eligible American Indian and Alaska Native (AI/AN) Veterans can choose to receive their health care from the Tribal Health Program (THP) facility and/or VA Medical Center (VAMC)
- Reimbursement agreements with Tribal Health Programs focus on increasing coordination, collaboration, and resource-sharing for eligible AI/AN Veterans
- The agreements promote quality health care through collaborative relationships
- Over $12.5M in reimbursements to date servicing approximately 4,000 Veterans

Basic THP Process for Establishing Agreements

- Using the agreement template, the VAMC, THP, and Contracting Officer work together to complete the draft reimbursement agreement.
- The national template shall always be used.
- Concurrently, the THP works to satisfy local implementation criteria.
- Once the draft is complete, it will be reviewed by VA's Chief Business Office, Network Contracting Office and Regional Counsel, respectively.
- After final signatures, reimbursement for direct care can commence

Lessons Learned :

- Communication:
  - Initial meet and greet with VA and THP staff
  - Ensure POCs at both VA and THP with direct phone numbers and contact info
  - Ensuring coordinated care between THP and VA
- Education:
  - Ongoing education and sharing with local subject matter experts and POCs about the issues impacting Native Veterans
  - Ongoing education and sharing on the VA processes and any changes for the THP
- Quality:
  - Consistent communication and education between local VA facility, VA payment services (CBO) and the THP ensure our Native Veterans get the best care possible.

LUNCH

TRIBAL UPDATES – Confederated Tribes of Warm Springs, PPT

TRIBES AND CANNABIS – Lael Echo-Hawk, PPT

Cannabis in Indian Country

MINUTES

National Indian Cannabis Coalition

Our Mission: *to educate tribal leaders and elected officials on the emerging regulated cannabis industry while advocating for parity on behalf of Indian Country.*

Why Are We Here?

- December 11, 2014 the DOJ released its internal Policy Statement on Marijuana Issues in Indian Country.
- Memo dated October 28, 2014
- Internal policy developed without consultation with Tribes.

DOJ Policy Statement Regarding Marijuana Issues in Indian Country

- Directs each U.S. District Attorney to:
  - Assess all threats within the District, including those in Indian Country.
  - Consult with the Tribes in their District on a government-to-government basis.
  - Focus enforcement efforts based on that district-specific assessment.
- Invitation to consult – not blanket authorization to legalize
- Guidance only!

Cannabis

- Cannabis is derived from the cannabis plant (cannabis sativa).
- Cannabis has at least 85 active **cannabinoids**
- **THC** – is a cannabinoid and can cause a "high"
- Cannabidiol (**CBD**) is one of at least 85 active cannabinoids identified in cannabis.
- Hemp – variety of Cannabis plant with less than 3% THC
  - Produces higher levels of CBD than THC

Across the Country…

- 23 states, plus WA D.C., recognize and permit the medical use of cannabis
  - 1996: California
  - 1998: Alaska, Oregon, Washington
  - 1999: Maine
  - 2000: Colorado, Hawaii, Nevada
  - 2004: Montana
  - 2006: Rhode Island
  - 2007: New Mexico, Vermont
  - 2008: Michigan
  - 2010: Arizona, New Jersey
  - 2011: Delaware, Washington, D.C.
  - 2012: Connecticut, Massachusetts
  - 2013: New Hampshire, Illinois
  - 2014: Maryland, Minnesota, New York

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- 4 states legalized the recreational, adult use of marijuana
    - 2012:
        - Washington
        - Colorado
    - 2014:
        - Oregon
        - Alaska
        - Washington D.C.*

Economic forecast – Marijuana

- Legal marijuana grew 74% in 2014 to $2.7B up from $1.5B in 2013.* Arcview Market Research report
- Colorado - $699M total combined sales
- Taxes - $63M Revenue (36% from recreational)
- Licensing - $13M Revenue
- 2.85M edible retail products sold
- Washington – estimated to increase by $252M in 2015*
- AMR estimates $10.8B in national sales by 2019*

Economic forecast – Hemp

- Hemp – estimated $500M market for hemp products
    - Renewable energy source?
    - Medical treatment
- Higher rate of return per acre than any other crop except Tobacco. (Congressional Research Service Report for Congress 2013)
- 22 states have passed pro-hemp legislation.

Across the Country…

- 13 states authorizing commercial hemp programs:
    - California
    - Colorado
    - Indiana
    - Kentucky
    - Maine
    - Montana
    - North Dakota
    - **Oregon**
    - South Carolina
    - Tennessee
    - Vermont
    - Virginia
    - West Virginia

- 7 states establish industrial hemp programs that are limited to agricultural or academic research programs:
    - Delaware
    - Hawaii
    - Illinois
    - Michigan
    - Nebraska
    - New York
    - Utah

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Marijuana - Research Steps

1. Submit your study proposal to the Food and Drug Administration for a thorough review of its "scientific validity and ethical soundness."
2. Submit your proposal to a separate Public Health Service (PHS) board, which performs pretty much the exact same review as the FDA.
3. Get a marijuana permit from the Drug Enforcement Administration.
4. Finally, obtain a quantity of medical marijuana via the Drug Supply Program run by the National Institute on Drug Abuse (NIDA), which maintains a monopoly on medical marijuana grown for research in the U.S.
    - **June 22, 2015 – Obama administration removed Step 2 – PHS review.**

HHS Patent – "Cannabinoids as antioxidents & neuroprotectants"

- Awarded October 2003, filed by National Institute of Health
- "This new found property makes cannabinoids useful in the treatment and prophylaxis of wide variety of oxidation associated diseases, such as ischemic, age-related, inflammatory and autoimmune diseases. The cannabinoids are found to have particular application as neuroprotectants, for example in limiting neurological damage following ischemic insults, such as stroke and trauma, or in the treatment of neurodegenerative diseases, such as Alzheimer's disease, Parkinson's disease and HIV dementia."

NIH grants license to KannaLife to study CBD

- 2010 - NIH granted KannaLife exclusivity to develop a treatment for Hepatic Encephalopathy, a disease of the liver and brain that stems from cirrhosis.
- August 2014 - NIH granted the company an additional license on their previous patent to study CTE.
- KannaLife is the only company with licenses on the US-government held patent on cannabinoids. NIH owns patent, but KannaLife has exclusive rights to develop drugs with it.

Changes?

- New President, 2016
- Republican controlled Congress, 2015
- New U.S. Attorney General Loretta Lynch
- New U.S. Deputy Attorney General Sally Yates
- Nebraska and Oklahoma's suit against Colorado alleging federal preemption
- Ever-Shifting federal enforcement priorities on tribal land

House Tribal DRAFT Legislation

- Draft attempts to provide clarity for Tribes wishing to produce, purchase and possess marijuana but concerned that participating in the marijuana industry might put their federal funding at risk.

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- This bill attempts to alleviate that concern by prohibiting federal agencies from considering the tribe's participation in the marijuana industry when:
    - Allocating federal funds, benefits, grants, contracts, or other agreement with the United States, determining compliance or evaluating eligibility for federal funding.
- National Indian Cannabis Coalition (www.niccdc.org) is providing input on the draft legislation.
    - Include IHS
    - Allow Tribes to participate in Hemp initiatives
    - Include Tribes engaged in processing and selling cannabis

Federal Tribal Legislation

- Keeping out Illegal Drugs Act of 2016 - Senator Lankford (R-OK)
    - "A bill to prevent Indian Tribes and tribal organizations that cultivate, manufacture, or distribute marijuana on Indian land from receiving Federal funds."
- **NICC Position** – "In a time where both Congress and the Administration are deferring to individual State decisions on marijuana legalization, this bill would eliminate the opportunity for Tribes to evaluate and make an individual determination regarding the legalization or prohibition of marijuana on their Indian lands."

HR 2029 - Military Construction and Veterans Affairs and Related Agencies Appropriations Act of 2015

- Section 246: "**None of the funds** appropriated or otherwise made available to the Department of Veterans Affairs in this Act **may be used** in a manner that would— (1) **interfere with the ability of a veteran to participate in a State-approved medicinal marijuana program**; (2) **deny any services** from the Department to a veteran who is participating in such a program; or (3) **limit or interfere with the ability of a health care provider of the Department to make appropriate recommendations,** fill out forms, **or take steps to comply with such a program."**
- NICC recommending a similar provision be included in this bill providing the same direction to the Indian Health Service.

Indian Health Service Position

- IHS Findings issued in June 6, 2011 -"Federal law specifically prohibits the use of marijuana under all but very controlled, investigational circumstances"
- Chief Medical Officer recommends:

"I recommend that all IHS, Tribal, and Urban programs fully adhere and comply with Federal law by not prescribing, recommending, possessing, cultivating, processing, manufacturing, or distributing marijuana for medical or other purposes."

- **But –** HHS Sec. Burwell Sec. Burwell reported to tribal advisory committee "...that HHS funding would not adversely be impacted if a Tribe operated a medical grow or dispensary on Tribal lands as long as federal funding is not used." (Sept 2015)

MINUTES

Washington-Tribal Marijuana Compacts

- HB 2000 – All marijuana "compacts" to address any marijuana-related issue that involves both state and tribal interests or otherwise has an impact on tribal-state relations.
- Compact provisions –
    - Allows tribe to buy and sell to State licensees
    - Protects tribal territory by requiring the State withhold issuing a license to any applicant without express permission of Tribe.
    - Tribal tax must be at least 100% of the State tax (WA = 37% plus sales tax up to 9.5%)
    - Medical marijuana is exempt from tax

Oregon

- July 1, 2015 – personal possession and use is permitted
- Liquor Control Commission is tasked with implementation.
- Temporary regs adopted 10/22/15
- License applications will be accepted starting January, 2016

Alaska

- Alaska has historically allowed possession in small quantities
- Rules adopted November 2015
- March 2016 – regulation effective date

Logistics: Gaming & Cannabis

- **Bank Secrecy Act** requires all financial institutions to file Suspicious Activity Reports ("SAR's") on businesses they suspect to be engaged in potentially illegal activity. Under the new guidelines, financial institutions must continue to file the following SAR's on marijuana businesses. These are:
    - **Marijuana Limited SAR** – on businesses that appear to be operating legally and not engaging in activities that will interest federal prosecutors as detailed in the Cole 2.0.
    - **Marijuana Priority SAR** – on businesses that appear to be in violation of state law or interfering with federal enforcement priorities.
    - **Marijuana Termination SAR** – where a financial relationship with a marijuana-related business is terminated due to suspected violations.

Current Tribal Marijuana Activity

- Suquamish Tribe and Squaxin Island Tribe sign Marijuana Compacts under HB 2000.
- Passamaquoddy Tribe inks deal for marijuana operation.
- Other Tribes exploring legalization.
    - Omaha
    - St. Croix Chippewa - WI

….but

- Alturas Rancheria, Pit River Rancheria marijuana raided by federal and state law enforcement

MINUTES

- Pinoleville Rancheria marijuana raids by State law enforcement
- Flandreau Santee Sioux burned its plants following discussions with DOJ

Menominee Raid – Warrant

- Issues identified in Warrant –
    - Appeared to be a non-tribal entity and employees operating facility
    - Non-Wisconsin citizens operating grow
        - Jurisdictional authority
    - Public Health and Safety issues
    - Plants tested positive for Marijuana, Hashish, THC and Hash Oil
    - Cannabis farm located in State without any legalized marijuana
    - Menominee has filed Complaint for Declaratory Judgment

Why Indian Country?

- Sovereignty as a tool -
    - Less bureaucracy in licensing
    - Lower tax rates
    - Access to land for grow operations – streamlined zoning and permitting processes
    - Blank slate for growing and processing standards.
    - Reasonable regulation
        - Tribes know how to regulate and how to work with feds
    - Foreign trade zones?
    - Banking solution?
    - Medical research?

CASEY EYE INSTITUE ON THE ROAD – Joan Randall, PPT

Casey Eye Outreach – Working to eliminate preventable blindness in Native communities

What is preventable blindness?

- "Blindness which could be either treated or prevented by known, cost-effective means"
    - International Agency for the Prevention of Blindness
- 3 main conditions in United States
- Diabetic Retinopathy
- Glaucoma
- Macular Degeneration

Why are people in the US still going blind?

- Knowledge that care is needed/education
- Lack of trust in system or providers

MINUTES

- Access to healthcare
  - Cost/insurance
  - Transportation
  - Maldistribution of physicians

Solution: Bring the Care to Those Who Need It

- In 2010, Casey Eye Institute built a van

Why Native Communities?

- Disease prevalence
  - 2.3 times higher risk of diabetes than Whites
  - Higher prevalence of visual impairment and low-tension glaucoma compared with other racial and ethnic groups
  - High rates of smoking
- High rates of poverty
- Geographic location

How Native Communities

- **We are learning!**
  - Very much guided and supported by our friends at the Paiute, Klamath, Cow Creek, Coos Tribes
- Work with tribal leadership – are there unmet needs?
- Listen to each tribe about individual needs; how can we help for the **long haul**
- Collaborate with local providers whenever possible

Casey Eye Outreach Van Medical Director

- Mitchell Brinks, MD, MPH
  - Burns Paiute Tribe
  - Dr. Miles Rudd, Deputy Director Portland Area HIS
  - Dr. Tom Becker, OHSU Public Health
  - Dr. Steve Mansberger, Legacy Devers Eye Institute
  - Michelle Singer, OHSU NAERG
  - Kerry Lopez, Director, NW Tribal Cancer and Western Tribal Diabetes Projects

Use the existing van model

- Establish partner sites within the communities
- Partner sites identify and invite participants to screening
- Partner sites assist with any follow up that needs to be done based on the screening

The Leap

- Cow Creek
- Klamath
- Coquille

Trip Details

- 795 miles
- 133 people screened

MINUTES

- 75 glasses Rxs
- 36 referrals
- Increased awareness of eye health issues

Other Native Screenings

- NARA – twice/year
- Burns Paiute yearly

Next Steps

- Partner with other Tribes
- Continue/expand outreach of educational opportunities in health careers to Native youth
- Expand eye health services to the aging
- Work with Tribes to integrate educational components

IDEA-NW REGISTRY & DATA SHARING AGREEMENTS – Sujata Joshi & Victoria Warren-Mears, PPT

Historical Context

- Historically, IHS was the source for health care delivery, disease surveillance, and data for Tribes
- 1990s: Expansion of self-governance in health care delivery led to diminished role and capacity for IHS to provide these services
- At the same time, there was increasing recognition that state public health departments were limited in their ability to provide Tribes with disease surveillance and health data.
    - Inaccurate data on race/ethnicity and tribal affiliation (racial misclassification)
    - Data not reported at Tribe-level
    - Limited knowledge and limited consultation with Tribes

Northwest Tribal Epidemiology Center

Mission: To collaborate with Northwest American Indian Tribes to provide health-related research, surveillance, training and technical assistance to improve the quality of life of American Indians and Alaskan Natives

Goals:

- Assist communities in implementing disease surveillance systems and identifying health status priorities.
- Provide health specific data and community health profiles for Tribal communities.
- Conduct tribal health research and program evaluation.
- Partner with tribal, state, and federal agencies to improve the quality and accuracy of AI/AN health data.

IDEA-NW Project – Improving accuracy of AI/AN health data through record linkages
AI/AN Misclassification in the NW

MINUTES

- Misclassification happens when AI/AN are recorded as being another race (usually White) in a dataset
- Ranges from 8-60% of AI/AN records in NW health data
    - Birth and death records have relatively low (8-10%) numbers of misclassified records
    - Cancer registries average at around 30% of records
    - Hospital discharge and trauma registries can have up to 60% of AI/AN records with incorrect or missing race/ethnicity data
- Why does this matter?
    - Small numbers get even smaller
    - Difficult to establish accurate baseline measures
    - Can obscure real disparities experienced by tribal communities

Linkages to correct misclassification
Tribal data – NW Triba Epicenter – State Data

- Accurate health statistics
- Data for planning
- Data and tools for evaluation
- Data for grant writing
- New Partnerships
-

Linages Completed to date

Idaho
Cancer Registry
Birth Records
Death Records

Oregon
Cancer Registry
Birth Records
Death Records
Hospital Discharge Records
Communicable Disease Registries
Oregon Health Plan (Medicaid)

Washington
Cancer Registry
Birth Records
Death Records
Hospital Discharge Records
Trauma Registry

Data Products

- State and CHSDA-level Tribal Health Profile Reports
- Fact Sheets on Cancer, Suicide, Hospital Admissions, and other topics
- Focused reports on NW AI/AN Cancer and Mortality
- Data request from Tribes
- Manuscripts and Conference Presentations

MINUTES

Challenges – Improving the Northwest Tribal Registry
Tribal data – NW Triba Epicenter – State Data

- Accurate health statistics
- Data for planning
- Data and tools for evaluation
- Data for grant writing
- New Partnerships

Data Sharing with Tribes

- Data sharing agreements formalize how, what, when, and with whom data will be shared between individual Tribes and NWTEC.
- Looking forward:
  - Work with Tribes to identify data sharing opportunities for data linkages and other projects
  - Establish or update data sharing agreements with all member Tribes

BREAK

21st Na-ha-shnee HEALTH SCIENCE INSTITUTE & NEW WSU MEDICAL SCHOOL - Robbie Paul & Yvette Robideau

WSU Native American Health Sciences – Overview of who we are & Updates on Recent Projects

Who We Are

- Director: Robbie Paul, PhD
- Outreach Coordinator: Emma Noyes, MPH
- WSU Native American Health Sciences is housed in the WSU College of Nursing
- We work across WSU campuses and programs to increase the number of Native American and Alaska Native students entering and completing health science degrees
- Big Picture:
  - Increasing the number of Native American/Alaska Native (NA/AN) health professionals dedicated to serving NA/AN communities
  - Eliminating health inequities faced by NA/AN communities

Who We Serve & What We Do

- **High School Students**
  - Recruitment

MINUTES

- Na-ha-shnee Native American Health Science Institute
- Near future: Research Internships

- **Undergraduate & Graduate Students**
  - Recruitment
  - Support Services
  - Networking & Mentoring Opportunities
  - Scholarship & Research Opportunities
  - Offer class in Plateau Tribes Culture and Health
- **Local Tribes**
  - WSU MOU with 10 Tribes in the Plateau Region
  - Native American Advisory Board for Health Sciences with the Chancellor of WSU Spokane
  - Research partnerships and support

Updates on Recent Projects

Graduated 56th nurse last semester!

- WSU Spokane – 2 BSN students, 2 DNP students, 1 Nursing PhD student, 2 Master's level Speech and Hearing students.
- WSU Yakima – 2 BSN students
- WSU Vancouver – 1 PhD student, 1 DNP student
- WSU Pullman – Students on the path to degrees in Medicine, Nursing, Nutrition and Exercise Physiology.

Government to Government Training

- Developing training plan for WSU Spokane administration, Faculty/Staff

Print for WSU Native American / Alaska Native graduates in health degrees

- Art contest to determine print design

21st Annual Na-ha-shnee Native American Health Science Institute

- June 19th – July 1st, 9th – 11th grade, See flyer for more details

TOBACCO PRESENTATION – William Lucero

ELECTION OF OFFICERS

Chairman- Nomination Andy Joseph, Jr. by Greg Abrahamson, 2nd by Rhonda Metcalf closed and nominated by acclimation

Closed by Cheryl Sanders

Secretary – Nominations Greg Abrahamson by Ronda Metcalf, 2nd by Kim

Closed by Janice Clements, closed by Sean, nominated by acclimation

MINUTES

Recess

Thursday January 21, 2016

CHAIRMAN'S REPORT

Andy Joseph: We have - move on to our agenda. First, part of it's my Chairman's report. I'm going to start by wishing everyone a, you know, Happy New Year and hope that all of you are able, were able to enjoy the holidays and got some rest. The New Year is always busy for us as we begin preparing for the second session of Congress, preparing for appropriations and IHS National Budget Formulation. It's coming up I believe in the second week in June, so right after ATNI we'll head into DNC. The president also is getting ready to submit the last budget request under this Congress. Hopeful that it includes a sizable increase for the in-house areas.

President Obama has done some good for IHS budget for the term, and I hope this change in - they also will have budget hearings in March, and the Board is always invited. In the past, quarter Acting Director Bob was named to Senior Acting Director position on a permanent bases, a term of this administration. The administration also appointed Mary Smith to it, an IHS deputy director. Mrs. Smith previously served in the White House during the present administration as the special council with the President, also Associate Director for Policy and Domestic Policy. Mary served at the general council at the Illinois Department of Insurance which was responsible for implementing the legal aspects of the Affordable Care Act. I've been fortunate to work with Mary on the IHS Contract Support Cost work group, and also involved with her addressing the ACA employer mandate, IHS definition issue. The administration has fostered the work of these two issues, she has represented several positions very well and we hope that we can have Mary attend our April's Board meeting and talk to her progress on these issues.

At the Contract Support Cost Meeting, Jim talked a little bit last year at our first meeting we had in Denver. It was different when Mickey Percey showed up there and he set the room up different because now that we know we can get 100% Contract Support Costs, he had us sitting across from them. He put an empty chair kind of like those ones in the middle, and basically started off, you know, requested to start off the meeting with some opening comments. He was glad to see Mary there and, you know, told her that some of these people here are not gonna let you accomplish what you set here to do, because your job is to get this Contract Support Cost policy and Consultation all done during this Administration, and then so just adding our thoughts is 0:05:44.6

[INAUDIBLE] where it starts moving a little bit faster.

We worked on some of those issues, and they had red line, we had our red line. And we kind of merged them together and we're looking at different bringing up, I guess, different phases in what we really wanted. But we had attorneys there. We had people like Jim Roberts there from every one of the Areas. And so there are a couple issues that are still, we're still knocking heads against. And one of them is the renewal, and almost like 0:06:48.6 [INAUDIBLE] and so our attorneys and some of our people that are on the work group are explaining how, that it isn't really, 0:07:10.5 [INAUDIBLE.] And you know, we're always there reminding them that if IHS was fully funded, the full amount we could get way, way more than what they're wanting to give. So I was reminding them that they're, the government's like being so tight, it can take away from the Services that we want to provide, and that's not what we want to do.

And another issue that we're in agreement with, but we're having - I want to put it into policy, but that medical inflation rate will be used in policy, and what we're up against OMB and IHS's money has to do with medical bills. It costs more and more to, everyone on the house to provide medical services, so they get the medical inflation rate, and after we attended the Purchase and Referred Care meeting I attended, they're using the medical inflation rate themselves. So I had to, you know, bring that up as an issue on, you know, the Purchase and Referred Care worker, and also 0:08:53.4 [INAUDIBLE.]

Had a conference call yesterday with them yesterday, and they seem to kind of go in and out, and so anyway, we want to work some of the issues and what we presume. We have a meeting next Friday in DC. I'm flying there on Thursday.

This past quarter I participated in Portland Area Facilities Advisory Committee, PAFAC. It has completed its preliminary review of the two potential locations of the first of the three Regional Specialty Referral Centers. Referral, Regional Referral Specialty Care Centers 0:09:50.3 [INAUDIBLE] were the things that the Principle Deputy Director, Mr. McSwain is supportive of the facility concept. Last summer, the PAFAC visited two sites has refined its recommendation to the area. The first recommendation site is in Fife, Washington because it is a centrally located, has sufficient user population with 120 minute driving time, has access to public transportation, and is in the market that is attractive to specialty provider recruitment and retention. We look forward to the PAFAC reporting on the regional facilities and the planning permits of the first specialty care center.

In November, conducted our annual Budget Formulation meeting at Embassy Suites in Portland. And this year the Portland Tribes submitted budget parts, recommending increases for IHS budget at 5% and 22% levels. Our Area Representatives with

national meetings this year include Chairman Steve Kutz, and myself. John Stephens and I also attended the Contract Health Services work group in Denver, and actually we, during that meeting there was, you know, we were really talking about one of those issues, and then we'd spent about 45 minutes of our time kind of going back and forth, back and forth. And then just before lunch, we got this email sent to us about the letter that Robert McSwain sent out to us, that really kind of got our Tribal leadership and our attorneys kind of upset, and so we called for an Executive Session. And just before lunch, we brought them back in and I guess our leadership really kind of gave them hell for - they basically put Mary Smith under bus, because she didn't even know this letter was being sent out, so you know, they were really upset with the government side of it. And then the issue. And so we went on to our lunch, and we decided to have a longer lunch, to take a while with them at the Caucus. And they came back in, I guess a lot more willing to give in to some of our askings. And one of them was to allow us to see what the shortfalls were, you know. There are some Tribes that don't want to share information, and we understand that. We're not asking for the names. We're just asking for the numbers so we can use those to make sure that the Contract Support Costs that we get will be at the highest level that we can. And bring it to our Tribes. So you know, that's I guess one area where they heard them to allow, you know, FCC that information. And things won't 0:14:09.9 [INAUDIBLE] so if your tribe will send in the letter saying "don't use any of my information," it gets used when it goes to Congress anyway. And it's, you know, becomes public record. You know. That information, so that Congress is aware of it as well.

Actually, last Friday I flew home from another Contract Support Costs meeting, and that meeting and that meeting went better and we're moving closer to our, I guess we want to kind of get this all done hopefully by June. So we're working on that. And 0:15:17.8 [INAUDIBLE.] I want to acknowledge the work at the Boards Dental Therapy Project, and dental Tribes' involvement in developing the Dental Therapy DHAT we had, special kudos to the Swinomish Tribe for the Coquille Tribe, the Coos, Lower Umpqua, and Siuslaw and to the Cow Creek Tribe. They're all leading the charge and paving the way for DHAT

I guess I can say it isn't just Tribes wanting to do this. We have states and other people that are also interested in getting that type of care for general public. And so we have people from different States that was at that meeting, and my Tribe I want the work to send a group up there and also invite Swinomish to come over and share what they're doing to see if we can bring DHATs to the Colville reservation. I actually needed this loose filling that I've had for six months now, and I can't even get an appointment to get in to get something like this. Well, DHAT can get it done in probably 10 or 15 minutes. It's a simple procedure. And just kind of putting a band-aid on you and I guess that helps seal things like from causing any pain. Kind of keeps me away from sweets too, so I guess that might be the benefit.

MINUTES

For some of you that might not have been at ATNI I was elected Third Vice-Chair ATNI has just someone from every one of the backgrounds, so we have this conference on health issues and hopefully we can bring that more I guess to the front, if they get more time. I was going to the meetings, and some of the committees - my biggest is, you'll see a big meeting on gaming and 0:18:31.7 [INAUDIBLE] with that. The rooms have exploded. So we've got to get more of the Tribal Leaders from our Tribes involved in health care, and so I'm hoping that we can, I guess, highlight more of that. I think maybe ATNI figures that, you know, our Board will. And our Board was obviously the best board. So they probably figure that we're taking care of everything. So I guess it's kind of, maybe that's why they 0:19:17.1 [INAUDIBLE] our help.

Anyway, with the elections coming around for the President, and I think our work is gonna be getting really busy. I'm hoping that if anything, that we have turnover in Congress and then in Senate and get people that are more willing to help our Tribes out. That will be more work educating them on our tribal issues. And hopefully get them to send more funding. One of the things that we're gonna have to really push this year at IHS Budget is Purchased and Referred Care. You look at the budget, that line item was flat lined. It was no increase to it at all. And so, and we all know that it costs more to send our people to doctors, and IHS flat lining, it's kind of like it's a decrease. Because when I mentioned that it medical inflation. I guess the only thing that we really use to help cover them is the third party. And so hopefully a lot of our Tribes, you know, have their tribal members to sign up for insurance. Some of our insurance can be covered by -- can be covered. So basically by the government. And one thing we've been asking at the Purchased and Referred Care also is to see if they'll open the door to Contract Services Tribes to youth purchase and reserve care in order to help pay for insurance if possible. If they do that, then that will kind of get replenished by, I guess, almost like paying responsibly to do that. 0:21:52.2 [INAUDIBLE] they'll get referred out and have the insurance covered a lot of these things.

I want to recruit Board members for the Personnel Committee. We need to reassign people to cover Jim's meetings. What we'll do is we'll probably send out an email to all of the Tribes of these different positions. Jim was on Sundays meetings was the alternative, and some of our Board members that wasn't able to make the meetings was really able to rely on Jim to do that. So we're gonna be having more discussions with him. I guess Joe will have them with me, to figure out all these different positions that are gonna be at the meetings. So if you're interested in sitting on some of those different work committees, I guess let us know. It means traveling if, it's IHS, IHS has their traveling process and how they process their travel.

Our Board members also remember silent auction items. The funding was a gift that helps send, you know, some of our people to the travel different things like that. That

MINUTES

would be over traveling. So that's my report. Is there any questions?

Okay. I'm not seeing any. We'll have our financial report.

Financial Report, Eugene Mostofi

Approve Finance Report, Motion, made by Greg Abrahamson, 2nd by Rhonda Metcalf, voted and passed

CDC/ATSDRD Rep:

Broadcast request to Tribal Leaders Cheryl Sanders would like to encourage will get back to Joe in a few days.

Rhonda Metcalf if there are no Tribal Leader interested

Committee Reports

Elders, Patti Kiwans [see written report]

Veterans – Rhonda Metcalf [see written report]

Public Health – Andrew Shogren [see written report]

Behavior Health – Victoria Warren-Mears [see written report]

Personnel – Bonnie Sanchez [see written report]
Approval of Personnel report, Motion by Cheryl Raser, 2nd by Cheryle Kennedy motion passed

Legislative/Resolution – Joe Finkbonner

We R Native: Text 4 Sex Ed Resolution

Motion, Andy Joseph, 2nd by Rhonda Metcalf motion voted and passed

Strategic Plan
Motion, Leslie Wosnig, 2nd Greg Abrahamson voted and passed 1 abstention

MINUTES

Approval of Minutes

July 2015 motion, Greg Abrahamson 2nd by Cheryle Raser, motion voted and passed

October 2015, motion Greg Abrahamson, 2nd by Bonnie Sanchez, motion voted and passed

Board Meetings

January 2017 - Chehalis motion to support by majority in agreement

Adjourn: motion by Greg Abrahamson, 2nd by Kim Zillyett-Harris motion voted and passed

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

JANUARY 2016 QUARTERLY BOARD MEETING

Silver Reef Casino Resort, Ferndale, WA

MINUTES

_____ _____

Prepared by Lisa Griggs,
Executive Administrative Assistant **Date**

_____ _____

Reviewed by Joe Finkbonner, RPh, MHA,
NPAIHB Executive Director **Date**

_____ _____

Approved by Greg Abrahamson,
NPAIHB Secretary **Date**

QUARTERLY BOARD MEETING
Silver Reef Casino Resort
Ferndale, WA
January 19-21, 2016

AGENDA

MONDAY, JANUARY 18, 2016

	Tribal Health Directors	*No Meeting due the Holiday*

TUESDAY, JANUARY 19, 2016

7:30 AM	**Executive Committee Meeting**	**Chairman's Board Room**
9:00 AM	Call to Order Invocation Welcome Posting of Flags Roll Call	Andy Joseph, Chairman Lummi Tribal School Drum Lummi Chairman, Timothy Ballew Lummi Tribal Veterans Group Shawna Gavin, Treasurer
9:15 AM	Area Director Report – **(1)**	Dean Seyler, Area Director
10:00 AM	Executive Director Report – **(2)**	Joe Finkbonner, Executive Director
10:15 AM	Policy & Legislative Update – **(3)**	Jim Roberts, Policy Analysts
11:00 AM	**BREAK**	
11:15AM	Region X Update	Susan Johnson, HHS Regional Director
11:30 AM	Hepatitis C – **(4)**	Jessica Leston, MPH – STD/HIV Clinical Services Manager
12:15 PM	**LUNCH** Committee Meetings *(working lunch)* 1. Elders 2. Veterans 3. Public Health 4. Behavioral Health 5. Personnel 6. Legislative/Resolution	Staff: Clarice Charging Staff: Don Head Staff: Victoria Warren-Mears Staff: Stephanie Craig Staff: Andra Wagner Staff: Joe Finkbonner

1:45 PM	Accountable Community of Health 101 – **(5)**	Jessie Dean, Washington Health Authority
2:15 PM	Strategic Planning – **(6)**	Joe Finkbonner, Executive Director
3:00 PM	**BREAK**	
3:15 PM	Strategic Planning	Joe Finkbonner, Executive Director
4:15 PM	Updating NPAIHB Tribal Organization P.L. 93-638 Tribal Resolutions	NPAIIHB Executive Committee; Joe Finkbonner, Executive Director
4:15 PM	Executive Session	
6:00 PM	***Tribal Dinner (video: Journey to Wellness) – Hosted by Lummi Nation & Honoring for Jim Roberts***	

WEDNESDAY JANUARY 20, 2016

9:00 AM	Call to Order	Cheryle Kennedy, Vice-Chairman
9:15 AM	WEAVE-NW and Program vs. Policy, Systems, and Environment – **(7)**	Nanette Star Yandell, MPH - WEAVE-NW Project Director & Epidemiologist
10:15 AM	**BREAK**	
10:30 AM	Health Sovereignty and DHATS – **(8)**	Chairman Brian Cladoosby, Swinomish Tribe & Stephen LeCuyer, Director of the Swinomish Legal Department
11:30 am	Veteran's Administration Updates – **(9)**	Terry R. Bentley, Tribal Government Relations Specialist & Dan Kelly, VISN20
12:00 PM	**LUNCH**	
1:15 PM	Tribal Updates ➢ Confederated Tribes of Grand Ronde ➢ Confederated Tribes of Siletz ➢ Confederated Tribes of Warm Springs	
1:45 PM	Tribes and Cannabis – **(10)**	Lael Echo-Hawk, Attorney
2:15 PM	Casey Eye Institute On the Road – **(11)**	Joan Randall, MPH, Research Associate, & Verian Wedeking, Outreach Administrator, OHSU Casey Eye Institute
2:45 PM	IDEA NW Registry & Data Sharing Agreements **(12)**	Sujata Joshi, IDEA NW Project Director and Victoria Warren-Mears, EpiCenter Director
3:15 PM	**BREAK**	

3:30 PM	21st Na-ha-shnee Health Science Institute & New WSU Medical School – **(13)**	Robbie Paul, PhD / Director of Native American Health Sciences Washington State University Spokane
4:00 PM	Tobacco Presentation	William Lucero, Lummi

THURSDAY, JANUARY 21, 2016

9:00 AM	Call to Order Invocation	Andy Joseph, Chairman
9:15 AM	Chair's Report	Andy Joseph, Chairman
9:45 AM	Financial Report	Eugene Mostofi, Fund Accounting Manager
10:00 AM	**BREAK**	
10:15 AM	Election of Officers ➢ Chairman ➢ Secretary Committee Representative ➢ CDC/ATSDR Tribal Advisory Committee	
10:45 AM	Committee Reports: 1. Elders 2. Veterans 3. Public Health 4. Behavioral Health 5. Personnel Legislative/Resolution	
11:15 AM	Unfinished/New Business 1. Approval of Minutes (July and October) 2. Resolutions 3. Future Board Meeting Sites: ❖ *April 19-21, 2016 – Nez Perce* ❖ *August 2016 – Colville* ❖ *October 18-20, 2016 – Yakama Nation* ❖ *January 2017, TBD*	
12:00 PM	Adjourn	

***** Washington Medicaid Transformation Waiver Tribal Workgroup will meeting January 20, 2016 from 6:30 – 8 p.m.*******

INDIAN HEALTH SERVICE PORTLAND AREA DIRECTOR'S UPDATE

Dean M Seyler - Area Director
January 19, 2016
NPAIHB Quarterly Board Meeting
SilverReef Casino

Renew And Strengthen Our Partnership With Tribes and Urban Indian Health Programs

- Special Diabetes Program for Indians (SPDI)- FY2016
  - Community-Directed Grants- $130,200,000 ($25,552,678 increase)
    - Portland Area- $6,932,564 ($1,198,021 increase)
    - National funding formula based on user population, tribal small-size adjustment, and disease burden (prevalence)
  - Thirty-seven successful grantees were announced in December.
  - Portland Area Funds Distribution Workgroup (FDWG) convened to recommend to the Area Director method for funds distribution.
    - Recommendation
      - 5% of Area funds set aside for NPAIHB Data Center
      - "Hold Harmless" concept- All sites begin with a base of the same amount they received in FY2015.
      - Remaining funds divided: 70% proportionally based on FY2014 user population and 30% equally divided among grantees.

Renew And Strengthen Our Partnership With Tribes and Urban Indian Health Programs

- Status of FY 2016 Funding
  - Continuing Resolution #1 (10/01 - 12/11) 19.67% (with .2108% reduction)
  - Continuing Resolution #2 (12/12 - 12/16) 1.37% (with .2108% reduction)
  - Continuing Resolution #3 (12/17) 0.27% (with .2108% reduction)
  - Continuing Resolution #4 (12/18 – 1/16) 8.20% (no reduction)
    - The final budget for IHS is pending OMB review and approval.

To Improve the Quality of and Access to Care

- **IPC 2.0**

- Nov 2015 -New Curriculum to IST
- Dec 2015-Feb 2016 -Site On-Boarding
- Mar-Dec 2016 -IPC 2.0 Implementation

- Site that are interested should contact one of the following Area Office Staff:
  - Jonathan Merrell Jonathan.merrell@ihs.gov
  - Tom Weiser – Thomas.Weiser@ihs.gov or tweiser@npaihb.org

To Improve the Quality of and Access to Care

- **RPMS Network On-Boarding**

  - RPMS DIRECT Messaging, IHS Personal Health Record (PHR), Master Patient Index (MPI), and Health Information Exchange (HIE)
    - All 6 Federal Service Units have completed the full on-boarding process and are now eligible to begin
    - No Tribal/Urban facilities have started the on-boarding process yet
    - Information and requirements have been distributed to all Portland Area Clinical Applications Coordinators
    - Any site that is interested in on-boarding to the IHS RPMS Network should contact CDR Roney Won (roney.won@ihs.gov | 503-414-5579)

To Improve the Quality of and Access to Care

- **Regional Specialty Referral Network Demonstration Project**
  - The PAFAC Found Both Proposed Sites Acceptable and Provided the Following Recommendation for Locating the First of Three Facilities:
    - Recommendation 1 – Fife, WA
    - Recommendation 2 – Grand Mound, WA
  - Recommendation Based on Three Factors
    - Area Master Plan Alignment
    - User Access
    - Specialty Provider Recruitment and Retention
  - Recommendation Conditioned Upon Identifying a Site Meeting Planning Criteria (i.e. Construction Feasibility and Expansion)
  - PAO Staff Accelerating Project Planning Activities.
  - PAFAC Will Continue Developing Recommendations to Maximize Benefits for all Portland Area Tribes

To Improve the Quality of and Access to Care

- **Anticipated FY 2016 Tribal Medical Equipment Funds**
  - Purpose:
    - Purchase Medical Equipment for New Tribally Constructed Healthcare Facilities.
  - Application:
    - Apply Online: https://facilops.ihs.gov/erds/
    - Due February 26, 2016
  - Requirements:
    - Design Contract Signed Before Application Deadline.
    - Construction Contract Signed Between October 1, 2014 and September 30, 2017.
    - Project Funded in Part or in Total with Non-IHS Funds.
    - The Applicant Has Not Received Prior Tribal Equipment Funding for the Respective Facility.
  - Questions: Jonathan McNamara, Biomedical Equipment Program Specialist at (503) 414-7770 or Email at jonathan.mcnamara@ihs.gov

To Improve the Quality of and Access to Care

- **Active SFC Construction Underway in First Quarter FY2016**
  - Spokane Tribe – Martha Boardman And Ford Water System Improvements For 105 homes. $710,097.92 Budget. Construction Is Over 2/3 Complete Since October. Project Completion Is Expected In Spring 2016.
  - Makah – Sooes Valley Water Extension For 26 homes. $505,200 Budget. Work Was Inspected In December And Complete.
  - Makah – Sewer Outfall Repairs Emergency Project For 517 Homes. $822,000 Budget Funded By IHS Emergency Funds And HUD ONAP Imminent Threat Grant. Construction Is Nearing Completion.
  - Tulalip – Mission Beach Wastewater Treatment Plant For 394 Homes: $1.4 Million Construction Contract. Work Is Nearly Complete, And Wastewater Treatment Has Been Reported To Be Improving. Completion Expected By February.
  - Swinomish – Water System Improvements For 200 Homes: A 300,000 Gallon Water Tank Has Been Constructed And Is Nearly Ready To Be Placed Online. Total Project Budget Is $1.2 Million, Cooperatively Funded By The Tribe And EPA . Completion Is Expected By February.

Renew And Strengthen Our Partnership With Tribes and Urban Indian Health Programs

- **The Department of Health and Human Services (HHS) Secretary's Tribal Advisory Committee (STAC)**
  - A primary delegate and an alternate from each
    - W. Ron Allen and Cheryl Kennedy
  - One National At-Large Alternate vacancy
  - February 5, 2016 Deadline
  - Albuquerque - Bemidji – California
  - Nashville - Oklahoma - Portland
  - National At-Large Primary Delegate (3)
  - National At-Large Alternate

To Improve the Quality of and Access to Care

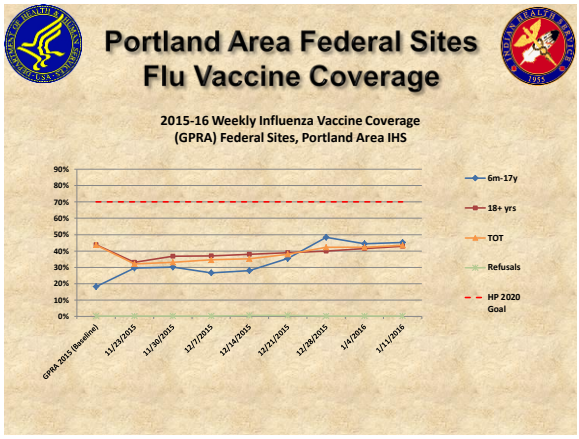
- **Government Performance and Results Act (GPRA)**
  - **GY 2016- 24 measures**
  - **Four new measures:**
    - Statin Therapy to Reduce CVD Risk with Diabetes
    - Influenza vaccination Rates Among Children (6 mo-17 yrs)
    - Influenza Vaccination Rates Among Adults (18 and older)
    - HIV Screening Ever (13-64 years old)
  - **Two revised indicators:**
    - FAS Prevention (alcohol screening)- Age range expanded to females 14-46 years.
    - DV/IPV Screening- Age range expanded to females14-46 years.

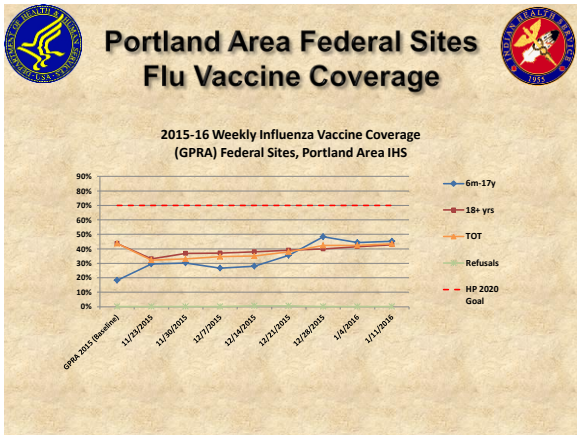
To Improve the Quality of and Access to Care

FY 2016 Targets (Federal, Tribal, & Urban Programs) DIABETES	Final 2015 Target	Final 2016 Target
Good Glycemic Control	47.7%	48.8%
Controlled BP <140/90	63.8%	65.0%
Statin Therapy to Reduce CVD Risk in Patients w/Diabetes	N/A	Baseline
Nephropathy Assessed	60.0%	61.1%
Retinopathy Exam	60.1%	61.6%
DENTAL		
Dental: General Access	27.9%	29.3%
Sealants	14.1%	14.8%
Topical Fluoride	26.4%	28.3%
IMMUNIZATIONS		
Influenza Vaccination Rates Among Children 6mo - 17yrs	N/A	Baseline
Influenza Vaccination Rates Amongs Adults 18+	N/A	Baseline
Pneumococcal Vaccination 65+	86.7%	87.3%
Childhood IZ	73.9%	76.8%
PREVENTION		
Pap Screening	54.6%	55.6%
Mammogram Rates	54.8%	55.9%
Colorectal Cancer Screening	35.2%	38.7%
Tobacco Cessation	46.3%	49.1%
Alcohol Screening (FAS Prevention)	66.7%	Baseline
DV/IPV Screening	61.6%	Baseline
Depression Screening	64.3%	67.2%
Comp. CVD-Related Assessment	47.3%	53.3%
HIV Screening Ever	N/A	Baseline
Childhood Weight Control	N/A	22.8%
Breastfeeding Rates	29.0%	36.8%
Controlling High Blood Pressure: Million Hearts Measure	59.8%	60.6%

To Improve the Quality of and Access to Care

- **<u>Naloxone: IHS-BIA MOU</u>**
  - The 7 Federal Pharmacy clinics have begun ordering small quantities of Naloxone Rescue Kits in preparation for full implementation in early 2016 when given the "go-ahead" from IHS HQ
  - Prior to this time, the pharmacies will be providing Naloxone to Tribal Police upon request
  - Available formulations:
    - VA Naloxone Rescue Kit (2 doses) – (off-label use) $39.20
    - Evzio® (Naloxone HCl) 0.4mg Auto-Injector (2 doses) - $379.20
    - Narcan® Nasal Spray – only FDA-approved intranasal formulation
      - Projected cost ~$70 | expected to be available in mid-January 2016


Portland Area Federal Sites
Flu Vaccine Coverage
2015-16 Weekly Influenza Vaccine Coverage
(GPRA) Federal Sites, Portland Area IHS
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
GPRA 2015 (Baseline)
11/23/2015
11/30/2015
12/7/2015
12/14/2015
12/21/2015
12/28/2015
1/4/2016
1/11/2016
6m-17y
18+ yrs
TOT
Refusals
HP 2020 Goal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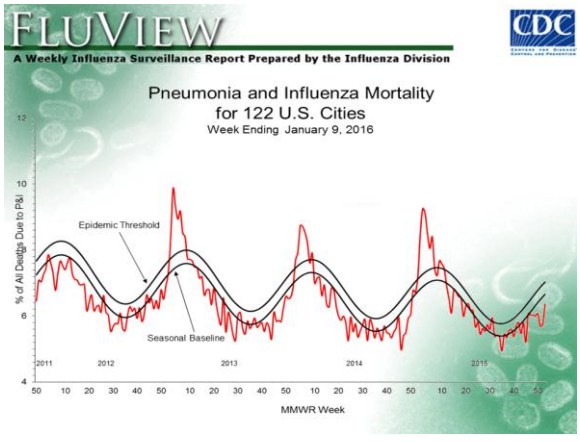
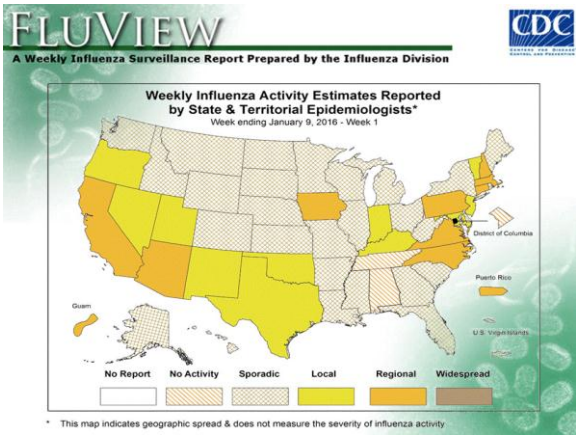
50%
40%
30%
20%
10%
0%
GPRA 2015 (Baseline)
11/23/2015
11/30/2015
12/7/2015
12/14/2015
12/21/2015
12/28/2015
1/4/2016
1/11/2016
6m-17y
18+ yrs
TOT
Refusals
HP 2020 Goal


FLUVIEW
A Weekly Influenza Surveillance Report Prepared by the Influenza Division
CDC
Pneumonia and Influenza Mortality
for 122 U.S. Cities
Week Ending January 9, 2016
% of All Deaths Due to P&I
Epidemic Threshold
Seasonal Baseline
2011
2012
2013
2014
2015
MMWR Week



Questions or Comments

Our Mission... to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

Our Goal... to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

Our Foundation... to uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

Northwest Portland Area Indian Health Board

Executive Director Report

Silver Reef Casino Resort
Ferndale, WA
January 19, 2016

Joe Finkbonner, RPh, MHA

Northwest Portland Area Indian Health Board

Personnel

- Promotions: Lisa Griggs, ProgOps & Executive Assistant
- Resignations: Jim Roberts, Policy Analyst
- Temp: Cathy Ann Ballew, TOTS2T Tween Site Coordinator

Northwest Portland Area Indian Health Board

Events

November 2015

- PHAB Accreditation, Alexandria, VA
- Advisory Committee UA

Northwest Portland Area Indian Health Board

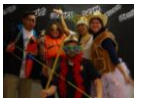
Staff Retreat









Northwest Portland Area Indian Health Board

Events Continued

December 2015

- Dental Therapy Convening, Portland, OR

❖NPAIHB Staff Holiday Party

- PHAB Board Meeting, Alexandria, VA

❖Hot Dog Feed…raised $$

January 2016

- Swinomish DHAT kickoff event

Northwest Portland Area Indian Health Board

Upcoming

- *ATNI Winter Conference, Suquamish (Feb. 2-4)*
- *CDC/TCAC, Atlanta, GA (Feb 9-11)*
- *NCAI Winter Session, Washington, DC (Feb22-25)*
- *NWIC Foundation Board Meeting (Feb. 26)*
- *State of Oregon Rules Committee (Mar 8)*

Upcoming

- *WDSF Board Meeting, Seattle, WA (March 18)*
- *PHAB Board Meeting, Alexandra, VA (March 30-31)*
- *2016 National Tribal Public Health Summit – Atlanta, GA (April 11-14)*

- *Audit is scheduled for the week of February 15. Stauffer & Associates are the auditors*.

Questions…?

Northwest Tribal Epidemiology Center
(*The EpiCenter*)

October-December 2015 Quarterly Report

Northwest Tribal Epidemiology Center Projects' Reports Include:

- **Adolescent Health**
- **Epicenter Biostatistician**
- **Immunization and IRB**
- **Injury Prevention Program (IPP)/Public Health Improvement & Training (PHIT)**
- **Maternal Child Health Projects**
- **Medical Epidemiologist**
- **Northwest Native American Research Center for Health (NARCH)**
- **Northwest Tribal Cancer Control Project**
- **Northwest Tribal Dental Support Center**
- **Northwest Tribal Registry Project-Improving Data and Enhancing Access (IDEA-NW)**
- **Wellness for Every American Indian to View and Achieve Health Equity (WEAVE)**
- **Western Tribal Diabetes Project**

Adolescent Health

Stephanie Craig Rushing, Project Director
Colbie Caughlan, THRIVE Project Manager
Jessica Leston, Project Manager
David Stephens, Multimedia Project Specialist
Tommy Ghost Dog, Project Red Talon Assistant
Celena McCray, THRIVE Project Assistant

Contractor: Amanda Gaston, MAT, IYG Project
Students: Lauren Adrian, VOICES MPH Intern; Steven Hafner, Harvard PhD Student Intern

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Technical Assistance and Training

Tribal Site Visits

- Umatilla: We R Native/HCV/SMAHRT Updates, NPAIHB Quarterly Board Meeting, Pendleton, OR. October 27, 2015.
- Chemawa: We R Native Presentation, Salem, OR, October 26, 2015.
- Cherokee Nation: Elimination of Hepatitis C Kick-off, October 29-30, 2015.
- Spokane: Presentation on *We R Native* @ UNITY, Today's Native Leaders Training, Spokane, WA, November 7, 2015.

Project Red Talon / We R Native / Native VOICES

During the quarter, Project Red Talon staff participated in thirteen planning calls, eleven partner meetings, and presented at five conferences/webinars, including:

- Call: Apokrisis Planning Mtgs
- Call: Jack Edmo – D&I Planning, October 14, 2015.
- Call: Native STAND Community of Learning, October 7, 2015.
- Call: SMAHRT Team meetings
- Meeting: Behavioral Health Committee, NPAIHB Quarterly Board Meeting, Pendleton, OR. October 27, 2015.
- Meeting: Liz – CDC, young worker safety, Nov 20, 2015.
- Meeting: Weekly Native STAND Team Meetings
- Presentation: IYG and Native VOICES, National HIV Prevention Conference, Atlanta, GA, December 6-9, 2015.
- Presentation: UNITY, Today's Native Leaders Training, Spokane, WA, Nov 7, 2015.
- Presentation: We R Native, Chemawa Boarding School, Salem, OR, October 26, 2015. Aprx 150 AI/AN youth in attendance.
- Presentation: We R Native/HCV/SMAHRT Updates, NPAIHB Quarterly Board Meeting, Pendleton, OR. October 27, 2015.
- Webinar: Native STAND Cohort 2 Recruitment, Nov 19, 2015.

Native It's Your Game

During the quarter, *Native It's Your Game* staff participated in five planning calls with study partners, and supported the following kick-off trainings and events:

- Kick-off Event: Sunridge Middle School, Pendleton, OR, December 18, 2015.

- Presentation: Native It's Your Game, National Indian Education Association Annual Convention, Portland, OR, October 16, 2015. Approx 40 AI/AN teachers in attendance.
- Webinar: D&I Advisory Workgroup, Nov 12, 2015.
- Webinar: D&I Advisory Workgroup, Nov 24, 2015.

Quality Improvement

During the quarter, STD/HIV QI staff participated in seventeen planning calls, seven Adobe meetings, and presented at one regional meeting, including:

- Adobe: Follow up CDC Measures with IHS, November 30, 2015
- Adobe: Great Plains Infectious Disease Update, November 5, 2015
- Adobe: Hep C Elimination Call Portland Area, December 14, 2015
- Adobe: Hepatitis C Update ABQ CD, December 2, 12015
- Adobe: iCare in patient panel for Muckleshoot, November 20, 2015.
- Adobe: Lummi Measures, November 12, 2015
- Adobe: Portland Area CAC Call- measures taxonomy and feedback, November 12, 2015
- HIV Team Meeting: November 5, 2015.
- Meeting: CDC Hepatitis Meeting, December 7, 2015.
- Presentation: Portland Area CD Meeting Hepatitis C, November 5, 2015
- Zoom: ECHO Hep C, December 2, 2015
- Zoom: ECHO Hep C, November 4, 2015
- Zoom: ECHO Hep C, October 7, 2015

Health Promotion and Disease Prevention

National HIV Testing Initiative: All promotional materials are available on the web, including logos, radio spots, fliers, snag bag inserts, and window decals. Orders are filled upon request. PRT staff participate in regular teleconferences for the HIV/STD/Hep C Listserv and the Viral Hepatitis Action Plan for IHS.

Native LGBT Proud Campaign: The campaign includes posters, fact sheets, and radio ads. Orders are filled upon request.

Tribal STD/HIV Policy Kit for Tribal Decision-makers: The Advocacy Kit is available on the IHS and NPAIHB website. Appx 250 hard copies and 300 jump drives with the kit have been distributed to date.

Native STAND Curricula: A culturally-appropriate, school-based healthy decision-making curriculum. PRT is working with the OHSU Center for Healthy Communities to recruit tribes to participate in the Native STAND dissemination project: http://oregonprc.org/projects/current/native-students-together-against-negative-decisions.html

Native VOICES: 23 videos are included in the Native VOICES playlist on We R Native's YouTube Channel. Since their release, the Native VOICES videos have been viewed 1,674 times on YouTube. In February and March 2015, the Native VOICES Facebook mini-series generated over 102,745 video views, reached 259,158

NATIVE VOICES

WERNATIVE

people, and was clicked on shared, liked, or commented on 61,441 times!

Website: The We R Native website launched on September 28, 2012: www.weRnative.org
The mobile site launched on September 28, 2013

In December, the site received:

Page views	8,347
Sessions	2,959
Percentage of new visitors	84.1%
Average visit duration	1:33
Pages per visit	2.14

- Over 400 health/wellness pages are included on the website.
- We continue to refine and improve the website, sitemap and wireframe:
  - Redesigned the Youth Ambassador and Ask Auntie sections – In 2015
  - Adding a Text 4 Sex Ed service – in 2016

Text Messages: The service currently has 2,889 active subscribers.

Twitter: Followers = 2,586

YouTube: http://www.youtube.com/user/wernative#p/f

The project currently has 335 uploaded videos, has had 41,827 video views, with 72,477 estimated minutes watched.

Facebook: http://www.facebook.com/pages/We-R-Native/247261648626123

By the end of the month, the page had 29,593 Likes.

Instagram: http://instagram.com/wernative

By the end of the month, the page had 2,157 followers.

MSPI - Gen-I Messages:

- Suicide = 2 posts, 25,200 people reached
- Mental health = 4 posts, 18,000 people reached
- Substance prevention = 1 post, 1,000 people reached
- Youth leadership/empowerment = 7 posts, 25,100 people reached

We R Native Contests: The December contest focused on: Snag Bag stocking stuffers.

Surveillance and Research

Native It's Your Game: We continue to provide TA to 3 tribal ACF sites implementing Native IYG + parent-child components.

Native VOICES: Data collection is complete for the study. A Community Report was sent to all study sites. Statistically significant improvements in sexual health knowledge, attitude, intention, and self-efficacy occurred across all three study arms, many of which were retained 6 months later. Native VOICES is the *only* intervention purposefully designed for AI/AN youth included in the CDC's compendium of effective HIV interventions: https://effectiveinterventions.cdc.gov/en/HighImpactPrevention/Interventions/VOICES.aspx ☺

Social Media Focus Groups: The NPAIHB has partnered with the Social Media Adolescent Health Research Team at Seattle Children's Hospital to carry out focus groups with AI/AN teens re: their perception of concerning posts on social media. The team has identified major themes.

Violence Prevention Messages: We R Native has partnered with Steven Hafner to carryout formative research to design a violence prevention intervention that will be delivered to Native young men via Facebook. 14 interviews with young men 18-24 have been collected and transcribed.

STD/HIV Measures Project: The project is monitoring STD/HIV GPRA measures for IHS sites throughout Indian Country. Infographics are being generated to provide visual feedback data to all 66 IHS sites, 13 Urban sites and any tribal site that provides access. PRT staff are assessing local strengths and weaknesses (administrative, staffing, clinical, and data) that influence screening.

Other Administrative Responsibilities

Publications

- Working on Native VOICES Outcomes paper
- Working on *Texting 4 Sexual Health* papers (x3)
- Working on *IYG* papers (x4)
- Chapter in Book Published: Indigenous People and Mobile Technologies

Reports/Grants

- Subcontract on research grant with the Social Media Adolescent Health Research Team at Seattle Children's Hospital – Due Nov 13th
- Subcontract on RWJF research grant with the Social Media Adolescent Health Research Team at Seattle Children's Hospital – Due Dec 10th

Epicenter Biostatitician

Nancy Bennett

Conference Calls:

- Washington Informatics Road map meeting planning call
- Call with Lou Schmitz and Dr. Weiser discussing WA informatics Road map
- EP Conference planning calls with WA state bi=weekly

NPAIHB Meetings:

- All staff meeting - monthly
- Data meeting bi-monthly
    - Discuss THP report
    - Discuss Brfss data
    - Discuss immunization data
    - Discuss text in THP reports
    - Discuss data analysis

- Immunization project
    - Monthly meeting to discuss progress of sites
- Training for Preventing Harassment & Discrimination Training
- Staff Retreat, Lincoln City, OR

Conferences/QBMs/Out of area Meetings

- Washington Informatics Road Map meeting
- APHA Chicago, IL
    - Presented oral presentation on IHS Suicide report
    - Assisted with the TEC Booth
- SAS Training, Orlando Fl

Miscellaneous

Reports

- Power point for APHA

Site Visits:

- Immunization program
    - Ft Hall
    - Coos Bay
    - Phoenix

Immunization and IRB

Clarice Charging

Meetings:

IHS Immunization flu prevention, October 1, 2015
NPAIHB Epi Center meeting, October 5, 2015
NPAIHB all-staff meeting, October 5, 2015
Preventing Harassment training, October 7, 2015
NPAIHB all-staff meeting, November 2, 2015
Immunization Policy Advisory Team (IPAT) meeting, December 3, 2015
Adult Composite Immunizations Project Stakeholders planning meeting, December 4, 2015
NPAIHB all-staff meeting, December 7, 2015

Quarterly board meetings/conferences/site visits:

NPAIHB quarterly Tribal Health Directors (THD), meeting, Wildhorse Casino and Resort, Pendleton, OR, October 26, 2015
NPAIHB quarterly board meeting, Wildhorse Casino and Resort, Pendleton, OR, October 27-29, 2015
PRIMR Conference, Hynes Convention Center, Boston, MA, November 13-15, 2015
NPAIHB staff retreat, Chinook Winds Resort, Lincoln City, OR, November 16-18, 2015
2016 Joint Tribal Public Health & Emergency Management planning meeting, December 16, 2015

Portland Area (PA) Indian Health Service (IHS) Institutional Review Board (IRB):

PA IRB Meetings:

PA IHS IRB Committee meeting, October 13, 2015
PA IHS IRB Committee meeting, October 19, 2015

PA IHS IRB Committee meeting, December 8, 2015

During the period of January 1 – March 31, Portland Area IRBNet program has 116 registered participants, received 4 new electronic submissions, processed 6 protocol revision approvals, 3 publications/presentations, and approved 4 annual renewals.

Provided IT and IRB regulation assistance to Primary Investigators from:

1) Cowlitz Tribes/NICWA
2) University of Colorado
3) NPAIHB
4) Confederated Tribes of Warm Springs
5) Oregon Health Sciences University
6) Portland State University

Injury Prevention Project/Public Health Improvement & Training

Bridget Canniff, Project Director
Luella Azule, Project Coordinator

Conference Calls

- 9/29 National Public Health Improvement Initiative partner call with CDC & Idaho Dept of Health & Welfare (Bridget)
- 9/21, 10/19, 11/16: WA DOH Emergency Preparedness and Response program update calls (Bridget)
- 11/6, 20, 12/16 Tribal Emergency Preparedness Conference planning calls (Bridget/Luella/Nancy/Clarice)

Meetings/Conferences/Presentations

- 9/17 WA Standards/Accreditation Coordinators meeting – Kent, WA (Bridget)
- 10/6, 20, 12/8 PHIT/IPP staff meetings (Bridget/Luella)
- 10/9 Meetings with Celeste Davis, IHS Project Officer for IPP (Bridget/Luella)
- 10/14 Tribal Public Health Accreditation Advisory Board meeting (alternate for Joe Finkbonner/Tim Gilbert) – Seattle, WA (Bridget)
- 10/15-16 National Network of Public Health Institutes Open Forum on Quality Improvement – Seattle, WA (Bridget)
- 10/14-16 National Indian Education Conference - Portland, OR (Luella)
- 11/1-4 American Public Health Association (APHA) Annual meeting, Chicago, IL - including AI/AN/NH Caucus events and staffing national Tribal EpiCenter booth (Bridget)
- 11/12-13 Transforming Injury and Violence Prevention Summit: Innovations in Policy, Practice and Partnerships, Northwest Center for Public Health Practice – Seattle, WA (Bridget/Luella)
- 11/19: CDC/NIOSH visit to NPAIHB re: Tribal Worker Safety & Health (Bridget et al)

Trainings/Webinars

- 10/9 Randall Child Passenger Safety seat checkup (Luella)
- 12/4 Webinar: Asleep at the Wheel: a Nation of Drowsy Drivers (Luella)

Funding
November

- UW/NWCPHP Year 2 contract amendment received; $50,000 to support NPAIHB as a Local Practice Site of the Northwest Public Health Training Center
- WA DOH TPHEP contract received and signed; $38,300 to support coordination of 2016 Tribal Public Health Emergency Preparedness Conference, May 2016

December

- WA DOH confirmed that our EP special project to document Northwest tribal public health emergency policies and codes was approved; contract pending for $44,691.

Core Activities

October

5 E-mails to Tribal IP Contacts, CPS Techs, Coalition Committee (Luella)

November

11/25 Y5 TIPCAP closeout final report submitted to IHS (Bridget, Luella)
2 E-Mails to Tribal IP Contacts, CPS Techs, Coalition Committee (Luella)

December

12/17 sent E-mail save the date for 1/20 IP Coalition Committee meeting @ QBM, Tribal IP Contacts, CPS techs (Luella)
6 E-mails to Tribal IP contacts, CPS techs, Coalition Committee (Luella)

Site Visits

Tribe: Confederated Tribes of Umatilla
Date: October 26-29
Who performed visit: Bridget and Luella
Purpose of Visit Tribal Health Directors and Quarterly Board Meetings

Tribe: Nez Perce Tribe
Date: November 1-6
Who performed visit: Luella, Tam, Nicole, Julia, Clarice
Purpose of Visit: Tots2tweens Nez Perce dental screenings Lapwai, ID

Tribe: Confederated Tribes of Siletz Indians
Date: November 16-18
Who performed visit: NPAIHB staff
Purpose of Visit: NPAIHB staff retreat, Chinook Winds

Maternal Child Health Projects:

Jodi Lapidus, Native CARS PI
Tam Lutz, PTOTS Project Director/Jr Investigator
Nicole Smith, MCH Biostatistician
Candice Jimenez, Research Assistant
Thomas Becker, Co-PI (TOTS to Tweens)

Native CARS Study

Background
The Native CARS study is a grant funded by the National Center on Minority Health and Health Disparities (NCMHHD), and is a partnership with the NPAIHB, University of Washington, and six Northwest tribes. This partnership aims to design and evaluate interventions to improve child safety seat use in tribal communities.

The six Northwest tribes that participated in the Northwest Tribal Safety Seat Project (under Dr. Francine Romero, Principal Investigator) in 2003 are the same tribes who participated in this study. From the 2003 observational survey, we learned that many American Indian children age 8 and under were riding either unrestrained or improperly restrained in vehicles.

In the dissemination phase of the study, all six participating tribes received community-based interventions. Three received the interventions in phase 1, and the remaining received the interventions in phase 2. We collaborated with the tribal communities to develop interventions that would meaningful and suited to each community. We evaluated child safety seat use in the community both before and after the intervention phases to see if the intervention had an impact on motor vehicle restraint use in the community.

Goal of the Intervention Phase
The goal of the Native Children Always Ride Safe (Native CARS) project was to prevent early childhood vehicle collision morbidity and mortality in American Indian Alaskan Native children through the use of community base participatory model that incorporated tribal differences in cultural beliefs, family and community structure, geographic location, law enforcement and economic factors.

Objectives/Aims of Intervention Phase
We used qualitative research methods to identify community-specific concerns and barriers, and incorporate these findings into an effective behavioral change campaign. We disseminated these results widely, and worked with tribes to design tailored community interventions based on theoretical models of health behavior change. Finally, we assisted tribes as they implemented and evaluated the interventions through a controlled community trial. During this five-year project we **specifically aimed** to:

- Determine the knowledge of AI community members about child passenger restraint systems, and determine barriers and facilitators that effect consistent and appropriate use in six tribes in the Northwestern US.
- Work with members of six Northwest tribes to determine effective methods to increase child safety seat use, developing tailored community intervention programs to address unique needs.
- Implement and evaluate the programs in the Northwest tribal communities, comparing improvement in child passenger restraint use to three comparison tribes in the Northwest through a controlled community trial.

Objective/Aims of Dissemination Phase
Because of the demonstrated success of the Native CARS Study, the study was award additional funds for a dissemination phase of the study, where the protocols, tools and intervention materials can be translated for use by other tribes both locally and nationally. These evidence-based tribal interventions will be adapted and disseminated via plans guided by a dissemination framework that leverages and expands upon tribal capacity built during the previous Native CARS cycle, by engaging the tribal

participants as experts throughout this phase. Demonstrating the translation potential of Native CARS interventions into other tribal communities is an essential step toward reducing the disparity in motor vehicle injuries and fatalities experienced by American Indian and Alaska Native children in the United States.

During the current *dissemination* phase, we specifically aim to:

- Develop the Native CARS Atlas (link to http://www.nativecars.org), a toolkit to assist tribes in implementing and evaluating evidence-based interventions to improve child passenger restraint use on or near tribal lands.

- Facilitate the use of the Native CARS Atlas (link to http://www.nativecars.org) in the six tribes that participated in the original initiative, to help sustain improvements in child passenger restraint use achieved during the intervention phase and provide lessons on use of the toolkit for other tribes.

- Use the Native CARS Atlas (link to http://www.nativecars.org) to assist at least 6 new tribes in the Northwest with demonstrated readiness to implement interventions to improve child passenger restraint use in their communities

Project News & Activities
This quarter the Native CARS Study continued with the developmental work of the dissemination phase of the study. We worked with the tribal site content experts to finalize specific dissemination modules. We also worked with individual sites who are testing dissemination modules at the existing sites.

TOT2Tweens Study

A staggering proportion, 3 of 4 American Indian/Alaska Native (AI/AN) children between the ages of 2-5, have experienced tooth decay, over two-thirds have untreated decay, and over half have severe tooth decay. While this may politely be referred to as a "health disparity," it could more aptly be termed a "health disaster." Many AI/AN children experience tooth decay before the age of two. Tooth decay in that age group leads to further tooth decay and other oral health problems later in childhood.

The newly funded TOTS to TWEENS is a follow up study to *The TOTS Study (Toddler Obesity and Tooth Decay) Study)* an early childhood obesity and tooth decay prevention program. The goal of this study is to survey and conduct dental screenings with the original group of toddlers to test whether interventions delivered in the TOTS will influence the prevalence tooth decay in older children. Through qualitative approaches, the study will also assess current community, environmental and familial factors that can influence oral health in children to understand any maintenance of preventive behaviors over the last ten years within the entire family.

The TOTS2Tween Study is administered through the NW NARCH program at the NPAIHB. The *TOTS2TWEENS* Study will be led by Co-Principal Investigators, Thomas Becker, MD, PhD and Tam Lutz, MPH, MHA.

Project News & Activities

The TOTS2Tweens Study completed preparations and approvals for the launch of the TOTS2Tweens Dental Screening, beginning with the first event at the Nez Perce Tribe in November. Study team also began preparing for the next screenings in Shoshone Bannock and Lummi in early 2016.

For more information about the TOTS to Tweens Study, contact Tam Lutz at tlutz@npaihb.org

BOARD ACTIVITIES

Meetings - Conference Calls – Presentations – Trainings

- Meeting: All Staff Mtgs and Staff Picnic, Oct-Dec (Tam, Nicole, Candice)
- Meeting: EpiCenter Staff, Oct-Dec (Tam, Nicole, Candice)
- Meeting: Project Directors, Oct, Nov (Tam)
- Meeting: Data Cmte, (Nicole)
- PRAMS mtg, Oct (Nicole)
- Annual Preventing Harassment Training, Oct (Tam, Nicole, Candice)
- Meeting: Wellness Cmte, Oct-Dec, (Tam, Candice)
- Holiday Party, (Tam, Candice)

Program Support or Technical Assistance

- Monthly Wellness tip and newsletter, Oct-Dec (Candice)
- BRFSS Technical Support, Oct-Dec (Nicole)
- Drafted budget for NARCH core and overall NARCH VII budget on spreadsheet, prepared NIH forms, collected needed documents, submitted to IHS NARCH contact and made revisions as necessary, Oct (Tam)
- Coordinated Holiday Party, Oct-Dec (Tam)

TOTS to Tweens

Meetings - Conference Calls – Presentations – Trainings

- Wednesday Project Meetings, Oct-Dec (Tam, Tom, Nicole, Julia, Candice)
- Staff Meeting, Jul-Sept, every Wednesday, (Tom, Tam, Julia, Candice)
- Lummi Dental Screening Meeting with Dr Iwaski Nov (Tam)
- Individual meeting with Shoshone Bannock Site Coordinator, Oct-Dec (Tam, Candice)
- Lummi Site Coordinator Meeting, Dec, (Tam, Nicole, Candice and Julia)
- Nez Perce Dental Screening, Nov (Tam, Nicole, Julia, Maxine, Eli, Gerardo, Clarice, Luella)
- Presented TOTS2Tweens resolution to Lummi Tribal Council, Oct, (Tam)

Program Support or Technical Assistance

- Meeting coordination, minutes and action item documentation, Oct-Dec (Julia)
- Dental, KAB, Child questionnaire testing and database revisions, Oct-Nov (Tam, Nicole, Candice, Julia)
- Case study files for Nez Perce research participants, Oct (Julia, Candice)
- Prepared/created research files for Site coordinators, Oct (Julia, Candice)
- IRB corrections and revisions to forms, Oct-Nov (Tam, Julia, Candice)

- IRB corrections and revisions to protocol, Oct-Nov (Tam, Julia, Candice)
- IRB additional submission of finalized voice consenting protocol and consenting document, Oct (Tam)
- Lummi revisions to data sharing agreement and resolution, Oct (Tam)
- Lummi Council Meeting Prep, Oct (Tam)
- Ordered external floppy drive for T2T data retrieval, Oct (Candice)
- Shoshone-Bannock Informed Consent form signature obtained, Oct (Candice)
- NARCH Re-submission, including continuation progress report, draft budget spreadsheet, filling out all NIH forms, proofing, revising, and responding to resubmission request, Oct (Tam, Candice)
- Dental referral letters, Oct (Candice)
- Nez Perce facility fee processing, Oct (Candice)
- Processed travel reports for T2T staff, Nov-Dec, (Julia, Candice)
- Prepared Nez Perce Screening Event Summary Report, Nov (Julia)
- Prepared and Nez Perce Screening Updates/Thank you letters and sent to Nez Perce partners and study investigative team, Nov (Tam)
- Completed Nez Perce dental data entry, Nov (Julia)
- Completed Nez Perce KAB data entry, Nov (Candice)
- Deliver dental items to Shoshone-Bannock & Meeting with Iola, Nov (Nicole)
- Backup child questionnaire databases, append multiple files, Nov (Nicole)
- Write stats code for child questionnaire, Nov (Nicole)
- Appended child questionnaire data sets, Dec (Nicole)
- Child questionnaire STATA coding, Dec (Nicole)
- T2T Contractor Payments and reconciliations, Oct-Dec (Candice, Julia)
- Revisions to NIH/NARCH budget forms, Nov (Tam)
- Lummi Dental Screening Event Prep (Tam, Nicole, Candice & Julia)
- Prepared and delivered all site-specific study materials for Lummi Site Coordinator, Dec (Julia)
- Revised /updated Lummi Site Coordinator Training Manual, Dec (Julia, Tam)
- Ongoing coordination for Shoshone-Bannock Dental Screening Event,Dec (Tam, Julia)
- Updated recruitment letter for Shoshone-Bannock, Dec (Julia)
- Updated tracking sheets , Dec(Julia)
- Processed travel requests and reports for T2T staff (Julia, Candice)
- Prepared and submitted PO's,Dec (Julia, Candice)
- Prepared travel cost projection for PI for carryover request submission, Dec (Julia)
- Prepared supplies and other cost projection for PI for carryover request submission, Dec (Candice)
- Prepared NARCH budget sheets, budget justifications, checklists, inclusion enrollment report, Dec (Tam)

CARS

Meetings - Conference Calls – Presentations – Trainings

- Staff Meetings, Oct-Dec – every other Monday (Jodi, Tam, Nicole, Candice)
- Site Coordinator Conference Call, 1st Thursday/3rd Friday, Oct-Dec (Tam, Candice)
- Met with individual potential web devlopers (Jodi, Nicole,Tam)

Program Support or Technical Assistance

- Meeting coordination, minutes and action item documentation, Oct-Dec (Candice)
- Reviewed Native CARS website bids, Oct-Nov (Jodi, Tam, Nicole, Candice)

- Native CARS Observation video storyboard, Oct-Nov (Nicole)
- Data module revisions (Nicole)
- Reviewed distribution module revisions from Becca, Oct-Nov (Candice)
- Shoshone-Bannock Contract Addendum Follow-up, Completion and Payment, Oct-Dec (Candice)
- Reviewed Native CARS website potential contractors (Jodi, Tam, Nicole, Candice)
- Coordination of Provider-CPSTech Seat Distribution Pilot, Oct-Dec (Tam, Katie)
- Enquired on grant renewal and submitted request for no cost extension, Oct (Tam)
- Nez Perce presentation design & prep, Dec (Nicole, Tam)
- Contract with Jeff Nye for website completion, Dec (Candice, Nicole)
- IRB renewal, Dec (Tam, Nicole)
- Revised data module, Dec (Nicole)
- Revised community intervention module, Dec (Tam, Becca)
- Revised coalition building module, Dec (Candice)
- Requested quotes from Native CARS website potential contractors, Dec (Tam, Nicole)

Site Visits

Lummi Nation
October 26-28
Present resolution to Council
Tam

Nez Perce
November 1-5
TOTS2Tweens Dental Screening Event
Tam, Nicole, Julia, Luella, Clarice

Project contact information

Jodi Lapidus, Principal Investigator
Lapidusj@ohsu.edu

Tam Lutz, Project Director, Co-Investigator, Co-PI
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Nicole Smith, Biostatistician
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Candice Jimenez, Graduate Research Assistant
503-416-3264, cjimenez@npaihb.org

Julia Putman, Project Coordinator
jputman@npaihb.org

Tom Becker, Co-PI
tbecker@npaihb.org

Medical Epidemiologist

Thomas Weiser, Epidemiologist (IHS)

Projects:

*Improvement Support Team
*Adult Immunization Improvement Project
*Hepatitis C
*Immunization Program-routine immunization monitoring
*IRB

Opportunities:

*Submitted application for EIS Officer Placement (pre-match and regular).
*Presented use of surveillance data for immunization/public health planning at OPHA and to Tribal leaders at QBM.
*Assist with evaluation of HCV tracking and Linkage to Care project, provided feedback on IHS HCV draft policy.
*Received announcement regarding new EIS class of 2016 selections. Contracts for interested pre-match officers should be sent to us in the next couple of weeks.
* Responded to request for access to OKC Area sites and provided limited technical assistance.
*Interviewed three candidates for EIS Pre-match and matched with our first choice.

Meetings/Conference Calls:

Meetings: *OPHA meeting, Corvallis, OR, October 12-13, 2015
*Adult Immunization site visit, Fort Hall, ID, October 21-22, 2015
*Washington Informatics Roadmap Stakeholders meeting, Kent, WA, October 23, 2015
*Met with OHS staff and MCH program at Yellowhawk Clinic to discuss Infant Mortality-Tobacco Cessation in pregnancy project, October 28, 2015
*Adult Immunization Site visits: PIMC (AZ), November 9-11, 2015 Coquille OR, November 11-13, 2015, Fort Thompson, SD, November 16-18, 2015

Milestones: IPC 2.0 curriculum released from IPC HQ on November 5, 2015

Clinic Duty: Fort Hall, October 20-21, 2015
Chemawa, November 11, 2015

IRB met in October and December.

Northwest Native American Research Center for Health (NARCH)

Tom Becker, PI
Victoria Warren-Mears, Director
Tom Weiser, Medical Epidemiologist
Tanya Firemoon

Tasha Zaback

This report covers activities related to NARCH 6, 7, and 8 funding cycles

Our last Summer Research Training Institute ended in June, 2015, but we began planning again right away for 2016. This last effort was the 12th such effort sponsored by the Board, with input from OHSU faculty and staff, as well as a host of consultants. The staff did a masterful job at getting the advertisements out and we hosted 100 trainees from around the country, almost all American Indian/Alaska Native. We tried to accommodate the needs assessment related to the course we offered, with some good success. The courses got excellent to outstanding reviews. We offered a new course on indigenous ways of knowing, comparing and contrasting some traditional approaches of observation and experimentation to western scientific methods.

Scholarships were awarded to many of the out-of-town students to help defray expenses for the winter grant writing course—we provide funds to pay for flights and hotels for as many as possible. Of course, we will do the same for summer 2016. Ms. Firemoon has established hotel contracts for 2016, and we expect to award as many travel scholarships as the budget will allow, again next summer.
.
Under NARCH funding, we recruited additional fellows and hope to support a larger group of Board-based scholars who will receive small scholarships to help advance their careers in Indian health. Our scholarship program continues to graduate new researchers, and seems to be successful overall. During the past quarter, we have added new fellows who will receive partial scholarships, and several new fellows who will receive full scholarships under the NARCH program. The grants provided funding for career development for five people per year who work at the Board, and all five of these staff members are performing at highest standards. Ms. Firemoon has been extremely helpful in watching over this part of the NARCH, and her efforts to help the summer program have also been very valuable.

The 8th funding cycle for NARCH funds have been awarded and we are starting into year 2: we will be conducting a dental survey of children ages 9-12 who participated in our earlier survey among toddlers. The national program awarded us some additional funds this fall that were unexpected, so, I assume that means we are doing a good job in their eyes. Ms. Fox worked very hard and did a lovely job in helping get the grant budget revisions out the door in a timely manner.

The Indian Health Service and NIH have required us, and the other NARCH programs nationwide, to send in extensive progress reports on each cycle of funding. This activity has consumed a substantial proportion of our time but will be ready for them by the end of this month. Soon the NIH will take over administrative control of the NARCH and will leave Indian Health Service out of the loop.

To date, the NARCH funding stream has brought in approximately $12 million to the Board to address health issues among tribal people in the Northwest and beyond. We are very pleased that the federal government continues to find funds to run this program. At the federal level, Drs. Kathy Etz and Sheila Caldwell have been instrumental in finding federal funds to advance the health of tribal people in this national program. Many others have assisted these efforts.

Northwest Tribal Comprehensive Cancer Control Project

Kerri Lopez, Director
Eric Vinson, Project Specialist

Special projects

BRFSS:

- Aggregated table for four tribes – demographic – added tobacco and spit
- Working on summary and placed aggregate tables
- Submitted aggregate summary report to CDC
- Tribe 5 – letter from chairman, newsletter and information posted at tribe
    - hired tribal staff to make initial phone calls
    - Final edits to CAPI
    - Gift cards for tribe 5 purchases
    - BRFSS orientation for employee
        - Resource materials
        - Project history and overview
        - Practice with phone script
    - Created and reviewed a spread sheet to track participants who agreed and their updated information
        - Confidential information was set up in the Box website for secure transfer of the spread sheet
    - Set up an NPAIHB email to create a shared calendar
        - Coordinated about schedules and booking interviews for BRFSS
    - Set up file system for BRFSS
    - Stored coversheets, incentives, and documents tracking calls
    - Cleaned up the BRFSS instrument for more efficient use
    - Interviews being conducted

Tobacco Quit line information

- Transferring data from Oregon into central spreadsheet

Cessation reimbursement for Oregon Pharmacists

- Followed up from Oregon Pharmacy Policy Analyst, waiting on next follow-up

Tobacco Questionnaire for Clinical Directors Meeting

- 14 responses
- Questions focused on tobacco cessation protocol, models, follow up
- Questions about what the clinical directors needs are for Pregnancy and smoking, e-cigarettes, resources, clinical or community training
- Training tribal staff on Basic Tobacco Intervention Skills in Native Communities

Preparation April 6th Northwest Tribal Clinical Cancer update

- Invitation for Nutrition, Native OB/GYN Oncologist, and Tribal Cancer center for presentations
- Contract for meeting room and food completed
- Needs assessment distributed to Portland Area clinical directors

Preparation March 22&23rd Tobacco Summit & NTCCP meeting

- Confirmed keynote presenter

- Preliminary hotel logistics

Preparation June 29th Risky Business Training

- Meeting room at Puyallup Tribe secured (Spirit House)
- Hotel room blocks setup

Motivational Interviewing training planning

- Waiting on updated status with Umatilla

Research Tobacco/Nutrition/Wellness

- sample school tobacco policies
- healthy eating toolkit
- MCH tobacco cessation curriculums

Attended presentation on AI/AN medical school experience

- Met new native OB/GYN oncologist
- Sent out to coalition – emphasis Oregon tribes

2015-16 Local Tribal Cancer Plan Implementation Funding Requests for Application
Ordered 20 copies of materials for Basic Tobacco Intervention Skills Instructor training
HPV environmental scan – worked on development

- CPR grant application

Tobacco Quit line information

- Received data from Oregon and transferring into central spreadsheet
- Received information on cost for information from Washington $1400

OHA contract finalized

- NPAIHB signature pages

Cessation reimbursement for Oregon Pharmacists

- Followed up from Oregon Pharmacy Policy Analyst, waiting on next follow-up

Information to new NPAIHB staff regarding travel logistics
Motivational Interviewing training planning

- Partnership with Umatilla
- Contacted trainer for availability

Information from Leukemia & Lymphoma Society on changes in their programming
Research Tobacco/Nutrition/Wellness

- sample policies
- healthy eating toolkit

Edit Oregon Tribal Tobacco Policy spreadsheet

<u>Technical assistance via telephone/email</u>

- Cow Creek – Coalition meeting support for local host, Great American Smokeout evaluation information (called all 9 Oregon tribes sent information to coalition)
- Grand Ronde – Cancer Plan Implementation Funding information, appointment companion
- Lummi – information on local cancer center survivorship program
- Nez Perce – Ethics Training for Health in Indigenous Communities Study
- Puyallup – Cancer Survivorship Information, information on Oncologist recruitment
    - information on Native OB/GYN oncologist
- Shoalwater Bay – Travel reimbursement information

- Spokane – Cancer Plan Implementation Funding information
- Umatilla – NIH library information
- Warm Springs – November Coalition meeting information for travel justification
- Yakama – information on local cancer center contact, information on fitbit use in wellness program

Training/Site Visits

- November 9&10 Northwest Tribal Cancer Coalition meeting – Cow Creek
    - Training tribal staff on Basic Tobacco Intervention Skills in Native Communities
    - Training 13 tribal staff from 6 tribes, 1 urban Indian clinic, and Oregon DOH on Basic Tobacco Intervention Skills in Native Communities
    - Follow-up with Hotel and tribe for payment of room and food invoices
- Umatilla – NPAIHB QBM
- Warm Springs HPCDP(Health Promotion and Chronic Disease Prevention) Grantees and Contractors meeting
- Coquille BRFSS meeting – in Portland
- Siletz Portland office – digital story telling attendance

Meetings/Conferences

- All Staff meeting (3)
- Data Meeting
- Staff project meeting (2)
- Staff project meeting
- Tobacco activities planning meeting
- Staff Retreat
- Meeting with Oregon Health Authority – Tobacco grant
    - Contract scope of work
    - Timeline
- American Association for Cancer Education meeting
- Met with new AI/AN Coordinator for Salish Oncology
- Annual Preventing Harassment & Discrimination Training
- Interview Panel Meeting
- Two interviews for WEAVE tobacco specialist
- Attended health director and quarterly board meeting

Conference calls

- CDC project officer (2)
- HPV-RT National Campaign Monthly Call (2)
- CPCRN HPV Vaccination workgroup meeting (2)
    - Scheduled meeting in December – Bend campus
    - Paige to meet with ACS; learn about resources/support they have re: HPV Vaccination at ACS resources and new program

- Idaho Colorectal Cancer Roundtable Web Conference
- Washington State Cancer Survivorship Workgroup Call
- Meet with IHS HPDP coordinator to discuss Tobacco/Immunization
- FRESH EMPIRE Webinar – youth tobacco prevention / hip hop
- Oregon's Title V MCH- Smoking Strategy webinar
- OHA Pregnancy and Tobacco Use workgroup
- OHA Webinar - Tobacco Prevention/Cessation programs for Native American Communities – Lou Moerner

Northwest Tribal Dental Support Center

Joe Finkbonner, Executive Director
Ticey Casey, Project Manager
Bonnie Bruerd, Prevention Consultant
Bruce Johnson, Clinical Consultant
Kathy Phipps, Epidemiology Consultant

The Northwest Tribal Dental Support Center (NTDSC) was awarded a grant to continue their work for another five years, making this our 16th year of funding. The overall goals of NTDSC are to provide training, quality improvement, and technical assistance to the IHS/Tribal Dental programs, and to ensure that the services of the NTDSC result in measurable improvement in the oral health status of the AI/AN people served in the Portland Area. NTDSC activities are listed in categories corresponding to the current grant objectives.

Ensure quality and efficient care is provided in Portland Area dental programs through standardization of care and implementation of public health principles to improve dental access and oral health outcomes.

- Clinical and prevention site visits were provided this quarter for Swinomish and NIsqually. NTDSC has completed site visits, including reports, at two Portland Area dental programs this fiscal year. An additional three visits are scheduled next quarter.
- Work has begun on the development of an orientation process for new dentists and dental hygienists.
- "Tips for Interviewing Dentists" was developed and distributed to all Dental Directors and Health Directors with the aim of hiring dental staff who are a good fit for IHS/Tribal dental programs.

Expand and support clinical and community-based oral health promotion/ disease prevention initiatives in high-risk groups to improve oral health.

- NTDSC has expanded their collaboration with WA Dental Services Foundation (Delta Dental) to meet some identified mutual objectives. Ten dental programs are currently participating in the "Baby Teeth Matter" program that is aimed at increasing dental access for 0-5 year olds and reducing the number of children referred for dental work under general anesthesia. This program includes data

collection, face to face and webinar meetings, and ongoing program evaluation. Data from the first year showed a large increase in dental access for 0-5 year olds.

- Portland Area met all 3 dental GPRA objectives this past year.

- Quality Improvement objectives focused on prevention initiatives will be completed by dental program staff during the NTDSC annual meeting in July, 2016.

- NTDSC Prevention Consultant serves as the Portland Area dental representative on the national HP/DP Committee.

Implement an Area-wide surveillance system to track oral health status.
Data from the surveillance system will be used to identify vulnerable populations and plan/evaluate clinical and community-based prevention programs.

- Portland Area completed the Basic Screening Survey for adults this fall, and are currently waiting for the results of the survey. This represents a significant effort from the dental programs who participated in the survey but provides useful data for clinical and community-based program planning.

Provide continuing dental education to all Portland Area dental staff at a level that approaches state requirements.

- During the past year, NTDSC provided a total of 4,648 continuing dental education credits to the dental staff in the Portland Area. Plans this year include one-hour lunchtime webinars, on site courses, orientation for new dentists and dental hygienists, NTDSC annual meeting, Baby Teeth Matter sessions for participating dental programs, and the Dental Directors' Meeting.

NTDSC consultants participate in email correspondence, national conference calls, and respond to all requests for input on local, Portland Area, and national issues.

Northwest Tribal Registry Project-Improving Data and Enhancing Access (IDEA)

Victoria Warren-Mears, P.I.
Sujata Joshi, Project Director
Kristyn Bigback, Project Support Specialist/Biostatistician
Jenine Dankovchik, Biostatistician

Project news and activities

This quarter we worked on updating the Tribal CHSDA cancer profiles, which were previously provided to Tribes in 2010 (using data from 2003-2007). The updated cancer profiles present cancer incidence and mortality data for each Tribes' CHSDA using data from 2008-2012. We completed initial drafts of the profiles, which are currently undergoing internal review. We continued work on CHSDA-level tribal health profile reports.

We finished our annual update of the Northwest Tribal Registry (NTR). This year's NTR includes data from the Portland Area IHS, NARA Inc., the Seattle Indian Health Board, and Puyallup Tribal Health

Authority. We completed our annual linkage with the Oregon State Cancer Registry. In the coming year, we plan to link with the Washington State Cancer Registry, the Cancer Data Registry of Idaho, Oregon and Washington hospital discharge data, and Oregon and Washington communicable disease registries.

We submitted a full proposal for the Robert Wood Johnson Foundation's Data Across Sectors for Health funding opportunity, but were not funded. We will look for other opportunities to improve Tribes' access to EpiCenter data through online platforms.

Current status of data linkage, analysis, and partnership activities

- *Northwest Tribal Registry (NTR) data linkages*
    - Updated our data use agreement with the Seattle Indian Health Board (SIHB)
    - Finished creating this year's Northwest Tribal Registry file (NTR 13) using data from Portland Area IHS, NARA Inc., SIHB, and Puyallup Tribal Health Authority
    - Completed linkage with Oregon State Cancer Registry (1996-2013 data), received analytic file

- Tribal Health Profiles (THP) project
    - CHSDA THPs
        - Finalized, printed, and mailed CTUIR Tribal Health Profile report to Tribe
        - Finished initial draft of Colville Tribes' THP report – waiting for updated BRFSS to be analyzed and included in final report
        - Continued work on indicators and reports for Nez Perce, Lummi, Cowlitz, and Chehalis Tribes
        - Worked on creating a CHSDA THP guidelines document for future THPs
- *Cancer Registry Data and Cancer Fact Sheets*
    - Completed first drafts of CHSDA-level cancer profiles using data from 2008-2012
        - Sent profiles to Eric Vinson (NTCCP) for internal review
    - Began formatting data for cancer survival analysis project

- Death certificate Data
    - Found problems with Oregon death certificate dataset; re-imported 1997-2005, 2013 records and worked on cleaning and coding to create updated analytic dataset(s)

- Yellowhawk Cancer Data Review
    - Worked with Jeff Soule (Oregon State Cancer Registry) and Angie Dearing (Yellowhawk Tribal Clinic) on completing approvals and data sharing agreement for release of OSCaR data
    - Completed initial report on cancer incidence, stage at diagnosis and mortality for Yellowhawk Clinic's four-county area (Union, Umatilla, Morrow, and Walla Walla Counties)
    - Met with Angie Dearing and Dan Peterson to review Yellowhawk cancer data

- Substance Abuse/Injury Analysis
    - Began work on an analysis examining substance abuse-related injuries among Northwest AI/AN; the first analysis will be submitted as an abstract for the Council for State and Territorial Epidemiologists' 2016 annual meeting

- *Health Data Literacy Training*
    - Reviewed and provided input on Health Data Literacy Training Evaluation Report (written by Jenine Dankovchik)

- *Data requests/Technical assistance*
    - Created maps of acute Hepatitis C infections in Washington for Tom Weiser using data from Washington Department of Health
    - Provided Eric Vinson with updated statistics and updated project information for NTCCP update of 20-year comprehensive cancer plan

- *Institutional Review Board (IRB) applications and approvals/Protocol development*
    - Received approval from the Washington State IRB to continue Birth Certificate linkages/infant mortality analysis
    - Received approval from the Washington State IRB to continue linkages with the Washington State Trauma Registry
    - Received approval from the Washington State IRB to continue linkages with Washington death certificates and CHARS (hospital discharge records)

- *Grant Administration and Reporting*
    - Submitted a full proposal for the Robert Wood Johnson Foundation's Data Across Sectors for Health funding opportunity; we were not funded
    - Submitted our Year 4 Quarter 1 Progress Report to the Office of Minority Health (OMH)

- *Collaborations with other programs and other activities*
    - Reviewed and provided input on EpiCenter Priorities Survey
    - Continued working with CSTE Tribal Epi Workgroup on data sharing manuscript - reviewed interim drafts and provided additional information to lead author

Data dissemination

- Sent printed and electronic copies of Confederated Tribes of the Umatilla Indian Reservation's Tribal Health Profile Report to tribal health leaders

Travel

Linkages

- Seattle Indian Health Board, Seattle, WA 12/10
- Oregon State Cancer Registry, Portland, OR 12/17

Site visits

- None

Meetings, Trainings, and Conferences

- NPAIHB Staff Retreat, Lincoln City, OR 11/16-11/18

Other Meetings, Calls and Trainings

- Annual Preventing Harassment & Discrimination Training 10/7, 10/12
- OSCaR Project Review Team Call 10/7
- CSTE Tribal Epi Manuscript Call 10/13, 11/24
- CSTE Tribal Epi Workgroup Call 10/15
- SAS Probability Surveys Online Training 11/2-11/9
- Meeting with NIOSH Program Officers 11/19
- OMH Grant Bi-Monthly Conference Call 11/20
- Call with OMH Evaluation Team 12/1
- NPAIHB Holiday Party 12/7
- Meeting to review IDEA-NW security protocols 12/16
- Data Meetings Ongoing
- Adult Composite Immunization Measure Project meetings Ongoing

Data reports, fact sheets, and presentations are posted to our project website as they are completed:
http://www.npaihb.org/epicenter/project/reports/
Please feel free to contact us any time with specific data requests.
Email: sjoshi@npaihb.org or IdeaNW@npaihb.org
Phone: (503) 416-3261

THRIVE (Tribal Health: Reaching out InVolves Everyone)

Colbie Caughlan, Project Manager
Celena McCray, Project Assistant

Site Visits

Tribal Site Visits

- Nez Perce Tribe, Lapwai, ID – October 20-21
- CTUIR, Pendleton, OR – October 27
- Siletz Tribe, Lincoln City, OR – November 16-18
- Suquamish Tribe, Suquamish, WA – November 25
- Jamestown S'Klallam Tribe, Sequim, WA – December 10

Out of Area Tribal Site Visits

- None during this reporting period

Technical Assistance & Training

During the quarter, project staff:

- Participated in 53 meetings and conference calls with program partners.

- Disseminated 11+ boxes of the new suicide prevention media campaign for AI/ANs.
- One of three *Healing of the Canoe* tribal subcontract sites began the HOC curriculum and project surveys during this quarter.
- Staff presented and participated in the first *Zero Suicide* Tribal Academy in December.
- Staff chose Buffalo Nickel Creative as the media company to develop the remaining suicide prevention related media campaigns slated to be released over the next four years.
- Announced recruitment of three more NW Tribes to begin implementing the *Zero Suicide Model* with the availability of ZS training dollars through the NPAIHB's MSPI funds, requests for training are due January 22.

During the quarter, THRIVE provided or participated in the following presentations and trainings:

- Presentations (5)– THRIVE/PRT staff presented THRIVE resources at the, Sources of Strength Training, October 20-21; NPAIHB Quarterly Board Meeting, 90+ attendees, October 27; ZS Tribal Academy, 65 attendees, December 1-3; Gov't-to-Gov't Meeting with the OR 9 Tribes, 20 attendees, December 4 and; AIHC WA meeting, 30 attendees, Sequim, WA.
- Booth – THRIVE materials were shared by the EpiCenter staff at the Annual APHA Conference, October 30 – November 2.

During the quarter, the THRIVE project responded to 120 phone or email requests for suicide, bullying, or media campaign-related technical assistance, trainings, or presentations.

Health Promotion and Disease Prevention

THRIVE Media Campaign: All THRIVE promotional materials are available on the web. The new We Are Connected materials include: two posters, a blank flyer for community use, informational rack card and tip card, t-shirts, lanyards, radio PSAs, 3 Lived Experience videos, and pre-loaded USB drives.

The campaign has gained momentum the week of Suicide Prevention Day, Sept. 7-11 when THRIVE officially launched the new campaign.

MSPI - Gen-I Messages: Number/Reach of We R Native Facebook messages addressing…

- Suicide = 7 posts, 70,800 people reached
- Mental health = 19 posts, 52,400 people reached
- Substance prevention = 3 post, 8,400 people reached

- Youth leadership/empowerment = 38 posts, 424,271 people reached

Other Administrative Responsibilities

Staff Meetings
- EpiCenter meetings
- All-staff meetings
- Project Director meetings
- Wellness Committee – monthly meetings and events

Publications
- None during this reporting period.

Reports/Grants
- Submitted Quarterly reports (Jul-Sept) to SAMHSA for the GLS grant.
- Submitted the Annual report for year 1 of the SAMHSA GLS grant on December 30.
- Prepared the carry over request for year 1 funds for the SAMHSA GLS grant, will submit in early January 2016.

Administrative Duties
- Budget tracking and maintenance: Ongoing.
- Managed Project Invoices: Ongoing.
- Staff/Intern oversight and annual evaluations: Ongoing.
- Managed Project Subcontracts: Ongoing

Wellness for Every American Indian to View and Achieve Health Equity (WEAVE)

Victoria Warren-Mears, Principal Investigator
Jessica Marcinkevage, Epidemiologist
Jenine Dankovchik, Evaluation Coordinator
Nora Alexander, Health Educator/Communication Spec.
Birdie Wermy, National Evaluation Specialist

Site Visits

Date(s)	Tribe	Short Summary	WEAVE-NW Staff
10/09/15	Coquille Tribe	Initial meeting with sub-awardee	JD, NY
10/14/15	Chehalis Tribe	Site Visit- Community Health Assessment Survery/ CHANGE tool	NA, JD, NY
10/27/15 -	10/29/15	Umatilla Tribe	QBM

VWM, NY			
11/12/15	Grand Ronde Tribe	Meeting to discuss YR1-YR2 workplan	NA, NY
12/02/15	Lummi Tribe	Met with Lummi to discuss progress on their sub-award project to date	JD, NY
12/03/15	Chehalis Tribe	Met with Chehalis interviewers to train them on conducting health survey	JD, NY

Total number of site visits this quarter: 6

Partnerships

Date Formed	Name of Partner	Type
11/10/2015	Bowman Performance Consulting	Private sector research or consultant
11/13/2015	American Indian Cancer Foundation	Tribal community organization
11/14/2015	Center for Public Health Systems Science Washington University in St Louis	Academic

Total number of new partnerships this quarter: 3

Presentations

Date Given: 10/28/2015 **Type:** Tribal Community Presentation (include QBMs)
Title: WEAVE-NW RFA
Presented at: QBM
Location: Pendleton, Oregon

Date Given: 12/17/2015 **Type:** Tribal Meeting Presentation
Title: WEAVE-NW presentation to GHWIC C2 partners
Presented at: GHWIC C2 monthly conference call
Location:

Total number of presentations given this quarter: 2

Publications

Date Published: 12/16/2015 **Type of Publication:** Newsletter/newspaper article
Title: WEAVE Introduction
Published in: Adolescent Health News & Notes

Total number of publications completed this quarter: 1

Professional Development

Date	Title	WEAVE-NW Staff	Topics
12/29/15- 12/29/15	TPEP meeting - digital storytelling	NA	Epidemiology/Analysis, Other training topic
11/16/15- 11/16/15	SAS Programming 2: Data Manipulation	JD	Epidemiology/Analysis
11/30/15- 11/30/15	SAS Base Programmer Certification	JD	
11/09/15- 11/14/15	American Evaluation Association annual confrence	JD	Evaluation
11/01/15- 11/04/15	APHA Annual Conference	NA	CVD/Stroke, Obesity, Diabetes, Tobacco, Nutrition, PSE, Physical Activity, Community Health Assessments, Evaluation
10/22/15- 10/22/15	AEA webinar - Visualization for Evaluation Design	JD	Evaluation
10/30/15- 10/31/15	APHA Annual Conference	NA	CVD/Stroke, Obesity, Diabetes, Tobacco, Nutrition, PSE, Physical Activity, Evaluation
11/09/15- 11/30/15	Capacity Building Curriculum workshop	RS	CVD/Stroke, Obesity, Diabetes, Tobacco, Nutrition, PSE, Physical Activity, Coalition Building, Training Methods, Community Health Assessments, Evaluation

Total number of professional development activities this quarter: 8

Technical Assistance Given

Start Date: 10/01/15 **Method:** Email **Type of Assistance:** Provided fact sheet
Tribe(s) Assisted: Chehalis
Topics Covered: Data

Start Date: 10/01/15 **Method:** Email **Type of Assistance:** Policy development
Tribe(s) Assisted: Cow Creek
Topics Covered: CVD/Stroke, PSE

Start Date: 10/05/15 **Method:** Email **Type of Assistance:** Sharing Resources (general)
Tribe(s) Assisted: C1 and sub-awardees
Topics Covered: CVD/Stroke, Obesity, Diabetes, Tobacco, Nutrition, PSE, Physical Activity

Start Date: 10/07/15 **Method:** Email **Type of Assistance:** Provided data report
Tribe(s) Assisted: Chehalis
Topics Covered: Obesity, Tobacco, Nutrition

Start Date: 10/07/15 **Method:** Email **Type of Assistance:** Survey design & implementation
Tribe(s) Assisted: Grand Ronde
Topics Covered: Diabetes, Nutrition, Evaluation

Technical Assistance Given

Start Date: 10/07/15 **Method:** Email **Type of Assistance:** Survey design & implementation
Tribe(s) Assisted: Chehalis
Topics Covered:

Start Date: 10/12/15 **Method:** Email **Type of Assistance:** Sharing Resources (general)
Tribe(s) Assisted: C1 and sub-awardees
Topics Covered: CVD/Stroke, Obesity, Diabetes, Tobacco, Nutrition, PSE, Physical Activity

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Start Date: 10/14/15 **Method:** Email **Type of Assistance:** Sharing Resources (general)
Tribe(s) Assisted: Chehalis, Grand Ronde, Lummi
Topics Covered: Data

Start Date: 10/15/15 **Method:** Email **Type of Assistance:** Survey design & implementation
Tribe(s) Assisted: Chehalis
Topics Covered:

Start Date: 10/19/15 **Method:** Email **Type of Assistance:** Sharing Resources (general)
Tribe(s) Assisted: C1 and sub-awardees
Topics Covered: CVD/Stroke, Obesity, Diabetes, Tobacco, Nutrition, PSE, Physical Activity

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Start Date: 10/20/15 **Method:** Phone **Type of Assistance:** Evaluation planning
Tribe(s) Assisted: Klamath
Topics Covered: Diabetes, PSE, Evaluation

Start Date: 10/20/15 **Method:** Phone **Type of Assistance:** Policy development
Tribe(s) Assisted: Port Gamble S'Klallam
Topics Covered: PSE

Start Date: 10/20/15 **Method:** Other (specify) **Type of Assistance:** Grant writing
Tribe(s) Assisted: C1 and sub-awardees
Topics Covered: PSE

Start Date: 10/23/15 **Method:** Email **Type of Assistance:** Policy development
Tribe(s) Assisted: Cow Creek
Topics Covered: CVD/Stroke

Start Date: 10/23/15 **Method:** Email **Type of Assistance:** Provided data report
Tribe(s) Assisted: Chehalis
Topics Covered:

Start Date: 10/23/15 **Method:** Email **Type of Assistance:** Provided data report
Tribe(s) Assisted: Chehalis
Topics Covered: Data

Start Date: 10/26/15 **Method:** Email **Type of Assistance:** Sharing Resources (general)
Tribe(s) Assisted: C1 and sub-awardees
Topics Covered: CVD/Stroke, Obesity, Diabetes, Tobacco, Nutrition, PSE, Physical Activity

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Technical Assistance Given

Start Date: 10/28/15 **Method:** Email **Type of Assistance:** Other (specify)
Tribe(s) Assisted: Colville
Topics Covered: Data

Start Date: 10/29/15 **Method:** Email **Type of Assistance:** Survey design & implementation
Tribe(s) Assisted: Chehalis
Topics Covered:

Start Date: 11/05/15 **Method:** Email **Type of Assistance:** Sharing Resources (general)
Tribe(s) Assisted: C1 and sub-awardees
Topics Covered: CVD/Stroke, Obesity, Diabetes, Tobacco, Nutrition, PSE, Physical Activity

Start Date: 11/05/15 **Method:** Email **Type of Assistance:** Survey design & implementation
Tribe(s) Assisted: NTCCP
Topics Covered: Tobacco, PSE

Start Date: 11/09/15 **Method:** Email **Type of Assistance:** Sharing Resources (general)
Tribe(s) Assisted: C1 and sub-awardees
Topics Covered: CVD/Stroke, Obesity, Diabetes, Tobacco, Nutrition, PSE, Physical Activity

Start Date: 11/16/15 **Method:** Email **Type of Assistance:** Sharing Resources (general)
Tribe(s) Assisted: C1 and sub-awardees
Topics Covered: CVD/Stroke, Obesity, Diabetes, Tobacco, Nutrition, PSE, Physical Activity

Start Date: 11/23/15 **Method:** Email **Type of Assistance:** Sharing Resources (general)
Tribe(s) Assisted: C1 and sub-awardees
Topics Covered: CVD/Stroke, Obesity, Diabetes, Tobacco, Nutrition, PSE, Physical Activity

Start Date: 11/23/15 **Method:** Email **Type of Assistance:** Guidance to analyze their own data
Tribe(s) Assisted: ANTHC
Topics Covered: Data

Start Date: 11/24/15 **Method:** Other (specify) **Type of Assistance:** Sharing Resources;
Tribe(s) Assisted: C1 and sub-awardees
Topics Covered: PSE

Start Date: 11/30/15 **Method:** Email **Type of Assistance:** Report writing
Tribe(s) Assisted: Chehalis
Topics Covered: Data

Start Date: 11/30/15 **Method:** Email **Type of Assistance:** Sharing Resources (general)
Tribe(s) Assisted: C1 and sub-awardees
Topics Covered: CVD/Stroke, Obesity, Diabetes, Tobacco, Nutrition, PSE, Physical Activity

Start Date: 12/02/15 **Method:** Email **Type of Assistance:** Sharing Resources;
Tribe(s) Assisted: C1 & Sub-Awardees
Topics Covered: CVD/Stroke, Obesity, Diabetes, Tobacco, Nutrition, PSE, Physical Activity

Technical Assistance Given

Start Date: 12/03/15 **Method:** Face-to-face at Tribal location **Type of Assistance:** Survey design & implementation

Tribe(s) Assisted: Chehalis
Topics Covered: CVD/Stroke, Obesity, Diabetes, Tobacco, Nutrition, Physical Activity, Data, Evaluation

Start Date: 12/07/15 **Method:** Email **Type of Assistance:** Sharing Resources;
Tribe(s) Assisted: C1 & Sub-awardees
Topics Covered: CVD/Stroke, Obesity, Diabetes, Tobacco, Nutrition, PSE, Physical Activity

Start Date: 12/08/15 **Method:** Email **Type of Assistance:** Sharing Resources;
Tribe(s) Assisted: Sub-awardees
Topics Covered: CVD/Stroke, Obesity, Diabetes, Tobacco, Nutrition, PSE, Physical Activity

Start Date: 12/16/15 **Method:** Email **Type of Assistance:** Other (specify)
Tribe(s) Assisted: GHWIC partners
Topics Covered: Obesity, Nutrition

Total number of times technical assistance was given this quarter: 33

Trainings Given

Start Date: 12/15/2015 **Training Length:** Less than 1 hour **Training Format:** Webinar
Title of Training: Traditional Foods Webinar
Topics Covered: Obesity, Nutrition, PSE

Total number of trainings given this quarter: 1

Western Tribal Diabetes Project

Kerri Lopez, Director
Don Head, Project Specialist
Erik Kakuska, Project Specialist

Meetings/Conferences

- All Staff meeting (3)
- Tribal Epicenter Meeting (1)
- Project directors meeting (3)
- Staff Holiday Party
- Annual Preventing Harassment & Discrimination Training
- NPAIHB Quarterly board meeting
    - Health Director Meeting
    - Legislative committee for WTDP resolution (passed 5% data fund set aside)
- Data Meeting (2)

Special projects

- Completed budget for WTDP
    - Prepared information for FDW on WTDP activities
    - Funding awarded per FDW 5%

    - Inquiry for contract funding
    - Completed final FFR for WTDP
- Prepared solicitation for contract (new mechanism for funding WTDP)
    - Goals, activities
    - Staff knowledge and experience
    - Accomplishments
    - Submitted final proposal to IHS
- Weave – NTCCP meetings
    - Planning for tobacco coalition/summit
    - Planning for Risky Business
    - AI/AN women pregnancy - presentation
    - Gathering policies for wellness in the workplace, nutrition, physical activity
- OHA meeting
    - Policy workbook created
    - Timeline for Oregon tribes
    - Input to Oregon TPEP RFA
    - Scope of work
    - Timeline
    - 4 conference calls
    - 2 meetings
    - Contact person
- Interview Panel Meeting
    - Screening for applicants
- Two interviews for WEAVE tobacco specialist
    - Specialist hired
- Native Fitness
    - Dates for 2016 August 30 and 31st 2016
    - Final invoicing – complete from last year
    - Still trying to complete shoe debacle
- Update for CFC application
    - Application
    - 990
    - Updated activities for attachment A
- Posted HSR Portland Area to website
- Development of needs assessment for SDPI programs
    - Create contact and excel sheet for TA needs of tribes
    - Additional part time assistance
    - Schedule of site visits
- Consolidated the WTDP databases into one
    - Trouble shooting for update
- Updated Shortcut & Reference Manual

    - new ICD-10 codes
    - posted to WTDP website
- Preparation for December Training
    - Confirmations and logistics sent out
    - Materials
    - Short cut and reference
    - Preparation of training room
- NPAIHB Newsletter
    - Final read of proof
- Completed WEAVE logo creation
- Preparation for December Training
    - Confirmations and logistics sent out
    - Materials
    - Short cut and reference
    - Preparation of training room

Trainings / Site Visit

- DMS training - Portland, Oregon 12/1-3
    - 11 participants (4 NW Tribes, 8 out of area)

Technical Assistance

25 technical assistance calls on various topics including:

- Request for December training
- CAC emailed about security keys QMAN;
- TA on how to enter new patients and how to clean up a register
- ICD-10 codes for diabetes. sent updated Shortcut & Reference Manual
- Request for copy of the HSR; TA for ICD-10 codes for diabetes
- Helped navigate audit numbers to the HSR; log in issues
- TA to print out a listing of patients with their Primary Care Provider
- Running GEN report, and sent the instructions from our manual
- TA on recreating new account registration
- QMAN; foot exams in a specified time frame.
- Metformin wasn't showing up taxonomy issue or the medication was recorded over six months before the audit date
- TA about what types of education covered under the audit indicator "other."
- instructions from our manual on how to fix taxonomies
- ta LDL Cholesterol comparisons and assistance with HSR (how to enter data);
- How to find IHS audit numbers for 2014-2015
- TA how to get access for staff to get to the pre-diabetes register;
- emailed instructions on changing the register creator and adding authorized users;
- ta on numbers for last two years audit, trouble shorting with patient status report, and sent HSR

- TA IHS audit numbers and new employee (how to get started with DMS)
- TA how to obtain an electronic copy of Excel files
- 4 copies of Short cut reference manual
- TA about printing while in the Browse portion of a report,

Conference Calls:

- Healthy people 2020
- Improving Health Care Delivery Data Project: Steering Committee Quarterly Conference Call
- Let's move in Indian Country
- Healthy people 2020

Legislative & Policy Update

NW Portland Area Indian Health Board
Quarterly Board Meeting
Hosed by Lummi Tribe

January 19, 2016

1

Report Overview

1. IHS Appropriations & Omnibus
2. Contract Support Cost Updates
3. Indian Health Legislation in 114th Congress
4. 100% FMAP & TTAG Updates
5. Legislation pending

FY 2016 Omnibus

- FY 2016 President Request $460 million increase
  - House bill is $315 less than President's Request – 3.1%
  - Senate bill is $324 million less than President's Request – 2.9%
  - $8.6 million difference with House mark higher
- FY 2016 Omnibus passed December 18, 2015
- Provides $4.8 billion for IHS programs, $295 million less than President's Request
- $165 million increase over FY 2015 level, a 3.6% increase

FY 2016 IHS Budget Highlights

- Very modest budget increases for H&C and Prevention accounts with exception of A&SA funding
- No funding for medical inflation or population growth
- $19.4 million is included for pay act increases
- Across the board H&C and Prevention receive less than 1.5% increase
- Alcohol & Substance Abuse receive additional $14 million, a 7.5% increase over FY 2015
- CHS Program is flat line funded at $914 million
- CSC receives $55 million increase, a 8.3% increase
- Facilities accounts receive very good increases of $20 million for M&I, Sanitation, Construction

FY 2016 IHS Budget

- Facilities Programs receive good increases
- Maintenance & Improvement additional $20 million after 2-3 years of flat line funding 37% increases
- Sanitation Facilities $20 million increase, 25% increase
- Health Facilities Construction $20 million increase—President requested $100 million increase
- California YRTC facilities funding is included

Contract Support Costs

- FY 2016 final appropriation includes indefinite appropriation for CSC
- IHS continues to meet with CSC Workgroup & initiated Tribal Consultation on its Policy – Tribal Redline with IHS responses prepared
- Denver meeting nearly imploded over developing letter on duplication and pass through issues—speaks to the relationship with Tribes & IHS
- Outstanding issues:
  - Cost incurred approach for reconciliation
  - Pass through and exclusions
  - Types of CSC reviewed for Duplication/Reconciliation
  - IHS marks to Tribal redline change some current practice

IHS CSC Practice and impact on Health Programs

- The costs incurred approach may impact Tribes that allocate CSC to their general fund
- IHS reconciliation process requires program to spend all health funding
- If you do not spend 100% of your funding, there is a requirement to pay back CSC funds on unspent program dollars
- This could pose accounting issues for Tribes that do not reserve CSC for health programs
- In carry over situations, CSC could have been spent by Tribe, and now poses an accounting issue for where the funds to pay back IHS will come from?
- Tribes may want to consider adopting accounting practice to deal with this issue.

CMS 100% FMAP Update

- CMS is still reviewing comments on its proposed 100% FMAP White Paper
- January 11, 2016, CMS letter to South Dakota reveals framework of new policy and CMS anticipates issuing SMD letter the construct of the SD letter
  1. CMS intends to allow 100% FMAP by non-I/T providers when a "written care coordination arrangement" are met
  2. Non- I/T provider must be enrolled as participating Medicaid Provider
  3. Established relationship patient and qualified practitioner at I/T facility (in person visit or telehealth)
  4. Patient records retained by facility
  5. 100% FMAP will be made on a permanent basis for such services

100% FMAP Update

- Next steps for CMS
  - Issue SMD letter outlining South Dakota framework
  - Develop minimum standards for "care coordination arrangement" (caution policy about referred services vs. authorized services)
  - Defining arrangements between IHS/Tribal facilities and Medicaid Providers
  - Defining the scope of Medicaid services
  - Defining billing and payment arrangements (I/T makes referrals and Medicaid provider bills, will require agreements)
  - CMS indicates technical assistance available to the states and to the Tribes

Accountable Health Communities Model Grants

- CMMI announced 5 year funding opportunity for up to $157 million to test screening for health related social needs
- Community based, non-profits, hospitals, and tribal organizations are eligible
- Program will require health personnel to screen patients for social issues like hunger, housing, domestic violence which can affect health care
  - Housing instability
  - Food insecurity
  - Utility needs
  - Interpersonal violence
  - Transportation needs /employment
- Funds are not for direct services but rather linkage types of activities
- CMS will award 44 cooperative agreements; **Letter of intent is due February 8, 2016**

Medicaid Access Rule Published

- November 10, 2015, CMS issued IFR for "Methods for Assuring Access to Covered Medicaid Services"
- Rule requires States to document access to care standards and provider payment rates
- Intent of the rule to ensure that payment rates are sufficient to attract providers on a geographic basis across a state
- Rule establishes standards for access to care and payment rates
- This can assist Tribes that are unable to get patient in for specialty care if clients are not enrolled in managed care
- States are required to complete access monitoring review by July 1, 2016—Tribes should ask to be part of this process
- Medicaid managed care rule pending...good language for Indian health programs

Veterans Choice Act Final Rule Issued

- October 29th NFR to implement Section 101, which established the Veterans Choice Program
- VCP expands access to non-VA care for veterans who qualified based on either wait time or distance from a VA facility
- IHS programs are eligible to participate in this program as participating providers, criteria include:
  1. Wait times exceed 30 days
  2. Live over 40 miles from VA facility or excessive burden to travel by ferry, air, boat to reach facility
- VA Tribal affairs staff will be here at QBM to answer questions

STAC Meeting Update

- CMS report of 100% FMAP was front and center
- ACA Updates and referrals, call center, Medicaid expansion with FFM
- ACA Employer Mandate fix
- Veteran Administration and IHS interoperability around services and MOA reimbursement agreements
- SAMHSA block grant funding and suicide in Indian Country
- IHS employee union settlement and worksheet of settled amounts by Area – None in Portland Area
- IHS discussed changes to SDPI funding
- Idaho 1915(b) Waiver for behavioral health services

Legislative Issues for second session of the 114th Congress

- Employer Mandate
- Advance Appropriations
- SDPI Reauthorization
- IHCIA Technical Amendments
- Medicare-like Rates for outpatient services
- Contract Support Costs mandatory funding and reconciliation language

Indian Legislative Bills in 114th Congress

- S. 286 – Department of Interior Tribal Self-Governance Act of 2015
  - Introduced by Sen. John Barasso; Co-sponsors include Senators Tester, Murkowski, Crapo, Schatz, Franken
  - Amends Title IV of of ISDEAA to make it consistent with Title VI, the Self-Governance Program for HHS
  - Creates the same administrative efficiencies for DOI that have been in place for HHS programs.
  - Sen. McCain Amendments cause alarm going to mark-up but were withdrawn and had to do with *"OIG Alert to Tribes on the use of ISDEAA and 3rd Party Funds"*
  - S. 286 passed Senate by Unanimous Consent and has now been sent to the House for consideration
  - Title IV Task Force is trying to find a primary sponsor in the House

Indian Legislative Bills in 114th Congress

- Senate bill Exempts Tribal Programs from Sequestration
  - S. 1497 would exempt IHS, BIA, HUD and other Indian programs from sequestration required under the Budget Control Act of 2011
  - Introduced by Sen. Tester (MT); only one cosponsor Sen. Udall (NM)
- House bill Exempts Tribal Programs from Sequestration
  - H.R. 3063 same companion bill to S. 1497
  - Introduced by Rep. Young (AK); Co-sponsors include Representatives Cole (OK), Ruiz (CA), McCollum (MN)
- Both bills referred to Budget Committees
- Likely to die in Committee
- Likely best chance to avoid sequester for Indian programs is language in specific appropriations (Interior, HUD, Labor-HHS)

Indian Legislative Bills in 114th Congress

- Exemption from ACA Employer Mandate (Shared Responsibility)
  - Tribal Jobs Employment and Protection Act
  - S. 1771 Introduced by Sen. Daines (MT); Co-sponsors Senators Crapo (ID) and Thune (SD)
  - H.R. 3080 introduced by Rep. Noem (SD); Co-sponsors Representatives Cole (OK) and Zinke (SD)
  - Senate bill referred to Finance; House bill referred to Ways & Means
- Cadillac Tax amendment?
- If passed what will the President do?

Indian Legislative Bills in 114th Congress

- S. 1964 Family Stability and Family Kinship Act of 2015
  - Introduced by Sen. Wyden; Co-sponsors Sen. Bennett, Brown, Cantwell, Casey, Gillbrand, Menendez, Schumer, Stabenow, Warner
  - Reforms the federal finance system supporting state and child welfare services
  - Funds preventive services and kinship placements for children at risk of foster placement
  - Current law creates incentives to place Indian children outside of families in order to receive federal funding
  - Encourages child welfare system to forego alternatives to prevent breakup of families like parent training, mental health counseling, trauma recovery, etc.

Discussion?

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Indian Health Service
Rockville MD 20852

JAN 7 2016

Dear Tribal Leader:

I am writing to initiate a consultation on the Indian Health Service (IHS) Contract Support Costs (CSC) policy. Our goal is to update and implement a new policy in 2016. The policy has been developed and revised several times since 1992 through coordination and consultation with American Indian and Alaska Native (AI/AN) Tribes and Tribal Organizations, with the purpose of providing uniform and equitable guidance on the preparation and negotiation of requests for CSC funds for new and existing awards authorized by the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 450 et seq.

The current policy is located in the Indian Health Manual at Part 6, Chapter 3 (2007). You may access the policy online at: https://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p6c3. The IHS last initiated consultation on this policy in October 2011 and identified the need to establish a workgroup of Tribal leaders to work with the IHS to review, evaluate, and make recommendations to the policy (IHS CSC Workgroup).

Shortly after, in June 2012, the Supreme Court rendered a decision on CSC claims against the Department of the Interior in the case of *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181 (2012) (*Ramah)*. The impact of this decision generated additional review for IHS, which was not a party to the *Ramah* case, and its CSC policy. After the decision, Congress requested that the IHS consult with AI/AN Tribes and Tribal Organizations on long-term solutions for CSC. The IHS utilized the expertise of the IHS CSC Workgroup to review and develop recommendations to improve CSC business processes, including the negotiation of CSC.

On November 23, 2015, I received a proposed draft IHS CSC Policy from the IHS Tribal Self-Governance Advisory Committee and I have since received input and recommendations from the IHS CSC Workgroup to refocus attention on updating this policy in light of the experience gained since the 2012 *Ramah* decision. To accomplish our goal to update the policy in 2016, the IHS CSC Workgroup will meet several times over the next two months to draft a revised policy that will be available for your review and comment in the first quarter of 2016.

Please watch for updates on the IHS website at http://www.ihs.gov/. In addition, the IHS will provide updates at national meetings such as the National Congress of American Indians or National Indian Health Board, as well as, during IHS Direct Service Tribes Advisory Committee and Tribal Self-Governance Advisory Committee quarterly meetings.

As we update the policy, I invite you to provide input or feedback in writing to me at the address below or electronically to the e-mail address consultation@ihs.gov.

Please send written comments to:

Robert G. McSwain
Principal Deputy Director
Indian Health Service
5600 Fishers Lane
Mail stop: 08E86
Rockville, MD 20857

Sincerely,

/Robert G. McSwain/

Robert G. McSwain
Principal Deputy Director

3b

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

PORTLAND AREA
INDIAN HEALTH SERVICE
1414 NW NORTHRUP, Suite 800
PORTLAND, OREGON 97209

DEC 14 2015

Dear Tribal Health Directors:

I am writing to you regarding the Centers for Medicare & Medicaid Services (CMS) which has released an Essential Community Provider (ECP) Petition to collect more complete data from providers who qualify as an ECP and wish to appear on CMS's ECP list for the 2017 benefit year. The ECP list is used by issuers to identify providers for inclusion on an issuer's plan network toward satisfaction of the ECP standard under 45 CFR § 156.235.

ECPs include providers that serve predominantly low-income and medically underserved individuals, and Indian health care providers (IHS, Tribal, and Urban Indian providers). In order to ensure network adequacy and access to services, CMS requires Qualified Health Plan issuers in the Marketplace to offer network contracts to ECPs in the plan's service area. CMS then publishes the ECP list and issuers use the list to meet the requirement.

Please submit your petitions by Friday, January 8, 2016 to EssentialCommunityProviders@cms.hhs.gov to be considered for the 2017 ECP list. If you have any questions or concerns about the petition, please contact Ms. Peggy Ollgaard, Business Office Coordinator, at (503) 414-5598 or at peggy.ollgaard@ihs.gov.

Sincerely,

/Dean M. Seyler/

Dean M. Seyler
Director

Enclosure

Instructions for the Essential Community Provider Provider Petition for the 2017 Benefit Year

A. OVERVIEW

In accordance with section 1311(c)(1)(C) of the Affordable Care Act (ACA), Qualified Health Plan (QHP) issuers, including Stand-alone Dental Plan (SADP) issuers, are required to include within their network essential community providers (ECPs), where available, that serve predominantly low-income, medically-underserved individuals. Under this same section of the ACA, the Secretary of the Department of Health and Human Services (HHS) is charged with establishing criteria for certification of health plans as QHPs, including criteria for issuer satisfaction of the ECP inclusion requirement.

Under 45 Code of Federal Regulations (CFR) 156.235, the Secretary of HHS has established criteria for inclusion of a sufficient number and geographic distribution of essential community providers (ECPs), where available, in an issuer's network to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in their service areas. Currently, issuers rely on the non-exhaustive HHS list of available ECPs to identify qualified ECPs that can be counted toward an issuer's satisfaction of the 30 percent ECP standard, along with qualified ECPs that an issuer writes in on their ECP template as part of their QHP application. The majority of issuers have relied more heavily on ECP write-ins than on ECPs from the HHS list to satisfy the 30 percent standard. Because an issuer's ECP write-ins count toward satisfaction of the ECP standard for only the issuer that writes in the ECP on their ECP template, this methodology for calculating the available ECPs has resulted in a variation of the available identified ECPs for a given service area based on the number of ECP write-ins a specific issuer includes on their ECP template.

To ensure that the HHS ECP list more accurately reflects the universe of qualified available ECPs in a given service area, HHS will collect more complete data from such providers so that all issuers are held to a more uniform ECP standard. HHS aims to achieve this outcome by soliciting qualified ECPs to complete and submit the ECP provider petition in order to be added to the HHS ECP list or address required missing data fields to remain on the list, resulting in a more robust listing of the universe of available ECPs from which issuers select to satisfy the 30 percent ECP standard. The degree of provider participation in this data collection effort through the ECP provider petition will help inform HHS's future proposals for counting issuers' ECP write-ins toward satisfaction of the ECP standard.

HHS has compiled a non-exhaustive list of available ECPs, based on data it and other Federal partners maintain, which has been used as an initial source of ECP information. The non-exhaustive HHS ECP list for the 2016 benefit year is available at http://cciio.cms.gov/programs/exchanges/qhp.html. HHS updates this ECP list annually to assist issuers with identifying providers that qualify for inclusion in an issuer's plan network toward satisfaction of the ECP standard under 45 CFR 156.235. Under that regulation, ECPs are defined as health care providers who serve predominantly low-income, medically underserved

individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service (PHS) Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act (SSA), including governmental family planning service sites and not-for-profit family planning service sites that do not receive funding under Title X of the PHS Act or other 340B-qualifying funding, and Indian health care providers.

The HHS ECP list for the 2016 benefit year contains the following provider types:[1]

- Federally Qualified Health Centers (FQHCs) and FQHC look-alikes.
- Ryan White HIV/AIDS Program providers.
- Health centers providing dental services, including all of the above organizations that have noted to Health Resources and Services Administration (HRSA) that they provide dental services in their scope of project.
- Hospitals: Critical Access Hospitals, Rural Referral Centers, Disproportionate Share (DSH) and DSH-eligible Hospitals, Children's Hospitals, Sole Community Hospitals, Freestanding Cancer Centers.
- Sexually Transmitted Disease Clinics, Tuberculosis Clinics, Hemophilia Treatment Centers, and Black Lung Clinics.
- Rural Health Clinics: a Medicare-certified Rural Health Clinic is included in the non-exhaustive ECP list if it meets the following two requirements: 1) Based on attestation, it accepts patients regardless of ability to pay and offers a sliding fee schedule; or is located in a primary care Health Professional Shortage Area (HPSA) (geographic, population, or automatic[2]); and 2) Accepts patients regardless of coverage source (i.e., Medicare, Medicaid, CHIP, private health insurance, etc.).
- Family planning providers receiving grants under Title X of the PHS Act; not-for-profit family planning service sites that do not receive funding under Title X of the PHS Act; and governmental family planning service sites that do not receive funding under Title X of the PHS Act.
- Indian Health Care Providers: Tribes, Tribal Organization and Urban Indian Organization providers, and Indian Health Service Facilities.

[1] The providers on the HHS ECP list for the 2016 benefit year were provided to HHS primarily by the Health Resources and Services Administration, the Indian Health Service, and the Office of the Assistant Secretary for Health/Office of Population Affairs as qualifying to be classified as one of these provider types.

[2] As of January 1, 2014, more than 1,000 Rural Health Clinics (RHCs) were designated as an automatic Health Professional Shortage Area (HPSA), the criteria for which include accepting patients regardless of ability to pay; offering a sliding fee schedule based on ability to pay (income); and accepting Medicare, Medicaid, CHIP, and private health insurance patients. To receive the automatic HPSA designation, each RHC is required to complete an attestation form, which is available here: http://bhpr.hrsa.gov/shortage/hpsas/certofeligibility.pdf. RHCs that are not listed on the current HHS ECP list and complete the attestation form to receive an automatic HPSA designation through the Health Resources and Services Administration will be considered for inclusion on future HHS ECP lists. More information about the HPSA designation requirements and process is also available here: http://bhpr.hrsa.gov/shortage/hpsas/ruralhealthhpsa.html.

B. PURPOSE

The purpose of the ECP provider petition is for HHS to achieve the following:

- For providers that are not on the draft 2017 HHS ECP list,
  - Collect information to determine whether a provider requesting to be added to the ECP list meets the definition of an ECP under 45 CFR 156.235.
- For providers that are on the draft 2017 HHS ECP list,
  - Allow providers an opportunity to update their provider data;
  - Collect missing data from critical data fields on the HHS ECP list, such as the National Provider Identifiers (NPIs), points of contact (POCs), and the number of MDs, DOs, PAs, NPs, DMDs, and DDSs authorized by the State to independently treat and prescribe medication within the listed facility; and
  - Obtain confirmation from providers that they are aware that they are on the list and elect to remain on the HHS ECP list.

The HHS ECP list for the 2016 benefit year is not exhaustive and does not include every provider that participates or is eligible to participate in the 340B drug program, every provider that is described under section 1927(c)(c)(1)(D)(i)(IV) of the Social Security Act, or every provider that might otherwise qualify under the regulatory standard at 45 CFR 156.235. For the 2017 benefit year and beyond, HHS will review provider petitions for inclusion on the HHS ECP list in an effort to build a more robust HHS ECP listing of the universe of available ECPs from which issuers select to satisfy the 30 percent ECP standard for a given service area. Additionally, issuers may use the points of contacts on the ECP list to aid in provider network development.

C. QUALIFIED PETITIONERS

HHS will be accepting petitions from providers that qualify as an ECP as defined under 45 CFR 156.235(c), both those on the prior year's HHS ECP list, and those who were not on the prior year's list. Such providers include medical practitioners that serve predominantly low-income, medically underserved individuals, including health care providers defined in section 340B(a)(4) of the PHS Act; or described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Pub. L. 111–8; or a State-owned family planning service site, or governmental family planning service site, or not-for-profit family planning service site that does not receive Federal funding under special programs, including under Title X of the PHS Act, or an Indian health care provider, unless any of the above providers has lost its status under either of these sections, 340(B) of the PHS Act or 1927 of the Act as a result of violating Federal law.

In addition, qualified provider petitioners must be MDs, DOs, PAs, NPs, DMDs, or DDSs authorized by the State to independently treat and prescribe medication within the listed facility and must attest to the following statements within the petition:

- Provider consents to be added to or remain on the HHS ECP list.
- Provider is either:
  - Eligible for or participating in the 340B program or is a Rural Health Clinic or is an Indian Health Care Provider; or
  - Located in a low-income ZIP code or HPSA[3].*
- Provider accepts patients regardless of ability to pay and offers a sliding fee schedule.*
- Provider accepts patients regardless of coverage source (i.e., Medicare, Medicaid, CHIP, private health insurance, etc.).
- Provider agrees to be listed in a consumer-facing directory of ECPs.
- List the number of FTE medical and dental practitioners at the given facility.
- List the number of executed contracts and good faith contract offers rejected.

A provider that has been included in one of the verified datasets from our Federal partners (i.e., HRSA, IHS, OASH/OPA) as reflected on the Draft 2017 ECP List, or is a not-for-profit or governmental family planning service site that does not receive Federal funding under Title X of the PHS Act or other 340B-qualifying funding, is exempt from attestations noted above with an asterisk (*) because these entities have been recognized as ECPs under section 1311(c)(1)(C) of the ACA and regulations at 45 CFR 156.235.

In order to most effectively achieve the ECP operational improvements described above, HHS will collect the data directly from providers through the ECP provider petition (see Appendix A). HHS will not accept petitions from third-party entities on behalf of the provider. Third-party entities include issuers, advocacy groups, State departments of health, State-based provider associations, and providers other than the provider that is the subject of the petition. However, if one of the above entities own or is the authorized legal representative of an ECP, it may submit a petition on behalf of the provider. For example, a local health department that operates its own family planning clinics may appropriately petition for those clinics. In contrast, a State department of health should not attempt to correct ECP listings based on its own database of similar providers.

Collection of the data directly from such providers will better ensure the integrity of the data to support issuers as they apply for QHP certification and recertification, build a more robust HHS ECP listing of the universe of available ECPs, and support HHS's QHP compliance monitoring on an ongoing basis. Feedback about the ECP petition will also be collected from stakeholders in an effort to improve the efficiency and value of the data collection.

D. REQUIRED PETITION FORMAT

HHS will accept provider petitions only in the required format, to ensure the integrity of the provider data received, and to reduce the burden on providers to provide their data. The required format lowers the burden on providers by virtue of interactive programming logic that imports

[3] Based on the HHS Low-Income and Health Professional Shortage Area (HPSA) ZIP Code Listing," available at http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html.

provider data from the draft 2017 HHS ECP list. The required format includes provider completion of all required data fields and will generate error messages that provide guidance to the petitioner on how to resolve any identified errors or incomplete data fields to assist the petitioner with validating and submitting the petition to HHS. Detailed instructions for completing each question appear within the petition.

HHS coordinates closely with our Federal partners, including HRSA, IHS, and OASH/OPA, to update the HHS ECP list annually and review requested corrections and additions received directly from providers. While we have verified the status of the providers that appear on the HHS ECP list, many of the provider datasets received from our Federal partners are missing data elements critical for issuers to identify such providers for contract offerings. HHS has designed the ECP petition process as a mechanism to reduce provider burden with respect to submitting and updating their data for inclusion on the HHS ECP list. Providers must complete required missing data fields in order to be added to or remain on the HHS ECP list.

E. ENTERING PROVIDER DATA INTO THE PETITION

Part A: Petition Instructions. These instructions apply to all providers that qualify as an ECP as defined under 45 CFR 156.235(c) and described in greater detail below.

Complete the following data fields in the ECP petition in the sequence provided, scrolling from top to bottom to ensure applicability of available data field options.

Part B: Complete the following data fields within the petition:

1. *"Full name of person completing this Provider Petition."* [Required field.] The data that you enter in this field will auto-populate POC 1 Name field. You may change the auto-populated data in the POC 1 Name field if it differs from the individual completing this provider petition.
2. *"Phone # of person completing Provider Petition."* [Required field.] If you seek to add a record, the data that you enter in this field will auto-populate POC 1 Name field. You may change the auto-populated data in the POC 1 Name field if it differs from the individual completing this provider petition.
3. *"Phone Ext of person completing Provider Petition."* [Required field.] If you seek to add a record, the data that you enter in this field will auto-populate POC 1 Phone Ext field. You may change the auto-populated data in the POC 1 Phone Ext field if it differs from the phone extension for the individual completing this provider petition.
4. *"Email address of person completing Provider Petition."* [Required field.] If you seek to add a record, the data that you enter in this field will auto-populate POC 1 Email field. You may change the auto-populated data in the POC 1 Email field if it differs from the email for the individual completing this provider petition.
5. *"Are you the Listed Provider or Otherwise Authorized to Submit this Request on behalf of the Facility?"* [Required field.] Qualified petitioners include providers petitioning to make a change to their own HHS ECP listing, providers petitioning to be added to or removed from the HHS ECP list, or individuals explicitly authorized by the provider to submit the petition on behalf of the provider. CMS is not accepting petitions from

unauthorized third-party entities, including issuers, advocacy groups, state Departments of Health, state-based provider associations, and providers other than the provider for which the petition is applicable. However, if any of the above entities own or are the authorized legal representatives of an ECP, then they may submit a petition on behalf of a provider.

6. *"Are you petitioning to be added to the list, change your data on the list, or remove your facility from the list?"* [Required field.] Select Add if you wish to be added to the HHS ECP List, including additional provider site locations. Affiliated providers located at same street location will appear only once on the ECP List, so please list the facility rather than individual practitioners located at same facility, indicating the number of qualified FTE practitioners available at the facility in questions 13 and 14. Solo practitioners may submit the petition under their individual provider location. Select **Change** if you are a provider that already appears on the Draft 2017 ECP List and want to change your data or complete required missing data fields (e.g., NPI, POCs, and FTEs). If you are unsure of whether you appear on the Draft 2017 ECP List, click the button labeled "Check to see if you are on the list" and enter your site name using the search functionality. Select **Remove** if you wish to be removed from the HHS ECP List. If you are requesting to be removed, please skip to question 17 to enter your row number from the Draft 2017 ECP List embedded within this petition. Please note that if you return to this question to revise your selection, any data that you have entered for questions 1-16 will be deleted.
7. *"Do you consent to be added to or remain on the list?"* [Required field.] Select **Yes** to consent to be included on the HHS ECP List. Providers may be asked to renew their consent for HHS ECP listings beyond benefit year 2017. Selecting **No** to this question means that you should return to question 6 and select **Remove** to ensure that your data are removed from the HHS ECP list. If you do not yet appear on the HHS ECP list and do not consent to be added to the list, then you should not submit this provider petition.
8. *"Are you eligible for or participating in the 340B program or are you a Rural Health Clinic or an Indian Health Care Provider?"* [Required field.] Select Yes if you are eligible for or participating in the 340B program, or are a Rural Health Clinic, or are an Indian Health Care Provider. For a complete list of organizations that are eligible for the 340B program, see http://www.hrsa.gov/opa/eligibilityandregistration/index.html. Select No if you are not eligible for or participating in the 340B program, and are not a Rural Health Clinic and are not an Indian Health Care Provider.
9. *"Are you located in a low-income ZIP code or HPSA?"* [Required field.] Select **Yes** only if you are located in a low-income ZIP code or Health Professional Shortage Area (HPSA), based on the HHS "Low-Income and HPSA ZIP Code Listing," available at http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html. Selecting No to this question means that you do not qualify as an ECP for purposes of being added to the ECP list, unless you have been included in one of the verified datasets from our Federal partners (i.e., HRSA, IHS, OASH/OPA) as reflected on the Draft 2017 ECP List, you are a Rural Health Clinic, or you are a not-for-profit or governmental family planning service site that does not receive Federal funding under Title X of the PHS Act or other 340B-qualifying funding (see 45 CFR 156.235(c)).

10. *"Do you agree to accept patients regardless of ability to pay and offer a sliding fee schedule?"* [Required field.] Select **Yes** only if you are willing to accept patients regardless of ability to pay and offer a sliding fee schedule. Selecting **No** to this question means that you do not qualify as an ECP for purposes of being added to the ECP list, unless you have been included in one of the verified datasets from our Federal partners (i.e., HRSA, IHS, OASH/OPA) as reflected on the Draft 2017 ECP List, you are a Rural Health Clinic, or you are a not-for-profit or governmental family planning service site that does not receive Federal funding under Title X of the PHS Act or other 340B-qualifying funding (see 45 CFR 156.235(c)).
11. *"Do you agree to accept patients regardless of coverage source (i.e., Medicare, Medicaid, CHIP, private health insurance, etc.)?"* [Required field.] Select **Yes** only if you are willing to accept patients regardless of coverage source (i.e., Medicare, Medicaid, CHIP, private health insurance, etc.). Selecting **No** to this question means that you do not qualify as an ECP for purposes of being added to the ECP list. If you already appear on the Draft 2017 ECP List that was published with this petition, then you should return to question 6 and select Remove and then enter the correct Row Number in question 17 to ensure that your data are removed from the HHS ECP list.
12. *"Do you agree to be listed in consumer-facing directory of ECPs?"* [Required field.] Select **Yes** only if you are willing to be listed in a consumer-facing directory of ECPs by an issuer with whom you have contracted to deliver health care services to their enrollees. CMS will continue to post the HHS ECP list on our publicly available website as a resource for QHP issuers, providers, and consumers seeking providers who are willing to serve low-income and medically underserved populations. Selecting **No** to this question means that you do not qualify as an ECP for purposes of being added to the ECP list. If you already appear on the Draft 2017 ECP List that was published with this petition, then you should return to question 6 and select Remove and then enter the correct Row Number in question 17 to ensure that your data are removed from the HHS ECP list.
13. *"Number of FTEs representing MDs, DOs, PAs, NPs authorized by the state to independently treat and prescribe medication within the listed facility?"* [Required field.] Enter number of FTEs representing MDs, DOs, PAs and NPs authorized by the state to independently treat and prescribe medication within the listed facility at this street location, as of the date of your petition submission. Two part-time practitioners can be counted as one FTE. Multiple affiliated MDs, DOs, PAs and NPs practicing within the same provider facility located at the same street location (regardless of different suite/floor number) will appear on one row on the HHS ECP List, so please list the facility and indicate number of affiliated FTE practitioners located at the facility rather than submitting a petition for each individual practitioner. Also, practitioners who practice within a multi-practitioner facility should not submit a petition under their individual practitioner NPI independent of the facility in which they practice; rather, only individuals authorized by the facility should submit the petition using the facility-level NPI and indicate the number of affiliated FTE practitioners practicing within the facility. Multi-practitioner facilities with multiple locations should submit a petition for each site location, entering the NPI associated with each of its facility-specific site locations, and indicating the number of affiliated FTE practitioners practicing only within the facility-specific site location. In contrast, solo practitioners may submit the petition under their

individual practitioner NPI. If you have only dentists (DMDs and DDSs) at this facility, please enter zero in this field.

14. "*Number of FTEs representing DMDs and DDSs authorized by the state to independently treat and prescribe medication within the listed facility?"* [Required field.] Enter number of FTEs representing DMDs and DDSs practicing at your facility at this street location, as of the date of your petition submission. Two part-time practitioners can be counted as one FTE. Multiple affiliated dentists practicing within the same provider facility located at the same street location (regardless of different suite number) will appear on one row on the HHS ECP List, so please list the facility and indicate number of affiliated FTE dentists located at the facility rather than submitting a petition for each individual dentist. Also, dentists who practice within a multi-practitioner facility should not submit a petition under their individual practitioner NPI independent of the facility in which they practice; rather, only individuals authorized by the facility should submit the petition using the facility-level NPI and indicate the number of affiliated FTE dentists practicing within the facility. Multi-practitioner facilities with multiple locations should submit a petition for each site location, entering the NPI associated with each of its facility-specific site locations, and indicating the number of affiliated FTE dentists practicing only within the facility-specific site location. In contrast, solo practitioners may submit the petition under their individual practitioner NPI. If you have only medical practitioners (MDs, DOs, PAs, NPs) at this facility, please enter zero in this field.
15. *"Number of contracts executed with QHP insurance companies (i.e., issuers)?"* [Required field.] Enter the number of contracts that you have executed with QHP insurance companies (i.e., issuers) for the 2016 benefit year, as of the date of your petition submission.
16. "*Number of contract offers received from QHP insurance companies (i.e., issuer)s that you have rejected?"* [Required field.] Enter the number of contract offers that you have received from QHP issuers and were offered in good faith that you have rejected for the 2016 benefit year, as of the date of your petition submission. As stated in the Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces, a good faith contract should offer terms that a willing, similarly situated, non-ECP provider would accept or has accepted. Collecting this information will assist CMS in better determining issuer compliance with the ECP requirements pertaining to the offering of contracts in good faith to qualified ECPs.
17. *"Row Number."* If you are a provider that already appears on the Draft 2017 ECP List published with this petition, please identify the row number on which your facility is listed, using the search functionality within this petition. Enter your row number and click the Populate button. The petition will auto-populate many of the data fields that currently appear on the Draft 2017 ECP List. Check that the auto-populated data from the Draft 2017 ECP List are correct, correct any errors, and provide missing data fields (e.g., NPI, POCs, FTEs, ECP Category, Site County, etc.) by proceeding through the petition. If the Row Number field does not appear, you have selected **Add** in question 6, indicating that you do not appear on the Draft 2017 ECP List and are petitioning to be newly added to the list, so this Row Number field would not be applicable.
18. *"Site Name."* [Required field.] Enter the Site Name at which you provide health care services to patients.

19. *"Organization Name."* [Required field.] Enter the Organization Name that the issuer would contact for purposes of contract negotiations.
20. *"National Provider Identifier."* [Required field.] Enter NPI in a 10-digit format (no hyphens). Affiliated practitioners who practice within a multi-practitioner facility should not submit a petition under their individual practitioner NPI; rather, only individuals authorized by the facility should submit the petition using the facility-level NPI, site name, and indicate the number of FTE practitioners practicing within the facility. In contrast, solo practitioners may submit the petition under their individual practitioner NPI. Providers who currently appear on the ECP List must enter their NPI in order to remain on the ECP List beyond the 2017 benefit year.
21. *"ECP category (Select all that apply)."* [Required field.] Select all categories that describe the health care services that you provide. For example, if the contracted provider is a Federally Qualified Health Center (FQHC) that is also a Ryan White HIV/AIDS provider, select both the **FQHC** and **Ryan White Provider** categories. If HHS is unable to verify your provision of these services with our Federal partners, we may default your listing to the "Other ECP Providers" category until such verification can be made.
    - Children's Hospitals
    - Community Mental Health Centers
    - Dental Providers
    - Family Planning Providers
    - Federally Qualified Health Centers
    - Freestanding Cancer Centers
    - Hemophilia Treatment Centers
    - Hospitals (other than Children's Hospitals)
    - Indian Health Service
    - Tribal Health Program operated under P.L. 93-638
    - Urban Indian Health Program
    - Rural Health Clinics
    - Ryan White Providers
    - Sexually Transmitted Disease Clinics
    - Tuberculosis Clinics
    - Other ECP Providers
22. *"Site Street Address 1."* [Required field.] Enter the street address at which you provide health care services to patients. If you currently appear on the HHS ECP List with a PO Box as your site street address, you must replace this with a street address in order to remain on the HHS ECP List. If an individual provider practices in the same group or company at the same street location with other affiliated providers, the facility should submit only one petition, indicating the number of qualified FTE practitioners available at the facility in questions 13 and 14.
23. *"Site Street Address 2."* Enter the suite number, floor number, or other secondary address information at which you provide health care services to patients. If you currently appear on the HHS ECP List with a PO Box as your site street address, you must replace this with a street address in order to remain on the HHS ECP List. If an

individual provider practices in the same group or company at the same street location with other affiliated providers, the facility should submit only one petition, indicating the number of qualified FTE practitioners available at the facility in questions 13 and 14.

24. *"Site City."* [Required field.] Enter the Site City in which you provide health care services to patients.
25. *"Site State."* [Required field.] Enter the Site State in which you provide health care services to patients.
26. *"Site ZIP Code."* [Required field.] Enter the Site ZIP Code in which you provide health care services to patients. If you are petitioning to be newly added to the HHS ECP List, your ZIP code must be located within a low-income ZIP code or Health Professional Shortage Area (HPSA) included on the "Low-Income and HPSA ZIP Code Listing" available at http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html. If you already appear on the Draft 2017 ECP List published with this petition and your ZIP code is not on the HHS low-income ZIP code or HPSA listing, you are exempt from this requirement because you have already been verified by one of our Federal partners, including HRSA, IHS, OASH/OPA, as qualifying as an ECP independent of being located in a low-income ZIP code or HPSA.
27. *"Site County."* [Required field.] Enter the Site County in which you provide health care services to patients. Site county information is used for purposes of issuers meeting the requirement in the Federally-facilitated Marketplace to offer a contract in good faith to at least one ECP in each ECP category in each county in the service area.
28. *"Org Street Address 1."* [Required field.] Enter the Organization Street Address that the issuer would use to contact you for purposes of contract negotiations.
29. *"Org Street Address 2."* Enter the secondary Organization Street Address that the issuer would use to contact you for purposes of contract negotiations.
30. *"Org City."* [Required field.] Enter the Organization City that the issuer would use to contact you for purposes of contract negotiations.
31. *"Org State."* [Required field.] Enter the Organization State that the issuer would use to contact you for purposes of contract negotiations.
32. *"Org ZIP Code."* [Required field.] Enter the Organization ZIP code that the issuer would use to contact you for purposes of contract negotiations.
33. *"Org County."* [Required field.] Enter the Organization County that the issuer would use to contact you for purposes of contract negotiations. Organization county information is not used for purposes of issuers meeting the requirement in the Federally-facilitated Marketplace to offer a contract in good faith to at least one ECP in each ECP category in each county in the service area. Instead, the Site County in question 27 is used for purposes of that ECP requirement.
34. *"POC 1 Name."* [Required field.] Enter the Primary Point of Contact Name that the issuer would use to contact you for purposes of contract negotiations.
35. *"POC 1 Title."* [Required field.] Enter the Primary Point of Contact Title that the issuer would use to contact you for purposes of contract negotiations.
36. *"POC 1 Phone."* [Required field.] Enter the Primary Point of Contact Phone # that the issuer would use to contact you for purposes of contract negotiations.
37. *"POC 1 Phone Ext."* Enter the Primary Point of Contact Phone Ext that the issuer would use to contact you for purposes of contract negotiations.

38. *"POC 1 Email."* [Required field.] Enter the Primary Point of Contact Email that the issuer would use to contact you for purposes of contract negotiations.
39. *"URL 1."* Enter the Primary URL that the issuer would use to contact you for purposes of contract negotiations.
40. *"POC 2 Name."* Enter the Alternate Point of Contact Name that the issuer would use to contact you for purposes of contract negotiations.
41. *"POC 2 Title."* Enter the Alternate Point of Contact Title that the issuer would use to contact you for purposes of contract negotiations.
42. *"POC 2 Phone."* Enter the Alternate Point of Contact Phone # that the issuer would use to contact you for purposes of contract negotiations.
43. *"POC 2 Phone Ext."* Enter the Alternate Point of Contact Phone Extension that the issuer would use to contact you for purposes of contract negotiations.
44. *"POC 2 Email."* Enter the Alternate Point of Contact Email that the issuer would use to contact you for purposes of contract negotiations.
45. *"URL 2."* Enter the Alternate URL that the issuer would use to contact you for purposes of contract negotiations.

F. VALIDATING AND SUBMITTING PROVIDER PETITION

1. Click the "**Preview your Petition before Submitting"** button at the bottom of petition.
2. If the petition has any errors, an error window will appear and indicate the data fields containing each error. **Correct** any identified errors and click "**Preview your Petition before Submitting**."
3. If you need assistance with correcting any errors, click the "**Need Help"** button to access the FAQs or email your question(s) to the ECP communications mailbox: *EssentialCommunityProviders@cms.hhs.gov*.
4. If the petition has no errors (or once all errors have been resolved), the preview screen will appear and display all data entries. Confirm the accuracy of the data entries and then click the final "**Submit Petition"** button to submit your petition. Submit your petition by no later than 11:59 p.m. ET on January 8, 2016, in order for HHS to consider your provider data for the 2017 ECP List. Petitions submitted after January 8, 2016, but by no later than August 22, 2016, will be allowed as a write-in for a respective issuer that has listed the provider on its ECP template for the 2017 QHP certification cycle.

3b3

ESSENTIAL COMMUNITY PROVIDER PETITION FOR 2017 BENEFIT YEAR FREQUENTLY ASKED QUESTIONS

Q1. Under what authority is HHS collecting this provider data?

A1. In accordance with section 1311(c)(1)(C) of the Affordable Care Act (ACA), Qualified Health Plans (QHPs), including Stand-alone Dental Plan (SADP) issuers, are required to include within their network essential community providers (ECPs), where available, that serve predominantly low-income, medically-underserved individuals. To satisfy this ECP requirement, QHP and SADP issuers must submit an ECP template as part of their QHP application, in which they must list the ECPs with whom they have contracted to provide health care services to low-income, medically underserved individuals in their service areas. HHS has compiled a list of available ECPs, based on data it and other Federal partners maintain, which has been used as an initial source of ECP information. HHS updates this ECP list annually to assist issuers with identifying providers that qualify for inclusion in an issuer's plan network toward satisfaction of the ECP standard under 45 CFR 156.235.

Q2. What is the purpose of the Essential Community Provider (ECP) Petition?

A2. The purpose of the ECP petition is to achieve the following:

- To ensure that the ECP list more accurately reflects the universe of qualified available ECPs in a given service area.
- To correct erroneous provider data on the HHS ECP list and collect missing provider data (e.g., National Provider Identifier, facility FTEs, points of contact, etc.).
- To ensure that providers are aware of their status on the HHS ECP list.
- To help inform HHS's future proposals for counting issuers' ECP write-ins toward issuer satisfaction of the ECP standard.

Q3. How does a provider access the Essential Community Provider (ECP) Petition?

A3. Providers may access the ECP petition at the following link: https://data.healthcare.gov/cciio/ecp_petition.

Q4. When should a provider submit its Essential Community Provider (ECP) Petition?

A4. Submit your petition by no later than 11:59 p.m. ET on January 8, 2016, in order for HHS to consider your provider data for the 2017 ECP List. Petitions submitted after January 8, 2016, but by no later than August 22, 2016, will be allowed as a write-in for a respective issuer that has listed the provider on its ECP template for the 2017 QHP certification cycle.

Q5. Can providers submit modifications to a previously submitted Essential Community Provider (ECP) Petition?

A5. Providers can re-submit the ECP petition multiple times until the deadline of January 8, 2016, for modifications to appear on the 2017 HHS ECP list. The version of the petition that the provider submits last will be the petition used to populate the 2017 HHS ECP list. Petitions submitted after January 8, 2016, will be considered for the 2018 HHS ECP list.

Q6. When is the next time that providers can update their provider data on the Essential Community Provider (ECP) list? What should providers do if they have an address or staffing change mid-year?

A6. The ECP petition window will remain open year-round, allowing providers to update their data on an ongoing basis. However, for purposes of adding or correcting data for the final 2017 HHS ECP list, providers must submit their petition by no later than January 8, 2016. Petitions submitted after January 8, 2016, will be considered for the 2018 HHS ECP list.

Q7. How does a provider determine whether it needs to submit an Essential Community Provider (ECP) Petition?

A7. All providers who qualify as an ECP and wish to be added to the ECP list, as well as providers who appear on the existing ECP list and need to correct their data or provide required data that are missing from the ECP list should submit an ECP petition.

Q8. If a provider is already included on the official Draft 2017 HHS Essential Community Provider (ECP) List and its provider data are accurately displayed on the ECP list, does the provider need to complete and submit the ECP Petition?

A8. Yes, a provider that appears on the official Draft 2017 HHS ECP List with accurately displayed data will need to complete several additional required data fields within the ECP petition, such as the provider's National Provider Identifier, facility FTEs, and points of contact.

Q9. When will the final 2017 HHS ECP list be published and how will it be made available?

A9. The final 2017 HHS ECP list will be published during the winter of the 2016 calendar year and made available at the following link: https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html.

Q10. Who is authorized to submit the Essential Community Provider (ECP) Petition?

A10. Authorized petitioners include the following:

- Providers petitioning to make a change to their own HHS ECP listing.
- Providers petitioning to remain, be added to, or be removed from the HHS ECP list.
- Individuals explicitly authorized by the provider to submit the petition on behalf of the provider facility.
- Practitioners who practice within a multi-practitioner facility and are authorized by the facility to submit the petition on behalf of the facility (using the facility-level NPI).
- Solo practitioners petitioning under their individual practitioner NPI.

CMS is not accepting petitions from unauthorized third-party entities, including issuers, advocacy groups, State Departments of Health, State-based provider associations, and providers other than the provider about which the petition is applicable. However, if any of the above entities own or are the authorized legal representatives of an ECP, then they may submit a petition on behalf of a provider.

- For example, a local health department that operates its own family planning clinics may appropriately petition for those clinics.
- In contrast, a State department of health should not attempt to correct ECP listings based on its own database of similar providers.

Q11. How can a provider determine whether it needs to update its provider data on the HHS Essential Community Provider (ECP) list or complete any missing data fields?

A11. Since there are several new data fields (e.g., National Provider Identifier, number of FTEs representing MDs, DOs, PAs, NPs authorized by the state to independently treat and prescribe within the listed facility, etc.) that will be included in the 2017 ECP list, every provider that currently appears on the HHS ECP list will need to provide such missing data through the ECP petition process. A provider can determine whether it needs to update or correct existing provider data on the ECP list by reviewing the draft ECP list available within the petition.

Q12. How does a provider know whether it qualifies to be included on the HHS Essential Community Provider (ECP) list?

A12. A provider can determine whether it qualifies to be included on the ECP list by completing the ECP petition and reading the instructions that accompany each question within the petition. Detailed instructions are available within the “i” icon that appears next to each question within the petition.

Q13. How does a provider know if it is eligible for or participating in a 340B Program?

A13. Please refer to http://www.hrsa.gov/opa/eligibilityandregistration/index.html for a complete list of organizations that are eligible for the 340B program.

Q14. Should practitioners list their individual National Provider Identifier (NPI) or their facility's NPI?

A14. If an individual practitioner practices within the same provider group or organization at the same street location with other affiliated practitioners, the facility NPI should be listed rather than the individual practitioner's NPI. Affiliated practitioners who practice within a multi-practitioner facility should submit a petition only if authorized by the facility to submit on behalf of the facility using the facility-level NPI and indicating the number of FTE practitioners practicing within the facility. In contrast, solo practitioners may submit the petition under their individual practitioner NPI.

Q15. Should a practitioner who works at multiple facilities submit a separate Essential Community Provider (ECP) Petition for each facility?

A15. No, practitioners who practice at multiple facilities should not submit a petition independent of the facilities in which they practice; rather, only individuals authorized by the facility should submit the petition using the facility-level NPI and indicating the number of FTE practitioners practicing within the respective facility. In contrast, solo practitioners may submit the petition under their individual practitioner NPI.

Q16. Should a facility with multiple locations submit an Essential Community Provider (ECP) Petition for each of its facility locations?

A16. Yes, a facility with multiple locations should submit a separate petition for each site location, entering the NPI associated with each of its facility-specific site locations and indicating the number of FTE practitioners practicing only within the facility-specific site location. For a provider that shares the same NPI among its multiple site locations, the provider should still submit a separate petition for each unique site location.

Q17. What should a provider do if they no longer want to be on the HHS ECP list?

A17. If a provider no longer wants to be on the HHS ECP list, then they should select 'Remove' when asked "Are you petitioning to be added to the list, change your data on the list, or remove your facility from the list?" to ensure that the data are removed from the ECP list.

Q18. How can providers confirm that their facility is located in a low-income ZIP code or Health Professional Shortage Area (HPSA)?

A18. Providers can determine if their facility is located in a low-income ZIP code or Health Professional Shortage Area (HPSA) by referencing the HHS "Low-Income and HPSA ZIP Code Listing," available at http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html.

Q19. How does HHS plan to verify my ECP category that I list in my Essential Community Provider (ECP) Petition?

A19. CMS coordinates closely with its Federal partners, including the Health Resources and Services Administration (HRSA), the Indian Health Service (IHS), and the Office of the Assistant Secretary for Health/Office of Population Affairs (OASH/OPA) to update the ECP list annually and review requested corrections and additions received directly from providers. If CMS is unable to verify a provider's specific ECP category with our Federal partners but can verify that the provider otherwise qualifies as an ECP, CMS may default the provider's ECP category listing to the "Other ECP Providers" category until such verification can be made.

Q20. Must all providers be located in a low-income ZIP code or Health Professional Shortage Area (HPSA), accept patients regardless of ability to pay, and offer a sliding fee schedule to successfully submit the Essential Community Provider (ECP) Petition?

A20. A provider that has been included in one of the verified datasets from our Federal partners (i.e., HRSA, IHS, OASH/OPA) as reflected on the Draft 2017 ECP List, or is a not-for-profit or governmental family planning service site that does not receive Federal funding under Title X of the PHS Act or other 340B-qualifying funding, is not required to be located in a low-income ZIP code or HPSA, accept patients regardless of ability to pay, or offer a sliding fee schedule, because these entities have been recognized as ECPs under section 1311(c)(1)(C) of the ACA and regulations at 45 CFR 156.235. All other providers must be located in a low-income ZIP code or HPSA, accept patients regardless of ability to pay, and offer a sliding fee schedule to successfully submit the ECP petition.

Q21. What is meant by a sliding fee schedule and is it equivalent to a percentage discount program?

A21. A percentage discount program is not equivalent to a sliding fee schedule. In a sliding fee schedule, a consumer could have zero cost, but in a percentage discount program, a consumer would still have costs that could be potentially burdensome. For example, a very low-income consumer could have zero out-of-pocket cost when a sliding fee schedule is applied to a medical procedure that costs $1,000. Whereas, in a percentage discount program, even if the

provider applies a ninety percent discount, the consumer would have to pay $100, which could be burdensome for a very low-income consumer.

Q22. Can a provider list a P.O. Box for its site address within the Essential Community Provider (ECP) Petition?

A22. No, a P.O. Box is not acceptable for a provider's site address, because the site address must reflect the location at which patients receive health care services from the provider. If a P.O. Box is currently included as the site address on the Draft 2017 ECP List, the provider should replace the P.O. Box with a street address using the ECP petition.

Q23. When indicating the number of contracts executed with Qualified Health Plan (QHP) issuers, should providers indicate only those contract offers made in good faith? And what constitutes a good faith contract offer?

A23. Yes, providers should indicate only those contract offers by QHP issuers made in good faith. As stated in the established policy in the Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces, a good faith contract should offer terms that a willing, similarly situated, non-ECP provider would accept or has accepted. Collecting this information will assist CMS in better determining issuer compliance with the ECP requirements pertaining to the offering of contracts in good faith to qualified ECPs.

Q24. Whom can providers contact regarding technical issues with the Essential Community Provider (ECP) petition?

A24. If you need technical assistance, click the "**Need Help?"** button within the ECP petition or email your question(s) to the following mailbox: *EssentialCommunityProviders@cms.hhs.gov*.

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January 12, 2016

GENERAL MEMORANDUM 16-005

Indian Health Service Fiscal Year 2016 Appropriations;
Includes FY 2016 Indefinite Appropriation for Contract Support Costs

On December 18, 2015, President Obama signed the Consolidated Appropriations Act, 2016 as PL 114-113. The Act contains funding for all federal agencies, combining what under regular procedures would be 12 separate bills. In this Memorandum we report on FY 2016 funding for the Indian Health Service (IHS) which is in Division G (Interior, Environment and Related Agencies) of the Act. *In addition to the Explanatory Statement accompanying the Act, House and Senate Interior Appropriations report language (H. Rept. 114-170; S. Rept. 114-70) is to be complied with unless specifically contradicted by the bill language or the Explanatory Statement.* (See our General Memorandum 15-049 of July 7, 2015 comparing the House and Senate Committees' and the Administration's recommendations regarding the FY 2016 IHS budget.)

While the ink is barely dry on the Consolidated Appropriations Act, 2016, we are ready to begin a new appropriations season with President Obama submitting his FY 2017 proposed budget to Congress on February 9, 2016.

FUNDING OVERVIEW

The Act provides $4.8 billion for the IHS, a 3.6 percent increase over FY 2015, but $295 million below the Administration's request. As with FY 2015, no funding is provided for medical inflation or population growth although the Administration had requested $71 million and the House had proposed $53 million for medical inflation. The Act does include $19.4 million for a 1.3 percent pay cost increase.

Also included are the higher Senate recommendations for the Facilities account, Immunization, and $2 million in new funding for health clinic operating costs. The Act includes the higher House recommendation for Self-Governance and splits the difference between the Committees' recommendations for Hospitals and Clinics, Mental Health, Dental Health, Health Education, Community Heath Representatives, and Facilities and Environmental Health Support. However, the following accounts ended up with higher funding than had originally been recommended by the House and Senate Committees: Alcohol and Substance Abuse, Public Health Nursing and Urban Indian Health. Funding for Purchased and Referred Care remained flat.

Contract Support Costs. Most notable is the moving of Contract Support Costs (CSC) into its own account and the instructions in the Act that it is to be funded at "such sums as may

be necessary." The Explanatory Statement assumes a need of $717.9 million ($55 million over FY 2015). Should the need for CSC exceed the amount listed in the budget chart, additional CSC funds would be made available and the agencies' program funding will not be reduced. This provision is applicable to only the FY 2016 Appropriations Act and so discussion will continue on the issue of providing permanent mandatory funding for CSC. See the CSC section elsewhere in this Memorandum for additional information.

New Funding. New funding of $2 million is provided for operating shortfalls at community health clinics, and $2 million for use in ensuring the accreditation status of IHS-operated facilities.

Staffing of New Facilities. The Act provides $14.1 million in the Services and Facilities account combined for the staffing of new facilities at the Southern California Youth Treatment Center ($2.8 million Services, $311,000 Facilities) and the Choctaw (MS) Alternative Rural Health Care Center ($10 million Services, $930,000 Facilities). The Explanatory Statement notes: "Funds are limited to facilities funded through the Health Care Facilities Construction Priority System or the Joint Venture Construction Program that have opened in fiscal year 2015 or will open in fiscal year 2016. None of these funds may be allocated to a facility until such facility has achieved beneficial occupancy status."

CONTINUING BILL LANGUAGE

The Act continues bill language from previous bills, including the following:

Contract Support Costs. See CSC section below.

IDEA Data Collection Language. The Act continues to authorize the BIA to collect data from the IHS and tribes regarding disabled children in order to assist with the implementation of the Individuals with Disabilities Education Act (IDEA):

> *Provided further,* That the Bureau of Indian Affairs may collect from the Indian Health Service and tribes and tribal organizations operating health facilities pursuant to Public Law 93-638 such individually identifiable health information relating to disabled children as may be necessary for the purpose of carrying out its functions under the Individuals with Disabilities Education Act. (20 U.S.C. 1400, et. seq.)

Prohibition on Implementing Eligibility Regulations. The Act continues the prohibition on the implementation of the eligibility regulations, published September 16, 1987.

Services for Non-Indians. The Act continues the provision that allows the IHS and tribal facilities to extend health care services to non-Indians, subject to charges. The provision states:

> *Provided,* That in accordance with the provisions of the Indian Health Care Improvement Act, non-Indian patients may be extended health care at all tribally administered or Indian Health Service facilities, subject to charges, and the proceeds along with funds recovered under the Federal Medical Care Recovery Act (42 U.S.C. 2651-2653) shall be credited to the account of the facility providing the service and shall be available without fiscal year limitation.

Assessments by DHHS. The Act continues the provision that has been in Interior appropriations acts for a number of years which provides that no IHS funds may be used for any assessments or charges by the Department of Health and Human Services "unless identified in the budget justification and provided in this Act, or approved by the House and Senate Committees on Appropriations through the reprogramming process."

Limitation on No-Bid Contracts. The Act continues the provision regarding the use of no-bid contracts. The provision specifically exempts Indian Self-Determination agreements:

> Sec. 411. None of the funds appropriated or otherwise made available by this Act to executive branch agencies may be used to enter into any Federal contract unless such contract is entered into in accordance with the requirements of Chapter 33 of title 41 United States Code or chapter 137 of title 10, United States Code, and the Federal Acquisition Regulations, unless:
>
> (1) Federal law specifically authorizes a contract to be entered into without regard for these requirements, including formula grants for States, or federally recognized Indian tribes; or
>
> (2) such contract is authorized by the Indian Self-Determination and Education and Assistance Act (Public Law 93-638, 25 U.S.C. 450 et seq.) or by any other Federal laws that specifically authorize a contract within an Indian tribe as defined in section 4(e) of that Act (25 U.S.C. 450b(e)); or
>
> (3) Such contract was awarded prior to the date of enactment of this Act.

CONTRACT SUPPORT COSTS

FY 2015 Enacted	$662,970,000
FY 2016 Admin. Request	$717,970,000
FY 2016 Enacted	*Such sums as may be necessary*

The conferees adopted the Senate Committee-recommended approach to Contract Support Costs funding, creating a separate account for it and making it an indefinite appropriation at "such sums as may be necessary." These provisions are specific to FY 2016.

The Act states:

> For payments to tribes and tribal organizations for contract support costs associated with Indian Self-Determination and Education Assistance Act agreements with the Indian Health Service for fiscal year 2016, such sums as may be necessary: *Provided*, That amounts obligated but not expended by a tribe or tribal organization for contract support costs for such agreements for the current fiscal year shall be applied to contract support costs otherwise due for such agreements for subsequent fiscal years: *Provided further*, That, notwithstanding any other provision of law, no amounts made available under this hearing shall be available for transfer to another budget account.

The Explanatory Statement notes:

> CONTRACT SUPPPORT COSTS. The agreement provides an indefinite appropriation for contract support costs estimated to be $717,970,000, which is an increase of $55,000,000 above the fiscal year 2015 enacted level. The budget request proposed to fund this program within the "Indian Health Services" account. Under this heading the Committees have provided the full amount of the request for contract support costs. By virtue of the indefinite appropriation, additional funds may be provided by the agency if its budget estimate proves to be lower than necessary to meet the legal obligation to pay the full amount due to tribes. This account is solely for the purpose of paying contract support costs and no transfers from this account are permitted for other purposes.

Fiscal Year 2016 Limitation. Section 406 of Division G of the Act provides that no FY 2016 funds may be used by the IHS or the BIA to pay prior year CSC or to repay for Judgement Fund for payment of judgments or settlements related to past year CSC claims.

The Act states:

> SEC. 406. Amounts provided by this Act for fiscal year 2016 under the headings "Department of Health and Human Services, Indian Health Service, Contract Support Costs" and "Department of the Interior, Bureau of Indian Affairs and Bureau of Indian Education, Contract Support Costs" are the only amounts available for contract support costs arising out of self-determination or self-governance contracts, grants, compacts, or annual funding agreements for fiscal year 2016 with the Bureau of Indian Affairs or the Indian Health Service: *Provided*, That such amounts provided by this Act are not available for payments of claims for contract support costs for prior years, or for repayments of payments for settlements or judgements awarding contract support costs for prior years.

Prior Year Fiscal Limitations. Section 405 of Division G of the Act continues by reference to Sections 405 and 406 of Division F of Public Law 113-235 (Consolidated and Further Continuing Appropriations Act, 2015) the comparable limitation as noted for FY 2016 above.

FUNDING FOR INDIAN HEALTH SERVICES

FY 2015 Enacted	$3,519,177,000
FY 2016 Admin. Request	$4,463,260,000
FY 2016 Enacted	$3,566,387,000

Definition of Indian. The House Committee repeats language from FY 2015 which notes the problems caused by various definitions of "Indian" referenced in various federal health programs and urges the Department of Health and Human Services, the IHS, and the Treasury Department to work together to establish a consistent definition of "Indian" with regard to health care.

> The Committee recognizes the Federal government's trust responsibility for providing healthcare for American Indians and Alaska Natives. The Committee is aware that the definition of who is an "Indian" is inconsistent across various Federal health programs,

> which has led to confusion, increased paperwork and even differing determinations of health benefits within Indian families themselves. The Committee therefore directs the Department of Health and Human Services, the Indian Health Service, and the Department of the Treasury to work together to establish a consistent definition of an "Indian" for purposes of providing health benefits. (H. Rept. 114-170, p. 76)

HOSPITALS AND CLINICS

FY 2015 Enacted	$1,836,789,000
FY 2016 Admin. Request	$1,936,323,000
FY 2016 Enacted	$1,861,225,000

The Act includes $12.8 million for a pay cost increase, $7.6 million for staffing of new facilities, $2 million for operational shortfalls of tribal clinics, and $2 million to address accreditation emergencies.

Initiatives Funding Distribution. The Act includes language proposed by the Administration providing that the funds for methamphetamine and suicide prevention and treatment, the domestic violence prevention initiative, and efforts to improve collections from public and private insurance at IHS and tribally-operated facilities are to be allocated at the discretion of the Director. The conferees also added funds used for accreditation emergencies to this category. (The Administration has announced that it will not allocate contract support costs for the meth/suicide and domestic violence prevention initiatives, and in the budget request allocated $10 million for use in improving third party collections.)

Health Clinics. As mentioned above, the Act includes a $2 million increase for operational funds for health clinics:

> *Provided further*, That, of the funds provided, $2,000,000 shall be used to supplement funds available for operational costs at tribal clinics operated under an Indian Self-Determination and Education Assistance compact or contract where health care is delivered in space acquired through a full service lease, which is not eligible for maintenance and improvement and equipment funds from the Indian Health Service

Accreditation. The Explanatory Statement includes the following regarding accreditation issues at some IHS-operated facilities:

> The Committees are concerned about loss and potential loss of CMS accreditation status at multiple IHS-operated facilities. These facilities are all located within the same Service Area, suggesting that the problems are systemic. Whatever the causes, the Committees consider the loss of accreditation to be an emergency. The agreement therefore includes $2,000,000 in new, flexible funding so that the Director may take actions necessary to ensure that CMS accreditation status is reinstated and retained, and, once accreditation has been reinstated, to restore third-party insurance reimbursement shortfalls.

Health Care Provider Shortage. The House Report repeats language from FY 2015, encouraging IHS "to work with Tribes and health care organizations to find creative ways to address the Service's health care provider shortage, including improvements to the credentialing process." (H. Rept. 114-170, p. 77)

DENTAL SERVICES

FY 2015 Enacted	$173,982,000
FY 2016 Admin. Request	$181,459,000
FY 2016 Enacted	$178,286,000

The Act includes a $1.4 million program increase, $1.4 million for a pay cost increase, and $1.5 million for staffing of new facilities. As it did in FY 2015, the House Report encourages the IHS to work with the BIE to establish a pilot program integrating preventive dental care at schools within the Bureau system. (H. Rept. 114-170, p. 76)

MENTAL HEALTH

FY 2015 Enacted	$81,145,000
FY 2016 Admin. Request	$84,485,000
FY 2016 Enacted	$82,100,000

The Act includes $616,000 for a pay cost increase and $339,000 for staffing of new facilities.

ALCOHOL AND SUBSTANCE ABUSE

FY 2015 Enacted	$190,981,000
FY 2016 Admin. Request	$227,062,000
FY 2016 Enacted	$205,305,000

Included is a $10 million increase for programs focusing on tribal youth. The Administration's proposal requested an expansion of the methamphetamine/youth suicide prevention initiative by $25 million. Also provided is $1.3 million for a pay cost increase and $3 million for staffing of new facilities.

PURCHASED/REFERRED CARE

FY 2015 Enacted	$914,139,000
FY 2016 Admin. Request	$984,475,000
FY 2016 Enacted	$914,139,000

The Act includes within the total $51.5 million for the Catastrophic Health Emergency Fund, the same as in FY 2015.

Medicare-Like Rates Legislation Encouraged. While the Act does not include legislative language addressing the Medicare-Like Rates issue, the House and Senate Committees commented on it. In addition, the Administration included in its budget recommendation a proposal supporting enactment of legislation to provide Medicare-like rates for non-hospital services, thus stretching the funding for Purchased/Referred Care. The House Committee agreed, stating:

> The Committee urges the Service to work expeditiously with the relevant Congressional authorizing committees to enact authorization for the Service to cap payment rates for non-hospital services, as recommended by the Government Accountability Office (GAO 13-272). Failure to do so costs the program an estimated $30 million annually that could be used to purchase more services. (H. Rept. 114-170, p. 76)

The House Committee also referenced a GAO report (GAO 12-446) critical of the program:

> The Committee urges the Service, Tribes, and the congressional authorizing committees to make reasonable and expeditious progress to address the concerns and recommendations made by the Government Accountability Office (GAO), most notably with regard to unfair allocations, third-party overbilling and under-enrollment in other qualifying Federal programs. (H. Rept. 114-170, p. 76)

The Senate Committee, on the other hand, addressed a Purchased/Referred Care issue specific to Indian people in Oregon:

> The Committee is aware that certain Indian people in Oregon have not been counted for purposes of purchased and referred care under current Service policies and that the Service is currently considering options to address the situation, including the potential expansion of service delivery areas. The Committee believes that it is important that this issue be resolved without impacting existing purchased and referred care allocations to California and Oregon. Within 60 days of enactment of this act, the Service is directed to provide a report to the Committee detailing its proposed management actions to address the situation. (S. Rept. 114-70, p. 70)

PUBLIC HEALTH NURSING

FY 2015 Enacted	$75,640,000
FY 2016 Admin. Request	$79,576,000
FY 2016 Enacted	$76,623,000

The Act includes $605,000 for a pay cost increase and $378,000 for staffing of new facilities.

HEALTH EDUCATION

FY 2015 Enacted	$18,026,000
FY 2016 Admin. Request	$19,136,000
FY 2016 Enacted	$18,255,000

The Act includes $133,000 for a pay cost increase and $96,000 for staffing of new facilities.

COMMUNITY HEALTH REPRESENTATIVES

FY 2015 Enacted	$58,469,000
FY 2016 Admin. Request	$62,363,000
FY2016 Enacted	$58,906,000

The Act includes $437,000 for a pay cost increase.

HEPATITIS B and HAEMOPHILUS
IMMUNIZATION (Hib) PROGRAMS IN ALASKA

FY 2015 Enacted	$1,826,000
FY 2016 Admin. Request	$1,950,000
FY 2016 Enacted	$1,950,000

The Act includes a $109,000 program increase and $15,000 for a pay cost increase.

URBAN INDIAN HEALTH

FY 2015 Enacted	$43,604,000
FY 2016 Admin. Request	$43,604,000
FY 2016 Enacted	$44,741,000

The Act includes a $1,137,000 program increase for Urban Indian Health which is higher than the amount initially recommended by the House or Senate. The Act includes new bill language instructing IHS to "develop a strategic plan for the Urban Indian Health program in consultation with urban Indians and the National Academy of Public Administration…"

The Explanatory Statement directs:

> The agency is directed to include current services estimates for Urban Indian Health in future budget requests. The Committees note the agency's failure to report the results of the needs assessment directed by House Report 111-180. Therefore, the recommendation

includes bill language requiring a program strategic plan developed in consultation with urban Indians and the National Academy of Public Administration.

INDIAN HEALTH PROFESSIONS

FY 2015 Enacted	$48,342,000
FY 2016 Admin. Request	$48,342,000
FY 2016 Enacted	$48,342,000

Programs funded under Indian Health Professions are: Health Professions Preparatory and Pre-Graduate Scholarships; Health Professions Scholarships; Extern Program; Loan Repayment Program; Quentin N. Burdick American Indians Into Nursing Program; Indians Into Medicine Program; and American Indians into Psychology. Consistent with the Administration's request, bill language provides $36 million for the loan repayment program.

Use of Defaulted Funds. The Act continues the provision that allows funds collected on defaults from the Loan Repayment and Health Professions Scholarship programs to be used to recruit health professionals for Indian communities:

> *Provided further*, That the amounts collected by the Federal Government as authorized by sections 104 and 108 of the Indian Health Care Improvement Act (25 U.S.C. 1613a and 1616a) during the preceding fiscal year for breach of contracts shall be deposited to the Fund authorized by section 108A of the Act (25 U.S.C. 1616a-1) and shall remain available until expended and, notwithstanding section 108A(c) of the Act (25 U.S.C. 1616a-1(c)), funds shall be available to make new awards under the loan repayment and scholarship programs under sections 104 and 108 of the Act (25 U.S.C. 1613a and 1616a).

TRIBAL MANAGEMENT

FY 2015 Enacted	$2,442,000
FY 2016 Admin. Request	$2,442,000
FY 2016 Enacted	$2,442,000

Funding is for new and continuation grants for the purpose of evaluating the feasibility of contracting IHS programs, developing tribal management capabilities, and evaluating health services. Funding priorities are, in order: 1) tribes that have received federal recognition or restoration within the past five years; 2) tribes/tribal organizations that are addressing audit material weaknesses; and 3) all other tribes/tribal organizations.

DIRECT OPERATIONS

FY 2015 Enacted	$68,065,000
FY 2016 Admin. Request	$68,338,000
FY 2016 Enacted	$68,338,000

The Act includes $273,000 for a pay cost increase. The IHS noted in its budget submission that 58.7 percent of the Direct Operations budget would go to Headquarters and 41.3 percent to the 12 Area Offices. Tribal Shares funding for Title I contracts and Title V compacts are also included.

SELF-GOVERNANCE

FY 2015 Enacted	$5,727,000
FY 2016 Admin. Request	$5,735,000
FY 2016 Enacted	$5,735,000

The Act includes $8,000 for a pay cost increase. The Self-Governance budget supports implementation of the IHS Tribal Self-Governance Program including funding required for Tribal Shares; oversight of the IHS Director's Agency Lead Negotiators; technical assistance on tribal consultation activities; analysis of Indian Health Care Improvement Act new authorities; and funding to support the activities of the IHS Director's Tribal Self-Governance Advisory Committee.

The IHS estimated in its budget justification that in FY 2015, $1.8 billion will be transferred to tribes to support 89 ISDEAA Title V compacts and 114 funding agreements.

SPECIAL DIABETES PROGRAM FOR INDIANS

While the entitlement funding for the Special Diabetes Program for Indians (SDPI) is not part of the IHS appropriations process, those funds are administered through the IHS. SDPI is currently funded through FY 2017 at $150 million (see our General Memorandum 15-032 of April 17, 2015).

FUNDING FOR INDIAN HEALTH FACILITIES

FY 2015 Enacted	$460,234,000
FY 2016 Admin. Request	$639,725,000
FY 2016 Enacted	$523,232,000

MAINTENANCE AND IMPROVEMENT

FY 2015 Enacted	$53,614,000
FY 2016 Admin. Request	$89,097,000
FY 2016 Enacted	$73,614,000

The Act includes a $20 million program increase. Maintenance and Improvement (M&I) funds are provided to Area Offices for distribution to projects in their regions. Funding is for the following purposes: 1) routine maintenance; 2) M&I Projects to reduce the backlog of

maintenance; 3) environmental compliance; and 4) demolition of vacant or obsolete health care facilities. The Act provides that up to $500,000 may be deposited in a Demolition Fund to be used for the demolition of vacant and obsolete federal buildings.

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

FY 2015 Enacted	$219,612,000
FY 2016 Admin. Request	$226,870,000
FY 2016 Enacted	$222,610,000

The Act includes $1.7 million for a pay cost increase and $1.2 million for staffing of new facilities.

MEDICAL EQUIPMENT

FY 2015 Enacted	$22,537,000
FY 2016 Admin. Request	$23,572,000
FY 2016 Enacted	$22,537,000

The Act continues language to provide up to $500,000 to purchase TRANSAM equipment from the Department of Defense and up to $2.7 million for the purchase of ambulances. The Administration's request was to distribute the FY 2016 requested funds as follows: $18 million for new and routine replacement medical equipment at over 1,500 federally- and tribally-operated health care facilities; $5 million for new medical equipment in tribally-constructed health care facilities; and $500,000 each for the TRANSAM and ambulance programs.

CONSTRUCTION

Construction of Sanitation Facilities

FY 2015 Enacted	$ 79,423,000
FY 2016 Admin. Request	$115,138,000
FY 2016 Enacted	$ 99,423,000

The Act includes a $20 million program increase. Four types of sanitation facilities projects are funded by the IHS: 1) projects to serve new or like-new housing; 2) projects to serve existing homes; 3) special projects such as studies, training, or other needs related to sanitation facilities construction; and 4) emergency projects. The IHS sanitation facilities construction funds cannot be used to provide sanitation facilities for HUD-built homes.

Most of the Administration's requested increase was for $30 million to service new and like-new homes, some of which could be used for sanitation facilities for individual homes of

disabled or ill persons with a physician referral, with priority for BIA Housing Improvement Projects.

Construction of Health Care Facilities

FY 2015 Enacted	$ 85,048,000
FY 2016 Admin. Request	$185,048,000
FY 2016 Enacted	$105,048,000

While the Act includes a $20 million increase over FY 2015, this is $80 million less than the Administration's request. We do not have a breakdown on the distribution of the funds, but the Administration's request of $185 million would have provided funds for the Gila River Southeast Health Center (Chandler, AZ); Salt River Northeast Health Center (Scottsdale, AZ); Rapid City Health Center; and New Dilkon (AZ) Alternative Rural Health Center.

If we may provide additional information or assistance regarding FY 2016 Indian Health Service appropriations, please contact us at the information below.

# # #

Inquiries may be directed to:
Karen Funk (kfunk@hobbsstraus.com)

3E

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JAN 1 1 2016

The Honorable Dennis Daugaard
500 East Capitol Street
Pierre, SD 57501

Dear Governor Daugaard:

Thank you for your thoughtful comments on the proposed change that the Centers for Medicare & Medicaid Services (CMS) is considering regarding the circumstances in which 100 percent federal funding would be available for services furnished to Medicaid-eligible American Indians and Alaska Natives (AI/AN) originating through facilities of the Indian Health Service (IHS), including facilities owned and operated by IHS or a Tribe under the Indian Self-Determination and Education Assistance Act, P.L. 93-638 (IHS/Tribal facility). CMS is continuing to review comments that we received from other stakeholders in response to our October 27, 2015, Request for Comment, entitled "Medicaid Services 'Received Through' an Indian Health Service/Tribal Facility."

We also appreciate the constructive input we received from the South Dakota Health Care Coalition. We share the Coalition's goal of improving access to health care services for Medicaid-eligible AI/ANs. We hope that the proposed change to our policies will help the state further support initiatives underway in South Dakota that are aimed at improving care coordination and quality of care for AI/AN Medicaid beneficiaries.

I am writing to provide an interim response to issues raised in your comments as well as those from the Coalition, based on CMS' review of comments to date. CMS' final policy determination will be reflected in a State Health Official letter, which we will issue shortly.

Defining Services "Arranged and Overseen" by IHS/Tribal Facilities

The Coalition asked for clarification on what constitutes services "arranged and overseen" by an IHS/Tribal facility. The Coalition also asked about options for serving AI/ANs who live in areas that are geographically distant from IHS/Tribal facilities.

CMS intends to make 100 percent federal funding available to states for services furnished to AI/AN Medicaid beneficiaries by a non-IHS/Tribal provider when those services are requested by an IHS/Tribal facility for its patient, provided certain conditions are met, including that the services are furnished in accordance with a written care coordination arrangement between the IHS/Tribal facility and the non-IHS/Tribal provider. First, the IHS/Tribal facility and the non-IHS/Tribal provider must both be enrolled in the state's Medicaid program as providers. Second, there must be an established relationship between the patient and a qualified practitioner at an IHS/Tribal facility. (Such a relationship could be established, for example, through an initial

visit, which could occur via telehealth if the IHS/Tribal facility has that capacity.) Third, care must be provided pursuant to a care coordination arrangement, under which the IHS/Tribal facility coordinates the care of its patient by the non-IHS/Tribal provider and retains control of the patient's medical record.

CMS will develop additional details around requirements for care coordination, but anticipates that care coordination will build upon an established relationship between the patient and a provider at the IHS/Tribal facility.

We intend that the 100 percent federal funding would apply on a permanent basis to all services "received through" an IHS/Tribal facility by an AI/AN Medicaid beneficiary who is a patient of that facility, regardless of whether the beneficiary is eligible under a Medicaid traditional eligibility category or is a newly eligible adult under the Medicaid expansion. We note that this policy would only affect the availability of the 100 percent federal funding for the state, and would not limit the ability of an IHS/Tribal provider to refer individuals to any qualified Medicaid provider, or limit the ability of any AI/AN beneficiary to obtain services from any participating Medicaid provider.

We understand the challenge of ensuring access for AI/AN individuals who live in areas that are geographically distant from IHS/Tribal facilities. CMS intends to make the 100 percent federal funding available for care both in cases where an IHS/Tribal facility is either providing services directly or is requesting care and undertaking care coordination (or both) where the other conditions described above are met. IHS/tribal facility involvement can be through telehealth to the extent that the providers have the capacity and meet state standards for recognition of telehealth services.

Defining Arrangements Between IHS/Tribal Facilities and Providers

The Coalition, in its comments, asked for flexibility at the State/Indian Health Program (IHP) level to establish the mechanisms and terms of agreements between IHS facilities and providers, such as a memorandum of agreement or a purchase of services agreements rather than establishing formal contracts that are governed by federal procurement rules. In addition, the Coalition requested that the state be given the opportunity to describe in the Medicaid state plan how it will meet the standards for approval of agreements between IHS facilities and providers. The Coalition also sought clarification as to whether medical record management can be defined by an agreement between the IHS/Tribal facility and non-IHS/Tribal providers.

CMS intends to consider a service "received through" an IHS/Tribal facility if it is requested by the IHS/tribal facility practitioner; furnished to an AI/AN patient of that practitioner, who remains responsible for overseeing the patient's care; and furnished by a non-IHS/Tribal provider with which the IHS/Tribal facility has established a written agreement that makes clear the responsibilities of both the facility and the provider with respect to care coordination and medical record management. Such an agreement could take various forms, including but not limited to a formal contract, a provider agreement, or a memorandum of understanding and would not be governed by federal procurement rules, to the extent it is consistent with IHS

authority. CMS does not intend to require a state to describe in its Medicaid state plan what the standards for a written agreement are or how it will ensure that those standards are met.

Defining the Scope of Medicaid Services Eligible for 100 Percent Federal Funding

In its comments, the Coalition seeks clarification on reimbursement for "facility-based" services, including whether 100 percent federal funding would apply to state expenditures for the cost of services provided by non-IHS/Tribal providers under contract with IHS, such as perinatology specialty care, neonatal hospital care, nursing home care, residential psychiatric treatment center services, and telehealth.

CMS intends to adopt the option under which the state can obtain 100 percent federal funding for services that meet all of the requirements above as long as they are within the scope of the services that the IHS/Tribal facility is authorized to provide, and that are covered under the approved Medicaid state plan. This includes services that are provided to AI/AN Medicaid beneficiaries who are patients of an IHS/Tribal facility and who have been referred to a non-IHS provider (who is also a participating Medicaid provider) by the IHS/Tribal facility under the care coordination arrangement described above. These services, could, for example, include inpatient hospital care, nursing home care, or specialty physician services like perinatology, to the extent that such services are covered under South Dakota's Medicaid state plan, and are services that could be offered by the IHS/Tribal facility at issue under governing law and, if applicable, the compact or contract between the Tribe and IHS.

Defining Billing and Payment Arrangements

In its comments, the Coalition strongly supported the option for non-IHS/Tribal providers under care coordination arrangements with IHS/Tribal facilities to bill the Medicaid program directly and sought clarification that, when non-IHS providers bill directly, the state Medicaid program is able to reimburse for these services at the state plan rates otherwise applicable for the service.

While operational and reporting requirements are still under development, CMS intends to adopt this option, with the clarification that the billing arrangement must be specified in the written agreements between IHS/Tribal facilities and non-IHS/Tribal providers. As discussed above, these written agreements need not be formal contracts. Under this option, the IHS/Tribal facility has flexibility to bill the state Medicaid program directly for facility services furnished by the non-IHS/Tribal provider under the care coordination arrangement, to the extent consistent with IHS authority, or to require the non-IHS/Tribal provider to bill directly. If the non-IHS/Tribal provider who is also a Medicaid provider bills the state Medicaid program directly, the provider would be reimbursed at the rate under the Medicaid state plan for that provider's services. If the IHS/Tribal facility bills the state Medicaid program directly, the reimbursement rate would depend on whether the service was within the scope of the facility benefit (e.g., inpatient or outpatient hospital, nursing facility, Federally Qualified Health Center, etc.). For services that are within the scope of the facility benefit, the facility would be paid at the applicable facility rate under the Medicaid state plan. For services like non-emergency transportation or personal care services that are not within the scope of the facility benefit, the facility would be paid at the

state plan rate for that non-facility service. States would retain flexibility in establishing economic and efficient payment rates to sufficiently reimburse for the provision of services consistent with access to care.

Technical Assistance in Implementing the Revised Policies

HHS is committed to assisting you and your staff as you move forward in improving access and quality of services for the AI/AN population. We are aware of the interest from South Dakota's Tribes to provide technical assistance as the state and the Tribes work towards implementing the changes we intend to make to our tribal policy. CMS, IHS, and HHS officials would like to meet with your staff and the Tribes in South Dakota for a day-long session to discuss operationalizing this policy in a manner that best supports access to care for AI/AN individuals.

This meeting is a first step in our commitment to assisting your staff and the Tribes in operationalizing this policy, and we are prepared to provide additional assistance as we work towards our shared goal of improving access to care for AI/AN individuals. Specifically, we are developing a new position in IHS that will serve as the primary IHS and CMS point of contact for South Dakota to help resolve federal policy and operational issues that arise during implementation. In addition, IHS intends to send an implementation team to the Great Plains Area to provide technical assistance on implementation as well as to work closely with the newly created liaison staff and with IHS and CMS headquarters staff. We also expect to be able to use existing funding to invest in telehealth resources to facilitate access to services for AI/AN individuals who live in areas that are geographically distant from IHS facilities but would benefit from IHS care.

Our revised policy will improve care coordination and quality of care for over 40,000 South Dakota AI/ANs who are already Medicaid eligible and receive IHS services, as well as for thousands more South Dakota AI/AN residents who might choose to begin utilizing IHS services or who could gain access to health care through Medicaid expansion. We stand ready to assist as the state continues to work to improve the health of South Dakotans.

Sincerely,

Sylvia M. Burwell

Sylvia M. Burwell

Hepatitis C:

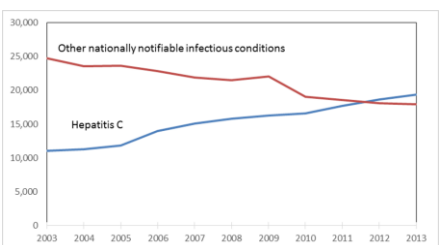
Where are we?
Where do we want to go?

JESSICA LESTON, MPH
PROGRAMS MANAGER
JLESTON@NPAIHB.ORG

Background

- Hepatitis C virus (HCV) infection is a substantial and largely unrecognized health problem.
- An estimated 3.5 million persons in the US are currently living with HCV, most of whom are unaware of their infection.
  - ¾ of persons living with HCV were born between 1945-1965.
- HCV is a major cause of liver disease, cirrhosis, hepatocellular carcinoma.

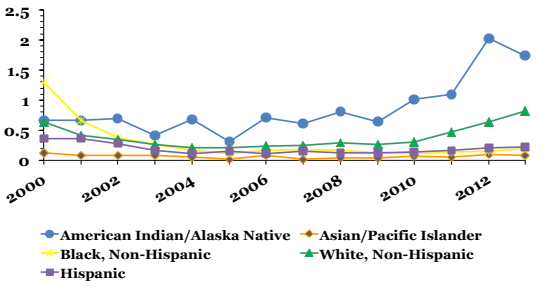
HCV Deaths and Deaths from Other Nationally Notifiable Infectious Diseases,* 2003- 2013



* TB, HIV, Hepatitis B and 57 other infectious conditions reported to CDC

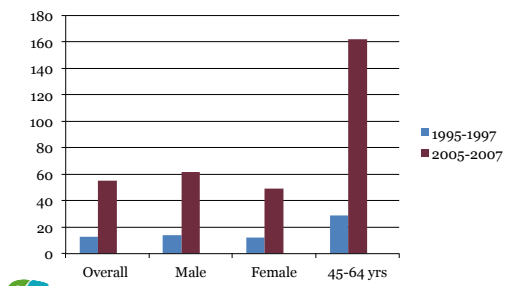
Holmberg S. et al. "Contin… ortality from Hepatitis C Virus in the United States, 2003-2013" Presented at ID Week 201… 2015, San Diego, CA

Incidence of Acute Hepatitis C, by Race/Ethnicity – United States, 2000-2013



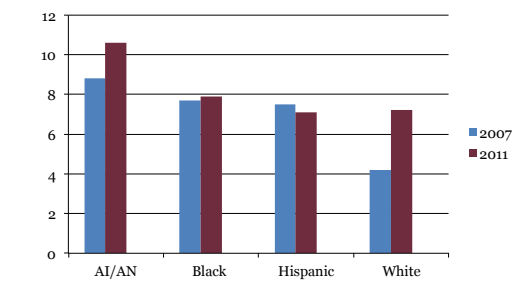
Source: National Notifiable Diseases Surveillance System (N

A 300% Increase in Hepatitis C –related Hospitalization for AI/AN – 1995-2007



Byrd KK, et al Pub Hlth Rep 2011

HCV – Related Mortality by Race/Ethnicity 2007 compared to 2011



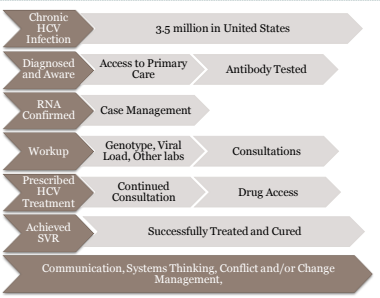
Byrd KK, et al Pub Hlth Rep 2011

Good and Bad News

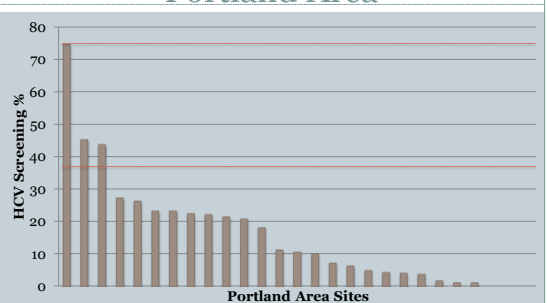
- The good news
  - Hepatitis C can be cured
  - Curing HCV reduces mortality and morbidity
  - Curing HCV reduces the risk of transmission
- The bad news
  - The HCV epidemic still remains ***invisible***
    - Public/Medical providers/Policy makers
  - It is the infectious diseases with the highest mortality[1]
  - Access to treatment is complicated
- Good news again
  - WE CAN CHANGE THIS

Holmberg SD, et al ID Week 2015 San Diego

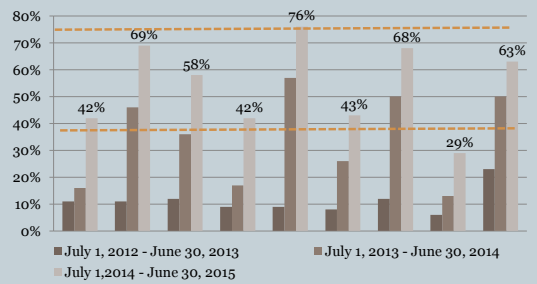
HCV Cascade



Hepatitis C Screening Portland Area



Hepatitis C Screening at CNHS

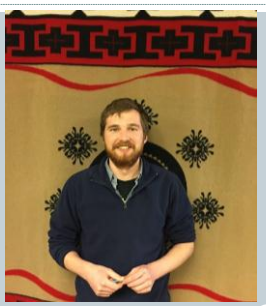


From Screening to Treating: Story from an FNP

"In my 4.5 year tenure with un-named Health clinic I have cured 85 patients of their hepatitis C. I have 20 patients in treatment and another 22 patients who have completed treatment and are waiting for their 12 week viral load to test for cure. I have only had 3 failures and we are working on developing a treatment plan for them. I have about 5 new hepatitis C patients a week.

One of my patients came to me having failed previous treatments regimens for her hepatitis C. She was barely able to lift herself off the table. Her daughter was very concerned for her. She had cirrhosis and was worried that she was going to die from her liver disease. She is now cured form her hepatitis C, she looks beautiful, puts on make-up, walks in unassisted and joins our hepatitis C support group. She looks vibrant and energetic and is grateful for her renewed life. We are happy to have her as part of our Clinic life."

Hepatitis C Paneling



Purpose: To provide sites with a list of current HCV+ patients and begin cascade of care

- Started with 6 Federal Sites (open to all)
- Remote access to iCare
- Paneled patients according to ICD9/10 codes

Hepatitis Patient Panel List									<0.5	<1.35
Clinic Name									>1.5	>3.25
Patient Identifier	**DOB**	**Age in 20**	**Antibody**	**RNA**	**AST**	**AST UL**	**ALT**	**Platelets**	**APRI**	**FIB 4**
Example		55			45	42	97	385	0.27829314	0.65272253
Example		54			42	55	52	64	1.19318182	4.91459706
Example		70			50	42	31	221	0.53867701	2.84442786
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HCV Panel Results

- 635 unique patients with an HCV diagnosis were identified.
- The median age was 53 (range 10-86).
- The proportion that were boomers was 61% (387/635).

	Hep C Antibody	HCV RNA, PCR QN			labelled as ALT!				"High" viral load, which is usually >800,000 IU/L, or a "low"			
Age in 2015	**Antibody**	**RNA**	**AST**	**AST UL**	**ALT**	**Platelets**	**APRI**	**FIB 4**	**Viral Load**	**Genotype**		
52		2,240,479	73	37	113	149	1.32414293	2.396628967	high	Genotype 1a		
51		83,600	75	37	143	168	1.20656371	1.303943862	low	Genotype 1a		
86	Reactive	comment & <15 not detected	25	37	49	455	0.14850015	0.282571668	not detected			
50		8,237,734	33	37	41	275	0.32432432	0.837042571	high	Genotype 1a		
46	Reactive	443,000	38	37	58	303	0.33895281	0.757503778	low	Genotype 1a		
33	Reactive	<43	42	37	90	254	0.4669036	0.575185937	low			
43	Reactive	65234	121	37	219	188	1.73950548	1.719673879	low	Genotype 3a		
36	Reactive	116000	59	37	53	101	1.57680643	2.470588235	low	Genotype 3a		
48		<43	34	37	57	201	0.45717359	1.075441197	low			
54		ZZHEP C VIRAL Load 248684	40	36	34	304	0.36548708	1.218452079	low			
38		<43	28	37	48	344	0.21998743	0.446439452	low			
49	Reactive		203	37	177	187	5.27272727	6.418181818				
31	Reactive per ne	see MD note 7/24/14					#DIV/0!	#DIV/0!		Not Detected		
32	Reactive	1010000	129	37	249	253	1.3780579	1.039997512	high	Genotype 2b		
58			90	37	65	149	1.87080241	3.557446808				
56	Reactive	<15 not detected	31	37	18	203	0.412728	2.01566075	not detected	Not Detected		
59	Reactive	<15 not detected	28	37	32	245	0.30888021	1.191980303	low			
53	Reactive	3792696	37	37	32	125	0.8	2.175534157	high	Genotype 2b		
56	Reactive	<15 not detected	23	37	20	201	0.30926449	1.43286346	low	Not Detected		

Cross-site Breakdown: APRI

- 360 (57%) RNA test documented
  - 43% need follow up
- 174 (48%) RNA+ (chronic HCV infection)
  - This implies a 52% clearance
- 138 (80%) had enough information to calculate APRI
- 28 (20%) had an acute APRI (stage 3 or 4 fibrosis)
  - 20 (71%) were born between 1945-1965
- Most common genotype GT1 (60%)

Consider

HCV cirrhosis risk 20% over 20 years =
HCC risk in HCV cirrhosis 17% over 5 years

So, when you CURE 25 patients with HCV
(in 8-24 weeks of treatment) you will prevent:
5 cases of cirrhosis
1 case of HCC

Compare, if you treat 104 patients with statins, you will prevent 1 first time heart attack and ¾ of a stroke.

Review Dr. David Newman July 2015

Access to Medication

- If patient has insurance – insurance will mostly cover.
  - Assistance with co-pay https://www.panfoundation.org/
- If patient is eligible for Medicaid – apply for Medicaid.
  - WA, ID, OR will treat stages 3 or 4
  - For exact rules, https://www.ohsu.edu/xd/research/centers-institutes/evidence-based-policy-center/evidence/med/upload/02b-HCV-Medicaid-Policy-SenFin-2015.pdf
- If patient is not eligible or denied – apply for patient assistance.

Breaking down cost

One case manager = $50,000 salary

50 courses of 8 weeks of Harvoni obtained via patient assistance = 1.9 million dollars of meds into the system

50 patients treated = 10 cirrhosis cases avoided and 2 cases of liver cancer avoided

$17,000 /year HCV no cirrhosis
$23,000 /year HCV comp cirrhosis
$60,000 / year HCV decomp cirrhosis

The economic cost of advanced liver disease, http://www.thehcn.org/2012/HBV/010212_01.htm
The current economic burden of cirrhosis, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3265008/#!po=26.96

Simple, Effective, but out of Reach?


The NEW ENGLAND JOURNAL of MEDICINE

EDITORIALS

Simple, Effective, but Out of Reach? Public Health Implications of HCV Drugs

John W. Ward, M.D., and Jonathan H. Mermin, M.D., M.P.H.

The results of four clinical trials showing the excellent safety and efficacy of a 12-week course of sofosbuvir (an NS5B inhibitor licensed in the United States in 2013) and velpatasvir (a new NS5A inhibitor) in treating patients with hepatitis C infection (HCV) are reported now in the Journal.[1,2] In two of these studies, ASTRAL-1 and ASTRAL-2, 97 to 100% of patients with HCV genotype 1a, 1b, 2, 4, 5, or 6 had a sustained virologic response at 12 weeks after the end of therapy, a marker that is indicative of virologic cure. Similar efficacy was observed among pe- 12-week regimen of sofosbuvir-velpatasvir a The proportions of patients with serious ad events were similar across treatment regi (16 to 19%). Indicators of liver function proved in nearly half the patients. Toge these studies indicate that this drug reg can achieve high rates of HCV cure regardle genotype.

The public health implications of simple, and curative HCV therapies could be profo HCV chronically infects 2.7 million to 3.5 m persons in the United States and 130 milli

Where do we WANT to go?

Veteran Medical Care: Key Areas of Focus Obligations ($ in millions)

	2014 Actual	2015 Estimate	2016 Estimate	2017 Estimate
Caregivers	350	482	555	642
Hepatitis C (New Drug Treatments)	379	697	690	660
Women Veterans (Gender-Specific Care)	380	412	446	482
Mental Health	6,676	7,106	7,455	7,715
Telehealth				
Rural Health Initiative				
Homeless Programs				
Activations				


Historic achievement for veterans in the fight against hepatitis C

By Thomas J. Berger, Ph.D.

COMMENTS 6

Congress made headlines last month by approving a funding measure to avert the looming government shutdown. But the measure doesn't just keep federal agencies funded until next fall. Buried within the 2000-plus page bill is a truly historic development for veterans battling the nation's deadliest blood-borne disease.

Veterans, especially those of my era who served in and around Vietnam in the 1960s and 1970s, experience hepatitis C infection rates that are twice as high as our civilian counterparts. Yet previously, too many people who tested positive for hepatitis C preferred to forego treatment and risk cirrhosis, hepatic cancer, liver damage, and/or organ failure, rather than undergo the harsh and largely ineffective regimen of chemotherapy required to attempt to rid their bodies of the virus.

Syringe Access: Partial Lift of Congressional Ban

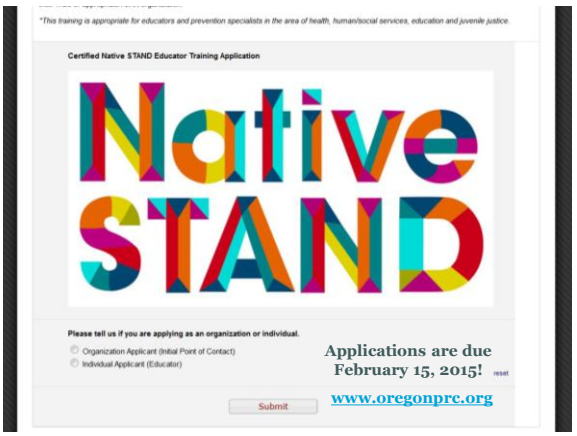
- A simple adjustment to congressional policy to help stop the spread of HIV and HCV and lower healthcare cost – without costing extra money.
- What is it –
  - A syringe access program provides free syringes and ensures safe disposal of used syringes. Most programs also offer other services, such as HIV/HCV/HBV screenings, referrals, vaccinations and on-site medical care.
- Public safety –
  - In Portland, OR, the number of improperly discarded syringes dropped by almost 2/3 after implementation of an access program.

Wide-spread support for Syringe Access

- Syringe access policies are supported by
  - American Academy of Pediatrics
  - American Bar Association
  - American Medical Association
  - American Nurses Association
  - American Psychological Association
  - American Public Health Association
  - National Academy of Sciences
  - National Police Association
  - U.S. Conference of Mayors
  - U.S. Surgeon General
  - World Health Organization

Interview Project with People Who Inject Drugs and Health Care Staff to Support Prevention and Healthcare Systems Improvement

- Gather **opinions, attitudes and beliefs** from AI/AN people who have injected drugs in the past (PWHID), from community members, and healthcare providers to guide future planning efforts around injection drug use, HIV and HCV.
- The project will be conducted in **four** AI/AN communities using semi-structure interviews.
- The project will be based on indigenous ways of knowing, community-based participatory research principles and implementation science.


*This training is appropriate for educators and prevention specialists in the area of health, human/social services, education and juvenile justice.
Certified Native STAND Educator Training Application
Native
STAND
Please tell us if you are applying as an organization or individual.
Organization Applicant (Initial Point of Contact)
Individual Applicant (Educator)
reset
Submit
Applications are due February 15, 2015!
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NPAIHB Quarterly Board Meeting:
Accountable Communities of Health 101

January 19, 2016

Jessie Dean, WA Health Care Authority
Kayla Down, WA Health Care Authority

Healthier WASHINGTON

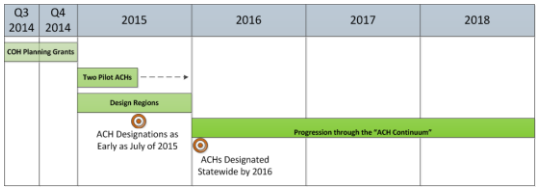
Presentation Agenda

- **1:45** – Introductions
  - North Sound ACH partners in attendance
- **1:50** – Accountable Communities of Health (ACH)
  - Background / Timeline
  - ACH Function/Designation Requirements
  - ACH-Tribal Engagement
- **2:00** – Upcoming work with AIHC and ACHs
- **2:05** – Questions
  - FAQ Document
  - ACH Contact Information
- **2:15** – HCA Contact Information

ACHs in WA

ACH Regions Map

ACH Development Timeline



ACH Functions

- 2015/early 2016: ACH Designation
- Requirements for Designation:
  - Balanced representation
  - Community engagement activities
  - Financial and administrative functions
  - Identify regional health needs, resources and priorities
  - Operating budget and sustainability planning
- Ongoing ACH work (SIM and beyond)

ACH–Tribal Engagement

- Guidance Sent to ACHs in 2014
  - Tribal engagement by ACHs continues to be a priority
  - ACHs should reach out to each Tribe and allow each Tribe to decide whether or not they will participate and how they will coordinate their participation
  - State maintains government-to-government relations with the Tribes; ACHs need to respect this
  - HCA is developing a Tribal coordination plan
- Experience since then:
  - ACHs at various stages of engagement with Tribes
  - HCA has contracted with the American Indian Health Commission for Washington State for assistance in developing a Tribal coordination plan

ACH–Tribal Engagement: AIHC Project

- Goals for 2016:
  - To inform ACHs on the government-government relationship
  - To inform Tribes/UIHOs on the function/role of ACHs in WA
  - To gather information on what the Tribes/UIHOs want for ACH engagement
- Report and recommendations due January 31, 2017
- Potential parallel model for Tribes/UIHOs:
  - Tribal Coordinating Entity

Questions?

- ACH FAQ
- ACH Contact Information
- For the most up-to-date information:
  http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx

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ACH Team: CommunityTransformation@hca.wa.gov

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ACH Leads and Staff Contact List

Coalition	Organization	Name	Role	Email
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Northwest Portland Area Indian Health Board

Strategic Plan -- 2010-2015

Northwest Portland Area Indian Health Board

The Northwest Tribes have long recognized the need to exercise control over the design and development of health care delivery systems in their local communities. To this end, they formed the Northwest Portland Area Indian Health Board (also referred to as NPAIHB or Board) in 1972. NPAIHB is a nonprofit tribal organization that serves the forty-three federally recognized tribes of Idaho, Oregon, and Washington on health-related issues. Tribes become voting members of the Board through resolutions passed by their governing body. Each member tribe designates a delegate to serve on the NPAIHB Board of Directors.

In keeping with the Board's strong advocacy for tribal sovereignty and control over the design and delivery of their own systems of care, Board delegates meet quarterly to provide guidance and leadership in establishing NPAIHB programs and services. Recognizing the need for accurate, culturally-relevant data, the NW Tribal EpiCenter was established in 1997 to engage the NW Tribes in public health research and surveillance. The NW Tribal EpiCenter houses the Portland Area IHS Institutional Review Board (IRB), which oversees protection of human subjects in research occurring in Northwest Indian communities. The EpiCenter now serves as an essential resource for supporting community-based, participatory data collection.

"It gives me great pleasure to provide you with the product of your thoughtful leadership. Strategic planning, while it sometimes seems like a modern business concept, is actually very much an Indian concept. When our leaders from the past contemplated decisions, it was always within the context of making life better for the seventh generation. We do not prepare a strategic plan for us, but we do so to make life better for our yet to be born Tribal members."

Joe Finkbonner, NPAIHB Executive Director

Vision: Wellness for the 7th Generation

Mission: Eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest tribes in their delivery of culturally appropriate, high quality healthcare.

Goal 1 - Build and maintain a strong organizational infrastructure supporting tribal health.

Goal 2 - Strengthen regional and national partnerships to ensure tribal access to the best possible health services.

Goal 3 - Maintain leadership in the analysis of health-related budgets, legislation, and policy.

Goal 4 - Support health promotion and disease prevention activities occurring among the Northwest Tribes.

Goal 5 - Support the conduct culturally-appropriate health research and surveillance among the Northwest Tribes.

Organizational Values: Tribal Sovereignty, Model Leadership, Holistic Health Promotion and Disease Prevention.

Mission Statement

The mission of the Northwest Portland Area Indian Health Board is to eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest Tribes in their delivery of culturally appropriate, high quality healthcare.

Vision for the Seventh Generation

The old people tell us to be careful in the decisions that we make today, as they will impact the seventh generation - our grandchildren's grandchildren. It was the spirit behind this teaching that guides our organization's mission and goals.

The People Spoke: This is their Vision

- The seventh generation will have balanced physical, mental, emotional, and spiritual lifestyles. They will have healthy diets, be fit, active, and happy.
- The seventh generation will live in sovereign communities that are politically effective, assertive, goal-oriented, thriving economically, and run by American Indian/Alaska Native (AI/AN) people.
- The seventh generation will live in a unified and poverty-free community made up of stable, loving families living in adequate housing.
- Children born to the seventh generation will be healthy and free of chemical substances. They will experience strong parenting, mentorship, and positive role models as youth and will become involved and empowered leaders.
- The seventh generation will live in accordance with their traditional values by knowing their native languages and practicing spiritual and cultural traditions.
- The seventh generation will live in a clean environment, have access to an abundance of natural resources, respect all life, and practice sustainable and socially responsible environmental stewardship.
- Every member of the seventh generation will have access to technologically advanced and culturally appropriate healthcare that includes well-equipped clinics, wellness centers, and health education; a health care delivery system that could serve as a national model.
- The seventh generation will have adequate resources to support healthcare delivery.
- The health of the seventh generation will be a model for the general population. They will experience no preventable illness and no substance abuse or addiction. Old age will be the leading cause of death.
- The seventh generation will respect and care for their elders and celebrate as they live to 100 years or more.

Goals and Objectives

GOAL 1: The NPAIHB will build and maintain a strong organizational infrastructure supporting tribal health in the Pacific Northwest.

Objective A. NPAIHB will provide a forum for developing timely tribal consensus on healthcare issues affecting the NW Tribes by hosting productive Quarterly Board Meetings that facilitate face-to-face communication and resource sharing with state and federal programs.

Indicators for Monitoring and Evaluation: NPAIHB will conduct Quarterly Board Meetings at rotating tribal sites. Meeting content and outcomes will be documented in quarterly activity reports.

Objective B. NPAIHB will support tribal delegates in regional and national AI/AN healthcare discussions, by providing them with orientation, training, and assistance.

Indicators for Monitoring and Evaluation: NPAIHB staff will document orientation, training, and capacity building activities in monthly and quarterly activity reports. Delegate training will occur by their 3rd quarterly board meeting.

Objective C. NPAIHB will maintain effective communication channels to inform tribal delegates and tribal decision-makers about emerging public health topics.

Indicators for Monitoring and Evaluation: NPAIHB projects will post and disseminate health information on a weekly, monthly, or quarterly basis, and will use available tools to evaluate their utility and uptake, including tracking and recording web "hits" and active list-serve subscriptions.

Objective D. NPAIHB will provide the NW Tribes with capacity building assistance (including training, technical assistance, and resource development) on healthcare management principles and Information Technology.

Indicators for Monitoring and Evaluation: NPAIHB staff will document health management and IT capacity building activities in monthly and quarterly activity reports.

Objective E. The NPAIHB will actively research health-related funding opportunities, will disseminate funding announcements to member tribes, and will educate federal agencies on strategies to ensure that federal funding opportunities align with the priorities, needs, and organizational capacities of the NW Tribes.

Indicators for Monitoring and Evaluation: NPAIHB staff will produce and circulate a weekly funding report, and will provide grant-writing technical assistance upon request.

Objective F. NPAIHB will build a strong organizational infrastructure by recruiting and retaining high-quality staff, by encouraging their ongoing education and training, and by actively implementing the organization's mission and values to provide employees with comprehensive wellness benefits.

Indicators for Monitoring and Evaluation: NPAIHB will document these policies and practices in its Program Operations manual and HR Procedures manual, and will update these documents on an annual basis.

Objective G. NPAIHB will help develop tribal youth into future leaders in healthcare by making NPAIHB meetings and trainings accessible to youth, and by offering internships to interested students. When appropriate, NPAIHB projects will integrate youth leadership training and travel opportunities into the scope of work of new projects.

Indicators for Monitoring and Evaluation: NPAIHB staff will include student interns and youth leadership activities in monthly and quarterly activity reports.

GOAL 2: The NPAIHB will strengthen regional and national partnerships to ensure tribal access to the best possible health resources and services.

Objective A. NPAIHB will build and maintain effective, collaborative relationships with current and potential partners, including the NW Tribes, the Indian Health Service, Indian organizations, Federal agencies, State Health Departments, Universities, funding agencies, community-based organizations, and other interdisciplinary social service providers that promote AI/AN health.

Indicators for Monitoring and Evaluation: NPAIHB projects will document active relationships with relevant partners, recording meetings and outcomes in monthly and quarterly activity reports.

Objective B. The NPAIHB will actively contribute to regional and national workgroups, coalitions, and committees that address priority health topics identified by the NW Tribes, and key health promotion and disease prevention workgroups.

Indicators for Monitoring and Evaluation: NPAIHB projects will document their contributions to regional and national workgroups, coalitions, and committees in monthly activity reports.

GOAL 3: The NPAIHB will maintain leadership in the analysis of health-related budgets, legislation, and policy, with the ability to facilitate consultation and advocate on behalf of member Tribes.

Objective A. The NPAIHB will facilitate communication among Tribes, Federal and State agencies, and Congress to support tribal sovereignty, promote self-determination, and ensure that government-to-government consultation occurs on health-related budgets, legislation, policies, and services.

Indicators for Monitoring and Evaluation: NPAIHB staff members will document communication activities in monthly and quarterly activity reports and in periodic QBM presentations. Pertinent meeting dates and agendas will be added to the NPAIHB online calendar.

Objective B. The NPAIHB will advocate on behalf of the NW Tribes to ensure that tribal interests are taken into account as health policy is formulated, and that Congress, State legislatures, and external agencies have a full understanding of AI/AN health needs and concerns (particularly in relation to treaty rights and healthcare in Indian Country).

Indicators for Monitoring and Evaluation: NPAIHB staff members will document their advocacy work in monthly and quarterly activity reports and in periodic QBM presentations. Pertinent meeting dates and agendas will be added to the NPAIHB online calendar.

Objective C. The NPAIHB will stay at the forefront of budgetary, legislative, and policy initiatives affecting the NW Tribes, including the President's annual budget, national healthcare reform initiatives, IHS policies and strategies, and proposed changes to Medicare and Medicaid, and will assess their impact on the Northwest Tribes.

Indicators for Monitoring and Evaluation: The NPAIHB Policy Analyst will develop and disseminate timely policy reports and budget enhancement packages using existing NPAIHB communication channels to provide a strong voice on health related issues at the state and national level, assure equitable resource allocation methodologies are in place, and improve the efficient and effective delivery of health services to AI/ANs living in the Pacific Northwest.

Objective D. The NPAIHB will analyze new and existing healthcare delivery systems and will and advocate for tribal consultation and participation in their development.

Indicators for Monitoring and Evaluation: The NPAIHB will document policy analysis and advocacy in monthly and quarterly activity reports and in periodic QBM presentations.

Objective E. The NPAIHB will evaluate the feasibility of assuming certain Portland Area Office programs, functions, services, or activities on behalf of Portland Area Tribes, and if approved and selected, will carry them out in an agreement negotiated under the Indian Self-Determination and Education Assistance Act (P.L. 93-638).

Indicators for Monitoring and Evaluation: The NPAIHB will produce a report for tribal leaders and Board delegates outlining the legal and budgetary issues associated with such an assumption, will carry out requisite planning and organizational preparation, and will apply for a planning and negotiation grant if deemed appropriate and applicable.

GOAL 4: The NPAIHB support health promotion and disease prevention activities occurring among the Northwest Tribes.

Objective A. The NPAIHB will focus its efforts on preventing avoidable morbidity and mortality - promoting the physical, mental, social, and spiritual health of AI/AN people throughout all phases of life.

Indicators for Monitoring and Evaluation: Priority health topics and intervention strategies will be identified on an annual basis by the NW Tribal EpiCenter, and will be considered when seeking new funds and designing new services.

Objective B. The NPAIHB will provide capacity building assistance (including training, technical assistance, and resource development) on priority health promotion and disease prevention topics and on key public health principles identified by the NW Tribes.

Indicators for Monitoring and Evaluation: NPAIHB projects will document capacity building activities in their monthly and quarterly activity reports, and in articles, newsletters, case studies, and funding reports.

Objective C. NPAIHB projects will support the development, implementation, and evaluation of culturally-rooted health promotion practices within the NW Tribes, and will adapt existing policies, educational materials, curricula, and evidence-based interventions to reflect the traditional values and teachings of the NW Tribes.

Indicators for Monitoring and Evaluation: NPAIHB projects will document these activities in monthly and quarterly activity reports, and in articles, newsletters, case studies, toolkits, and funding reports. Projects will promptly share these resources with the NW Tribes and relevant partners using existing NPAIHB communication channels.

Objective D. To improve tribal awareness about important health topics, the NPAIHB will facilitate community education and public relations efforts by developing social marketing campaigns, cultivating media contacts, and by producing press releases and "expert" health articles for placement in tribal papers.

Indicators for Monitoring and Evaluation: The NPAIHB will maintain up-to-date media contact lists, and will document the dissemination of community awareness materials in monthly and quarterly activity reports.

Objective E. NPAIHB projects will facilitate regional planning and collaboration by developing and implementing intertribal action plans that address priority health topics, and by hosting regional trainings, meetings, webinars, and conference calls that produce a coordinated, regional response to tribal health needs.

Indicators for Monitoring and Evaluation: NPAIHB projects will document regional planning activities and outcomes in their monthly and quarterly activity reports, and in articles, newsletters, case studies, and funding reports.

GOAL 5: The NPAIHB will support the conduct of culturally-appropriate health research and surveillance among the Northwest Tribes.

Objective A. The NW Tribal EpiCenter will respond to the needs and interests of the NW Tribes by obtaining regular feedback and guidance from tribal advisory groups, target audience members, and key personnel during all phases of the research process, and by conducting an annual survey to prioritize public health topics, capacity building needs, and research activities.

Indicators for Monitoring and Evaluation: The EpiCenter will document strategies used to obtain community input and guidance in quarterly and annual activity reports.

Objective B. The NW Tribal EpiCenter will assess the health status and health needs of the NW Tribes by conducting culturally-appropriate research and by accessing new and existing AI/AN health data.

Indicators for Monitoring and Evaluation: EpiCenter projects will document quantitative and qualitative research activities in monthly and quarterly activity reports, and will generate or locate data using data collection tools, RPMS, and state and national data sources.

Objective C. The NW Tribal EpiCenter will communicate the results of its research, surveillance, and capacity building activities to appropriate stakeholders. This information will be designed to: 1) assist the NW Tribes in their community outreach activities, public health planning, and policy advocacy; 2) share important findings across Indian Country and extend the scholarly AI/AN research agenda; and 3) increase public awareness about the function and benefits of tribal EpiCenters.

Indicators for Monitoring and Evaluation: EpiCenter projects will document research and surveillance reports, publications, presentations, and other data-sharing activities in quarterly and annual activity reports.

Objective D. The NW Tribal EpiCenter will protect the rights and wellbeing of the NW Tribes and tribal research participants by using and housing the Portland Area IHS Institutional Review Board (IRB). The IRB and EpiCenter projects will recognize tribal research methods and requirements, and will work to ensuring tribal ownership of resultant data.

Indicators for Monitoring and Evaluation: EpiCenter projects will obtain IRB approval before initiating research with the NW Tribes, and will carry out research protocols required by the IRB and the NW Tribes.

Objective E. The NW Tribal EpiCenter will provide the NW Tribes with capacity building assistance (including training, technical assistance, and resource development) on epidemiologic skills and research methods.

Indicators for Monitoring and Evaluation: The EpiCenter will document capacity building activities that address epidemiologic skills and research methods in monthly and quarterly activity reports.

Core Organizational Values

The Northwest Portland Area Indian Health Board:

- Is a tribally driven organization, which respects tribal leadership, recognizes the diverse needs of tribes, is inclusive and equitable, values consensus decision making, and seeks to preserve the unity of Northwest Tribes.
- Acknowledges and actively supports efforts to uphold the federal trust responsibility.
- Is a role model of holistic health (physical, mental, spiritual, and emotional), derived from traditional values – both in personal and organizational behavior.
- Respects the traditional and cultural values of all member tribes and communities.
- Strives to provide service to member tribes at the highest possible standard in the quality of work performed.
- Models leadership, which is visionary, courageous, progressive, hard working, dedicated, resilient, committed, knowledgeable, creative, respectful, and trusting.
- Provides Northwest Tribes with influential and effective advocacy, which supports tribal sovereignty and strong government-to-government relations.
- Believes in and promotes community education, health promotion and disease prevention.
- Is a credible resource for health-related technical assistance, education, information, and coordination.
- Is family centered and provides for work-family-community balance.
- Acknowledges, respects, and values the wisdom of our tribal elders.

1978 Articles of Incorporation

This organization was formed as a result of the President's desire to promote self-determination of Indian people. Its purpose is to advise Indian Health Service in the development and implementation of health care and delivery to Indians in the tri-state area of Washington, Oregon and Idaho. It provides resource help and training to Indian Community Health Representatives, health education designed to promote Indian community development and conducts research activities designed to evaluate current government programs and to suggest areas of improvement in current programs of Indian reservations as well as the development of new programs. We are currently providing a monthly Health Newsletter designed to foster inter-tribal communications between the tribes in the Northwest. On-going training is developed in health related areas. Research at the present involves the evaluation of the Indian Health Service Contract Health Service System. We also carry out a counseling and recruitment program for Indian students preparing for health related careers.

Signed by: *Delbert Frank Jr., Violet Hillaire, & Melvin Sampson*

Frequently Asked Questions – Accountable Communities of Health

Accountable Communities of Health (ACHs) are an essential component of Washington's Health Innovation Plan, known as "Healthier Washington," which aims to transform the health system in the state to bring better health, better care and lower costs to Washington residents. The following provides basic information about ACHs, what they could mean to you or your organization, and how to become involved.

Washington's nine ACHs are each at different stages of development. As a part of the Innovation Plan testing how to best achieve needed transformation, they will continue to evolve. This document will be updated and the most up-to-date version will be available on the website (http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx). Please inform the Community Transformation Team (CommunityTransformation@hca.wa.gov) if the information you are looking for is not here, or if what is said here does not match your actual experience.

1. **What is an Accountable Community of Health?**
   An Accountable Community of Health is a group of leaders from a variety of sectors in a given geographic area with a common interest in improving health. Participating, among others, are health and long-term care providers, health insurance companies, public health agencies, school districts, criminal justice agencies, non-profit social service agencies, legal services organizations, tribes, and philanthropic agencies. With support from the state, they are voluntarily organizing to coordinate activities, jointly implement health-related projects, and advise state agencies on how to best address health needs within their area. They are not intended to duplicate or replace existing services.

   There are nine ACHs that together cover the entire state, with the boundaries of each aligned with the state's Medicaid regional service areas.

2. **What is the history of ACHs? Where did the idea come from?**
   Community-based, cross-sector coalitions dedicated to improving health at the local level have existed in Washington for many years. Recognition or support from the state has been limited and inconsistent, including a grant program in statute since 2006, but not funded since 2008. Their potential was explicitly revisited and acknowledged in Washington's 2013 State Health Care Innovation Plan. It called for creating a new partnership between the state and these types of organizations that would draw on the unique strengths of each.

   At the same time, other states were moving in a similar direction with their health reform efforts, and their success with "Accountable Communities" gave Washington further reason to pursue its own version – built on existing organizations, but designed to serve other interests called out in the Innovation Plan. State legislation passed in 2014 provided criteria and funding for two community of health pilot sites.

Additional specifications and funding to support ACHs were included in the State Innovation Model Test Award received by the state from the federal government later that year.

3. **Why is Washington State supporting ACHs?**
   Because working with community-based, cross-sector coalitions is an effective and efficient way to transform the health system in the state. In developing its Innovation Plan, the state sought an approach that:
   - Takes advantage of local knowledge and relationships to drive change in places where individuals are directly served;
   - Allows those involved at the local level to each focus on what they do best, but in ways connected to and complementary of the contributions of others nearby; and
   - Addresses through this collaboration both clinical care and social factors affecting health such as poor nutrition and inadequate housing. The state understands these things will not happen if they depend solely on random, informal contacts, but require the structure and intentional action brought by ACHs.

4. **Which state agencies are supporting the development of ACHs and how are they doing so?**
   Primary support for ACHs, in the form of grants and technical assistance, comes from the Health Care Authority (HCA), the state agency leading the implementation of Healthier Washington. Working with the Department of Social and Health Services and the Department of Health, HCA establishes grant criteria, evaluates applications and makes the awards, and monitors performance and compliance with the terms and conditions of the grant. Technical assistance to support the development and initial operation of ACHs is being provided by a team of outside experts and consultants under contract with the HCA. Internally, these three agencies are looking at their own programs to determine if and how they might be better aligned to model the same collaboration expected at the local level, while eliminating any inadvertent obstacles to ACH success.

5. **Are all ACHs the same?**
   ACHs are similar in matters of statewide significance or where necessary for them to function as part of Healthier Washington. Each ACH, for example, shares the same general purpose, has (or will have) a formal governance structure and bylaws, and includes representation from a diverse and broad cross-section of entities. Each ACH will also play a similar role in projects implemented statewide, such as the Practice Transformation Support Hub. ACHs are different based on regional preference and priorities, such as the details of their governance structure, the particular entities participating, and the projects each undertakes in response to the unique health concerns of their region.

6. **Who administers and governs ACHs?**
   ACHs are administered and self-governed at the regional level along general guidelines in the state's funding criteria. This gives each ACH discretion to do what works best for its region, but also means that none are organized or operate in exactly the same way.

   For some ACHs, the backbone organization is a local public health agency. For others, it is a non-profit organization with a history of health reform activity in the region.

   While the backbone organization may help develop the governance structure, it does not itself govern the ACH. Each ACH is instead governed by its local participants under a structure they design. It typically involves a board or committee to discuss issues brought to it and to make decisions.

   The challenge for each ACH is to involve enough people in governance that the appropriate regional interests are represented, but to do so in a way that decisions get made and the organization remains functional. Achieving this balance will continue to result in creative, bottom-up approaches, the merits of which Healthier Washington is intended to test.

7. **How are ACHs funded? What does this money buy?**
   ACHs are funded partly with grants from the Washington State Health Care Authority (HCA), using money from the State Innovation Model grant issued by the federal Center for Medicare and Medicaid Innovation (CMMI). These funds allow each ACH to have part-time staff for design and initial development, and hold necessary regional meetings.

   In 2014, the legislature also made a state general-fund appropriation to the HCA for two pilot ACHs. ACHs supplement these funds with in-kind contributions and grants from other private and public sector organizations, some who participate in the ACH. The grant from CMMI also funds staff and consultants at the HCA and other state agencies who partner with and support ACHs statewide.

   ACHs are working with the state to develop financial sustainability plans. These plans will likely draw on both local and state resources, including additional state grants and contracts, and the reinvestment of any savings that the ACHs help generate in health care or other areas.

8. **Do ACHs have regulatory authority? What are they otherwise authorized to do?**
   ACHs do not have regulatory authority. They are community-based organizations acknowledged in state statute. They will be called on, as are many others, to provide state agencies with advice and recommendations and help implement state

programs. Although some receive administrative support from a local public health agency, ACHs themselves are not political subdivisions of the state and have not been delegated any independent authority to regulate or otherwise control activities of individuals or institutions within their region.

Although not granted any unique statutory authority, ACHs otherwise have the same general powers enjoyed by any organization. What each does is determined by agreement of their local participants based on their governance structure and process. Among other things, they can agree to accept grants or otherwise contract with outside parties, including the state. An ACH doing so would then be expected to execute the contract, and be subject to any of its terms and conditions, including performance standards.

9. **What role will ACHs play in Medicaid purchasing? What is their relationship to Medicaid Managed Care Organizations?**
   ACHs will evaluate health needs within their region, take local action on those needs, and where appropriate, advise state agencies. Given Medicaid's importance to health, ACHs will join others in providing feedback on the design and operation of the program, and how it might be improved, particularly from a local perspective.

   As Medicaid changes to better integrate physical and behavioral health care, and to link clinical care with other community services, the collective, multi-sector insights of ACHs will be critical to designing a supportive payment structure. However, ultimate legal and financial responsibility for Medicaid contracting, including monitoring and oversight, will remain with the state.

   Medicaid Managed Care Organizations (MCOs) are active participants in ACHs throughout the state, and some have contributed funding and other resources. Independent of their participation in ACHs, however, the state will continue to contract with MCOs as the risk-bearing entities for Medicaid. There is no intent to transfer this risk-bearing function to ACHs.

   More details on expectations surrounding the ACH-MCO partnership can be found on the Healthier Washington website.

10. **What is the role proposed for ACHs in Washington's Medicaid transformation waiver? Are they prepared for this?**
    The waiver application proposes that the Health Care Authority (HCA) contract with ACHs to coordinate Medicaid transformation projects within their region. In this role, an ACH will oversee projects intended to further the goals of Healthier Washington. This could include soliciting, reviewing or helping prepare project applications, distributing state funds to those within the region responsible for implementation, and reporting on progress. This role is consistent with the general purpose and

developing capacity of ACHs to facilitate regional collaboration towards improved health.

The HCA has begun negotiating the terms and conditions of the waiver with the federal Centers for Medicare and Medicaid Services. If they reach agreement and the application is approved, the state will allow ACHs the time and resources needed to prepare for and carry-out the particular expectations it makes of them. If an ACH is not ready it will not be given this responsibility, with the state then contracting with another organization to implement this portion of the waiver.

More information about the waiver, including the application and directions on how to provide input as it progresses, is available on the Healthier Washington website.

11. **What does it mean for an organization to be formally "designated" an ACH by the Health Care Authority? Does it change its responsibilities or authority?**
Formal designation as an ACH by the Health Care Authority is a step in the organization's development process that qualifies it for additional state grant funding. It generally recognizes the ACH has the basic infrastructure to continue building a successful organization. Designation requirements include:
    - Balanced, multi-sector representation;
    - The launch of community engagement activities;
    - The ability to perform basic financial and administrative functions;
    - Initial identification of regional health needs and priority projects; and
    - Establishment of an initial budget, including a plan for continued funding.

    Designation is an important benchmark that demonstrates progress and potential, and qualifies an ACH for additional grant funding to support its ongoing development. However, it does not change the general role or legal status of the ACH, or indicate a readiness to take on all conceivable ACH functions.

    For details on ACH designation, including the relevant criteria and process, see the Healthier Washington website.

12. **What are ACHs actually doing to improve health? Are there concrete examples?**
Many ACHs are still in the planning and development stage and have yet to decide which health improvement projects they will pursue. The Health Care Authority's Community Transformation Team will compile a list and share information about all of the projects as they are identified. A project started by the Cascade Pacific Action Alliance (CPAA) as a pilot ACH offers an example of the type of work ACHs across the state may do.

    CPAA found a need within their region for earlier identification and treatment of children with mental health or chemical dependency issues. They formed a work

group, including representatives of school districts, social service organizations, health care providers and others. The work group selected behavioral health screening tools, identified treatment resources within the region, discussed the roles of school staff and treatment providers, and mapped how these roles would be coordinated on behalf of the children. It developed a test site selection process, and by early 2016 will begin testing the project at four schools.

13. **Who should be involved with ACHs? What types of entities are already involved?**
    If you or your organization have any responsibility for the health of your community, through clinical care, social services or otherwise, you should consider becoming involved with ACHs. ACHs represent a formal opportunity to achieve results you will not get working alone. They do this by connecting those with similar concerns and goals, allowing them to share information and coordinate activities. They are also a place to discuss what is expected, and from whom, in transforming health care in the region. And with the cross-sector representation, you will learn when and how to engage others to help residents whose needs are beyond your responsibility or expertise. Becoming involved will also give you a greater voice in identifying regional health needs and advising how to address them.

    Those already involved include but are not limited to: health and long-term care providers, health insurance companies, public health agencies, school districts, criminal justice agencies, non-profit social service agencies, legal services organizations, tribes, and philanthropic agencies.

14. **Are ACHs only about Medicaid? Should those whose interests are primarily related to commercial health coverage also be involved?**
    Healthier Washington is intended to transform all parts of the state's health system. As such, ACHs focus not only on a particular sub-population or payment system but represent health across the entire continuum and population within the region, from babies to seniors. Medicaid is expected to lead by example, primarily by changing the way it purchases care and services, with ACHs contributing to this process.

    However, Medicaid payment reform and corresponding changes in care delivery will influence – and be influenced – by what goes on in the commercial market. With the right people involved, ACHs can help keep all participants appropriately aligned, avoiding inconsistent approaches that serve primarily to confuse. If you or your organization have any responsibility for the health of your community, either for Medicaid enrollees or otherwise, you should consider becoming involved with ACHs.

15. **What is the best way to become involved with ACHs? Is it too late? Are there any prerequisites?**
    It is certainly not too late to become involved. The only prerequisites are that you have an interest and/or role – through clinical care or other community services – in

the health of residents within the region covered by the ACH, and a willingness to abide by its process. How to best become involved depends on who you are, the resources you have available, and in which of the nine ACHs you are interested.

Statewide associations (such as health care provider associations) should encourage their individual members to engage with their local ACH, with the association's leadership working with Healthier Washington partners and state agency staff. Other statewide organizations that provide services to residents of more than one region (such as health insurance companies or health systems) will want to be involved at the state level, and at the regional level with as many corresponding ACHs as their resources allow.

Because each ACH is structured differently and is at a different stage of development, seek advice on becoming involved directly from those ACHs in which you have an interest. Contact information for the ACH backbone leads and administrative support team is here.

16. **Frequent mention is made of ACH "members." Do members have responsibilities or privileges others involved with ACHs do not? How does one become a member?**
"Member" was the term initially used in Health Care Authority documents to describe any individual or organization formally involved with ACHs. It was not meant to imply a preferential status for some in the region over others. Going forward the intention is to use the term "participants" rather than "members."

Like any organization, ACHs have an operational structure in which participants may each have different roles. It is not practical to give everyone a position on the governing board, and a position on the governing board is not the only way to participate. Involvement at the project level will become increasingly important as ACHs develop. ACHs are confronting the challenge of collectively but effectively engaging the large number of entities across multiple sectors with a role in improving health. And as with any innovation, the ACHs will evolve as they determine what works and what does not.

17. **How can state agency policies concerning the role and operation of ACHs be influenced?**
Because agencies are looking to ACHs themselves to help shape relevant state policies, participating at the regional level is a way to influence them.

Organizations that typically, work directly with the state, such as statewide organizations, may continue to contact the Community Transformation Team or other agency staff directly. State agencies are considering development of a more structured, efficient and timely process for gathering state level input on ACH policy. Thoughts on what this should look like are welcome.

Northwest Portland Area Indian Health Board

Established in 1972, the Board is a non-profit tribal organization serving the 43 federally recognized tribes of Oregon, Washington, and Idaho.

INDIAN LEADERSHIP FOR INDIAN HEALTH

NPAIHB: 2010-2015

Vision: Wellness for the 7th Generation

Mission: Eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest tribes in their delivery of culturally appropriate, high quality healthcare.

Goal 1 - Build and maintain a strong organizational infrastructure supporting tribal health.

Goal 2 - Strengthen regional and national partnerships to ensure tribal access to the best possible health services.

Goal 3 - Maintain leadership in the analysis of health-related budgets, legislation, and policy.

Goal 4 - Support health promotion and disease prevention activities occurring among the Northwest Tribes.

Goal 5 - Support the conduct culturally-appropriate health research and surveillance among the Northwest Tribes.

2016-2020

Handout: To Provide Feedback

NPAIHB: Vision

The People Spoke: This is their Vision

- The seventh generation will have balanced physical, mental, emotional, and spiritual lifestyles. They will have healthy diets, be fit, active, and happy.
- The seventh generation will live in sovereign communities that are politically effective, assertive, goal-oriented, thriving economically, and run by AI/AN people.
- The seventh generation will live in a unified and poverty-free community made up of stable, loving families living in adequate housing.
- Children will be healthy and free of chemical substances. They will experience strong parenting, mentorship, and positive role models as youth and will become involved and empowered leaders.

NPAIHB: Vision

The People Spoke: This is their Vision

- The seventh generation will live in accordance with their traditional values by knowing their native languages and practicing spiritual and cultural traditions.
- The seventh generation will live in a clean environment, have access to an abundance of natural resources, respect all life, and practice sustainable and socially responsible environmental stewardship.
- Every member of the seventh generation will have access to technologically advanced and culturally appropriate health care that includes well-equipped clinics, wellness centers, and health education; a health care delivery system that could serve as a national model.

NPAIHB: Vision

The People Spoke: This is their Vision

- The seventh generation will have adequate resources to support health care delivery including: established networks with state and federal agencies, foundations and universities, research and information availability, financial resources, professional staff, and information technology.
- The health of the seventh generation will be a model for the general population. They will experience no preventable illnesses and no substance abuse or addictions. Cures will be found for cancer, diabetes, mental health diseases, and HIV/AIDS. Old age will be the leading cause of death.
- The seventh generation will respect and care for their elders and celebrate as they live to 100 years or more.

The mission of the Northwest Portland Area Indian Health Board is to eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest Tribes in their delivery of culturally appropriate, high quality healthcare.

VISION

Mission

Has our VISION changed?

Has our MISSION changed?

Organizational Values

Discussion:
Vision and Mission

GOAL 1: The NPAIHB will build and maintain a strong organizational infrastructure supporting tribal health in the Pacific Northwest.

A. NPAIHB will provide a forum for developing timely tribal consensus on healthcare issues affecting the NW Tribes by hosting productive Quarterly Board Meetings that facilitate face-to-face communication and resource sharing with state and federal programs.

B. NPAIHB will support tribal delegates in regional and national AI/AN healthcare discussions, by providing them with orientation, training, and assistance.

C. NPAIHB will maintain effective communication channels to inform tribal delegates and tribal decision-makers about emerging public health topics.

GOAL 1: The NPAIHB will build and maintain a strong organizational infrastructure supporting tribal health in the Pacific Northwest.

D. NPAIHB will provide the NW Tribes with capacity building assistance (including training, technical assistance, and resource development) on healthcare management principles and Information Technology.

E. The NPAIHB will actively research health-related funding opportunities, will disseminate funding announcements to member tribes, and will educate federal agencies on strategies to ensure that federal funding opportunities align with the priorities, needs, and organizational capacities of the NW Tribes.

GOAL 1: The NPAIHB will build and maintain a strong organizational infrastructure supporting tribal health in the Pacific Northwest.

F. NPAIHB will build a strong organizational infrastructure by recruiting and retaining high-quality staff, by encouraging their ongoing education and training, and by actively implementing the organization's mission and values to provide employees with comprehensive wellness benefits.

G. NPAIHB will help develop tribal youth into future leaders in healthcare by making NPAIHB meetings and trainings accessible to youth, and by offering internships to interested students. When appropriate, NPAIHB projects will integrate youth leadership training and travel opportunities into the scope of work of new projects

GOAL 2: The NPAIHB will strengthen regional and national partnerships to ensure tribal access to the best possible health resources and services.

A. NPAIHB will build and maintain effective, collaborative relationships with current and potential partners, including the NW Tribes, the Indian Health Service, Indian organizations, Federal agencies, State Health Departments, Universities, funding agencies, community-based organizations, and other interdisciplinary social service providers that promote AI/AN health.

B. The NPAIHB will actively contribute to regional and national workgroups, coalitions, and committees that address priority health topics identified by the NW Tribes, and key health promotion and disease prevention workgroups.

GOAL 3: The NPAIHB will maintain leadership in the analysis of health-related budgets, legislation, and policy, with the ability to facilitate consultation and advocate on behalf of member Tribes.

A. The NPAIHB will facilitate communication among Tribes, Federal and State agencies, and Congress to support tribal sovereignty, promote self-determination, and ensure that government-to-government consultation occurs on health-related budgets, legislation, policies, and services.

B. The NPAIHB will advocate on behalf of the NW Tribes to ensure that tribal interests are taken into account as health policy is formulated, and that Congress, State legislatures, and external agencies have a full understanding of AI/AN health needs and concerns (particularly in relation to treaty rights and healthcare in Indian Country).

GOAL 3: The NPAIHB will maintain leadership in the analysis of health-related budgets, legislation, and policy, with the ability to facilitate consultation and advocate on behalf of member Tribes.

C. The NPAIHB will stay at the forefront of budgetary, legislative, and policy initiatives affecting the NW Tribes, including the President's annual budget, national healthcare reform initiatives, IHS policies and strategies, and proposed changes to Medicare and Medicaid, and will assess their impact on the Northwest Tribes.

D. The NPAIHB will analyze new and existing healthcare delivery systems and will and advocate for tribal consultation and participation in their development.

GOAL 3: The NPAIHB will maintain leadership in the analysis of health-related budgets, legislation, and policy, with the ability to facilitate consultation and advocate on behalf of member Tribes.

E. The NPAIHB will evaluate the feasibility of assuming certain Portland Area Office programs, functions, services, or activities on behalf of Portland Area Tribes, and if approved and selected, will carry them out in an agreement negotiated under the Indian Self-Determination and Education Assistance Act (P.L. 93-638).

GOAL 4: The NPAIHB support health promotion and disease prevention activities occurring among the Northwest Tribes.

A. The NPAIHB will focus its efforts on preventing avoidable morbidity and mortality - promoting the physical, mental, social, and spiritual health of AI/AN people throughout all phases of life.

B. The NPAIHB will provide capacity building assistance (including training, technical assistance, and resource development) on priority health promotion and disease prevention topics and on key public health principles identified by the NW Tribes.

GOAL 4: The NPAIHB support health promotion and disease prevention activities occurring among the Northwest Tribes.

C. NPAIHB projects will support the development, implementation, and evaluation of culturally-rooted health promotion practices within the NW Tribes, and will adapt existing policies, educational materials, curricula, and evidence-based interventions to reflect the traditional values and teachings of the NW Tribes.

D. To improve tribal awareness about important health topics, the NPAIHB will facilitate community education and public relations efforts by developing social marketing campaigns, cultivating media contacts, and by producing press releases and "expert" health articles for placement in tribal papers.

GOAL 4: The NPAIHB support health promotion and disease prevention activities occurring among the Northwest Tribes.

E. NPAIHB projects will facilitate regional planning and collaboration by developing and implementing intertribal action plans that address priority health topics, and by hosting regional trainings, meetings, webinars, and conference calls that produce a coordinated, regional response to tribal health needs.

GOAL 5: The NPAIHB will support the conduct of culturally-appropriate health research and surveillance among the Northwest Tribes.

A. The NW Tribal EpiCenter will respond to the needs and interests of the NW Tribes by obtaining regular feedback and guidance from tribal advisory groups, target audience members, and key personnel during all phases of the research process, and by conducting an annual survey to prioritize public health topics, capacity building needs, and research activities.

B. The NW Tribal EpiCenter will assess the health status and health needs of the NW Tribes by conducting culturally-appropriate research and by accessing new and existing AI/AN health data.

GOAL 5: The NPAIHB will support the conduct of culturally-appropriate health research and surveillance among the Northwest Tribes.

C. The NW Tribal EpiCenter will communicate the results of its research, surveillance, and capacity building activities to appropriate stakeholders. This information will be designed to: 1) assist the NW Tribes in their community outreach activities, public health planning, and policy advocacy; 2) share important findings across Indian Country and extend the scholarly AI/AN research agenda; and 3) increase public awareness about the function and benefits of tribal EpiCenters.

GOAL 5: The NPAIHB will support the conduct of culturally-appropriate health research and surveillance among the Northwest Tribes.

D. The NW Tribal EpiCenter will protect the rights and wellbeing of the NW Tribes and tribal research participants by using and housing the Portland Area IHS Institutional Review Board (IRB). The IRB and EpiCenter projects will recognize tribal research methods and requirements, and will work to ensuring tribal ownership of resultant data.

E. The NW Tribal EpiCenter will provide the NW Tribes with capacity building assistance (including training, technical assistance, and resource development) on epidemiologic skills and research methods.

VISION

Mission

Have our GOALS changed?

Have our OBJECTIVES changed?

Organizational Values

Discussion:
Goals and Objectives

NPAIHB: Priorities 2013

NPAIHB: Priorities 2013

Arthritis and joint diseases	7.69%
Asthma	3.85%
Cancer	23.08%
Commercial tobacco use	7.69%
Dental health	15.38%
Diabetes	42.31%
Environmental health	0%
Heart health and cardiovascular disease	42.31%
Immunizations	0%
Infectious diseases	3.85%
Maternal and child health	11.54%
Mental health	19.23%
Nutrition and availability of healthy food	7.69%
Occupational Health	0%
Overweight and obesity	23.08%
Sexual health and sexually transmitted infections	0%

Substance abuse	61.54%
Suicide	7.69%
Unintentional injury (traffic crashes, falls)	0%
Violence and abuse	11.54%
Vision or hearing loss	3.85%
Other priority area(s) not listed above:	3.85%

VISION

Mission

Have our health PRIORITIES changed? We'll review and discuss this tomorrow…

Organizational Values

NPAIHB: Organizational Values

The Northwest Portland Area Indian Health Board:

- Is a tribally driven organization, which respects tribal leadership, recognizes the diverse needs of tribes, is inclusive and equitable, values consensus decision making, and seeks to preserve the unity of Northwest tribes.
- Acknowledges and actively supports efforts to uphold the federal trust responsibility.
- Is a role model of holistic health (physical, mental, spiritual, and emotional) derived from traditional values – both in personal and organization behavior.

NPAIHB: Organizational Values

The Northwest Portland Area Indian Health Board:

- Respects the traditional and cultural values of all member tribes and communities.
- Strives to provide service to member tribes at the highest possible standard in the quality of work performed.
- Models leadership, which is visionary, courageous, progressive, hard working, dedicated, resilient, committed, knowledgeable, creative, respectful, and trusting.
- Provides Northwest tribes with influential and effective advocacy, which supports tribal sovereignty and strong government-to-government relations.

NPAIHB: Organizational Values

The NPAIHB:

- Believes in and promotes community education, health promotion and disease prevention.
- Is a credible resource for health-related technical assistance, education, information, and coordination.
- Is family centered and provides for work/family balance.
- Acknowledges, respects, and values the wisdom of our tribal elders.

VISION

Mission

Have our ORGANIZATIONAL VALUES changed?

Organizational Values

2016-2020

Discussion:

2016-2020 Review Process

NPAIHB 2010 STRATEFIC PLAN WORK PLAN REPORT

To view the full NPAIHB Strategic Plan follow this link.

GOAL 1: The NPAIHB will build and maintain a strong organizational infrastructure supporting tribal health in the Pacific Northwest.

Objective	Indicators for Monitoring/ Evaluation	Timeline	Projects' Goals (Accomplishments in Line with Strategic Plan)
1. NPAIHB will provide a forum for developing timely tribal consensus on healthcare issues affecting the NW Tribes by hosting productive QBM that facilitate face-to-face communication & resource sharing with state & federal programs	Number of Quarterly Board Meetings Held Number of Resolutions passed	October 2010 to October 2015	Twenty one Quarterly Board meetings were held between October 2010 to October 2015, inclusive. During the rating period, three collaborative meetings were held with the California Rural Indian Health Board (CRIHB), two in California and one in Washington. During the rating period 102 resolutions were developed and passed by the Board.
2. NPAIHB will support tribal delegates in regional & national AI/AN healthcare discussions, by providing them with orientation, training & assistance	Training will be provided in the form of new delegate orientation	October 2010 to October 2015	All new delegates received orientation; most orientation has occurred during the first day of the first Board meeting attended at the same time as Board Committees are meeting with follow-up as needed to answer questions. The orientation manual was updated regularly, including input form Board Secretary & Treasurer The updated orientation manual is also posted to the delegates iPad
3. NPAIHB will maintain effective communication channels to inform tribal delegates & tribal decision-makers about emerging public health topics	Issues of Health News and Notes will be developed quarterly A weekly e-mail correspondence to tribal leadership will be undertaken	October 2010 to October 2015	During the period of October 2010 to 2015, 21 issues of health news and notes were developed. During the rating period of October 2010 to 2015, over 250 postings and updates were provided to tribal leadership. In addition to the quarterly Health News & Notes, a weekly posting of health information has occurred regularly on Friday during this strategic plan with exception of December holidays in 2013. The weekly posting subscription list has grown; as of October 2015 it is sent to 141 email addresses, including all tribal chairman, health directors & delegates

			IT: 4 tribal health director meeting presentations with MU updates NWTEC Staff developed numerous fact sheets on disease specific concerns at the regional and local level for tribes in the Northwest.
4. NPAIHB will provide the NW tribes with capacity building assistance(including training, TA, resource development) on healthcare management principles & information technology		October 2010 to October 2015	Established NPAIHB regional extension center MU Support center section of NPAIHB.ORG website, including training materials & locally developed resources Provided assistance to 15 Portland Area sites for e-prescribing, a requirement for MU and a patient safety improvement Regular one-on-one work with sites on MU questions Comprehensive Cancer Tribal BRFSS: Provided BRFSS interview training to 5 NW sites. Provided each site with a tailored presentation of the specific interview manual and instrument for their survey. Assisted in the BRFSS interview training manual, provided feedback & went through mock interviews with each research assistant, During the rating period, six trainings on Public Health Emergency management were held. NPAIHB provided Public Health Accreditation 101 training multiple times. NPAIHB provided understanding data training to 30 participants in 2015. This training will be provided again. Each year during the reporting period, the Risky Business Training, Native Fitness Training, DMS Training, and Immunization support training were provided. Training and TA were provided for the Portland Area Office Institutional Review Board submission process. Additionally, during the rating period NPAIHB provided host facilities for numerous IHS trainings, including EHR training, and ICD-10 training.
5.NPAIHB will actively research health-related funding opportunities, will disseminate funding announcements to member tribes and will educate federal agencies to ensure that federal funding	Number of funding newsletters provided during the period of	October 2010 to October 2015	Funding newsletters were included in the Friday information e-mail on a monthly basis, with other opportunities added to the mail out on an ad hoc basis. Staff provided TA to delegates of the Board to a variety of HHS standing committees:

opportunities align with the priorities, needs and organization capacities of the NW tribes	evaluation Provide membership and staffing to tribal advisory committees to HHS		Direct Service Tribes Advisory Committee IHS Budget Formulation Workgroup IHS FAAB CMS Tribal Technical Advisory Committee CDC Tribal Consultation Advisory Committee National Indian Health Board TSGAC Technical Workgroup Portland Area Facilities Advisory Committee Fund Distribution Workgroup Health Research Advisory Committee
6. NPAIHB will build a strong organizational infrastructure by recruiting & retaining high-quality staff, by encouraging their ongoing education training and by actively implementing the organizations mission & values to provide employees with comprehensive wellness benefits	Number of employees Number of employees hired Longevity of staff Number of staff utilizing wellness benefits; including wellness time, baby friendly workplace policies, and education leave Number of staff utilizing Board provided scholarships for training (NARCH scholars and fellows)	October 2010 to October 2015	The Program Operations manual has been annually updated to conform to federal & state regulations that have come into being during the period under review. This includes disclosure of financial interest in research, OFLA changes & Portland sick leave, as well as a change regarding lay-offs & annual evaluations Current staff: 47 Staff hired from 2010-2015: 21 Staff longevity: Four staff at 15 years or greater Eleven staff at 10 years to 14 years of service Thirteen staff at 5 to 9 years of service The majority of staff have taken classes at the Summer Institute, sponsored by NARCH, to continue their professional development. Twelve employees have taken advantage of the paid education leave to continue their education in health related course (2010-2015) Many staff have taken training specific to their projects & paid for by NPAIHB. In-house courses on giving presentations, effective meetings are examples of general professional opportunities & are made available to all staff, regardless of educational level The NARCH project has provided regular lunch hour speakers from various research fields & these are also available to all staff as well as to other organizations in the area The number of applicants for each open position has steadily increased, with more Indian applicants than in previous years, due to recruiting through Indian organizations, college clubs and Indian programs. The wellness benefits of the Board's employees continue to be acknowledged as being

			outstanding, by staff & outside observers. Sick leave accruals are most primarily used for preventive care & to care for family members or for parental leave when an employee has a baby. NPAIHB has been award the outstanding workplace award by the Oregonian in 2010, 2014 and 2015. This award is given based on input from employees on a survey. We consistently finish in the top 20 for small workplaces.
7. NPAIHB will help develop tribal youth into future leaders in healthcare by making NPAIHB meetings & trainings accessible to youth, and by offering internships to interested students. When appropriate NPAIHB projects will integrate youth leadership training and travel opportunities into the scope of work of new projects		October 2010 to October 2015	To date, we have had almost 36 interns, either in the office or assigned to tasks elsewhere through one of our projects. Over 60% of these interns have been AI/AN. The majority of internships at the Board are paid internships. THRIVE has held 5 Youth Specific Trainings between 2010 and 2015. A total of 359 youth have attended. We R Native have had 66 Youth Ambassadors between 2014 and 2015. The first year's leadership cohort included 16 Ambassadors and the current cohort includes 50 Ambassadors. The purpose of the Ambassadors is to provide youth leadership training to promote wellness in their communities.

GOAL 2: The NPAIHB will strengthen regional and national partnerships to ensure access to the best possible health resources & services.

1. NPAIHB will build & maintain effective, collaborative relationships with current & potential partners, including the NW tribes, IHS, Indian organizations, federal agencies, State health departments, universities, funding agencies, community-based organizations & other interdisciplinary social service providers that promote AI/AN health		October 2010 to October 2015	Sexual Assault Prevention Project: Partnered with the Oregon Sexual Assault Task Force in 2011 for the NW Collaboration Against Sexual Assault in Tribal Communities Project offering multiple trainings, webinars & TA to the NW tribes. NTCCP: Developed & maintained partnerships with the Spirit of Eagles (Mayo Clinic) Oregon, Washington & Idaho chronic disease programs, CDC, Tribal comprehensive cancer programs, OHSU, Knight Cancer Center, Legacy & Providence cancer centers, IHS, AI/AN women's health resource center WTDP: Developed & maintained partnerships with the IHS DIRM PAO, Cimarron, SDPI diabetes coordinators, Native American Fitness Council, Nike, Washington State Chronic Disease, Idaho Department of Health, Nutrition Council of Oregon Conducted DMS training for IHS Areas including Aberdeen, Alaska, Albuquerque, Billings, Nashville, Oklahoma, Phoenix IT: Partnership with WIREC/Qualis Health on Security Risk Analysis services NWTEC: The Director of the NWTEC maintains partnerships with the IHS DEDP, CDC Project Staff, HHS Staff and Directors and staff of the 11 other Tribal Epidemiology Centers.

2. NPAIHB will actively contribute to regional & national workgroups, coalitions & committees that address priority health topics identified by the NW tribes and key health promotion/disease prevention workgroups		October 2010 to October 2015	Contributions made to: Direct Service Tribes Advisory Committee IHS Budget Formulation Workgroup IHS FAAB CMS Tribal Technical Advisory Committee CDC Tribal Consultation Advisory Committee National Indian Health Board TSGAC Technical Workgroup Portland Area Facilities Advisory Committee Fund Distribution Workgroup Public Health Accreditation Advisory Board Washington State Dental Foundation meetings have been attended at least quarterly with an AI/AN focus Monthly meetings with the IHS PAO Director (pending travel schedules) NTCCP: Contributions made to: OPCC cancer advisory group, NADDC council member, Oregon Health Authority, Oregon Public Health Association (board member), IHS National Colorectal Cancer Task Force, American Association for Cancer Education WTDP: Contributions made to: National Diabetes Data Project Advisory members, Tribal Leaders Diabetes Committee, IHS National Data Team, IHS Health Literacy Workgroup, PAO ICD-10 workgroup, PAO IPC workgroup, Annual IHS Audit workgroups, Division of Diabetes Treatment & Prevention Audit Team IT: Vice Chair of IHS Pharmacy Professional Services Group (a national committee that serves as a liaison between IHS computer systems analysts & pharmacy computer system users & is charged with recommending, reviewing, implementing and evaluating appropriate pharmacy software for use in all IHS facilities & those tribal and urban health facilities using the IHS RPMS system)

GOAL 3: The NPAIHB will maintain leadership in the analysis of health-related budgets, legislation and policy with the ability to facilitate consultation and advocate on behalf of member Tribes.

1.NPAIHB will facilities communication among tribes, federal and state agencies & Congress to support tribal sovereignty, promote self-determination and ensure that government-to-government consultation occurs on health-related budgets, legislation, policies & services		October 2010 to October 2015	Communication has been facilitated via e-mail, newsletter, videoconferencing, face to face meetings and position papers.
2. NPAIHB will advocate on behalf of the NW tribes to ensure that tribal interests are taken into account as health policy is formulated and that Congress, State legislatures and external agencies have a full understanding of AI/AN health needs & concerns (particularly in relation to treaty rights & healthcare in Indian Country)		October 2010 to October 2015	Analysis performed and extensive comments submitted during public comment period for MU Stage 2 Final Rule. Staff have advocated with NIH, CDC, SAMHSA, HRSA and other HHS departments to promote NW Tribal interests and priorities in funding and programmatic areas. This advocacy is in addition to advocacy efforts with Indian Health Service, and congressional members.
3. NPAIHB will stay at the forefront of budgetary, legislative & policy initiatives affecting the NW tribes, including the President's annual budget, national healthcare reform initiatives, IHS policies & strategies , & proposed changes to Medicare & Medicaid and will assess their impact on the NW tribes		October 2010 to October 2015	NPAIHB has provided annual budget analysis to all tribal delegates and congressional staff for advocacy. IHS Budget evaluation Active in National Budget formulation Instrumental in reinstatement of All Tribes Meeting in 2015 Policy development and advocacy for: Indian definition, State Insurance Exchanges, Contract Health Support Costs, Medicaid Expansion, and all items related to the Affordable Health Care Act.
4. NPAIHB will analyze new & existing healthcare delivery systems & will advocate for tribal consultation & participation in their development		October 2010 to October 2015	Extensive on-going analysis of the Affordable Care Act and the Indian Health Care Improvement Act have been undertaken in the 5 year strategic period including; multiple meetings, marketing materials, articles and technical assistance meetings with tribal leaders, Indian Health Service partners, HHS partners, and congressional leadership.

5. NPAIHB will evaluate the feasibility of assuming certain Portland Area Office programs, function, services or activities on behalf of Portland Area tribes, and if approved and selected, will carry them out in an agreement negotiated under the Indian Self-Determination and Education Assistance Act (PL 93-638)		October 2010 to October 2015	Formal grant application for planning submitted to IHS in 2014 unfortunately was not funded. Plan for functions for potential assumption has been outlines with key positions identified. Further work needed in this area.

GOAL 4: The NPAIHB support health promotion and disease prevention activities occurring among the Northwest Tribes.

1.NPAIHB will focus its efforts on preventing avoidable morbidity & mortality – promoting the physical, mental, social & spiritual health of AI/AN people throughout all phases of life	Number of resolutions passed and project during the rating period Number of new project funding received in the period Types of funding received	October 2010 to October 2015	Area MU consultant duties – reporting on progress of each site, interpreting & disseminating updates & information about the MY program, assisting sites through registration & attestation, assisting with qualification through patient volume reports & any other help sites need in meeting MU. New Projects During this Period include – Tots to Tweens, IDEA-NW, and WEAVE-NW, Oral Health. Continued funding both competitive and continuation was obtained for a variety of programs. Funding areas include: data, car seat safety, oral health, diabetes, cancer prevention, sexual assault prevention and domestic violence prevention, adolescent health, suicide prevention, health professional training, immunization, public health policy systems and environment, injury prevention, and public health accreditation.
2. NPAIHB will provide capacity building assistance (including training, technical assistance & resource development) on priority health promotion & disease prevention topics and on key public health principles identified by the NW tribes	Number of trainings in rating period Number of TA responses and percentage of tribes requesting TA from the	October 2010 to October 2015	NARCH has provided a total of 4 Summer Institutes between October 2010 and 2015. Each summer between 12 and 18 classes are offered. Each year approximately 110 summer institute students sign up for classes, many of whom have attended previously. During the performance period three additional seminars were offered with approximately 30 students per training. Sexual Assault Prevention Project: Provided 6 Sexual Assault Response & Resource Circle trainings; 2 Sexual

	EpiCenter		Assault Nurse Examiner trainings; 1 Tribal Sexual Assault Advocacy training; 12 Tribal Sexual Assault Dynamics trainings & 4 Risky Business trainings to the NW tribes Western Tribal Diabetes Program: Responded to well over 100 requests for TA on an annual basis. IDEA-NW: Responded to over 30 requests for data & TA annually from NW tribes, NPAIHB programs, urban programs, state partners & others Public Health Improvement Program Provided 4 public health accreditation trainings; 1 quality improvement basics, 1 Cherokee Nation Lessons Learned, 2 Digital Storytelling. Public Health Improvement Program web page, 3 articles in Health News & Notes, weekly mailout posting. Provided ongoing public health accreditation & quality improvement TA to the tribes Grant evaluation and TA was provided as requested. Public Health Assessment, Action and Policy TA was provided upon request. We have provided TA to at least 39 tribes or 90% of our member tribes, at their request, as documented in our TA log.
3. NPAIHB projects will support the development, implementation & evaluation of culturally-rooted health promotion practices within the NW tribes and will adapt existing policies, educational materials, curricula and evidence-based interventions to reflect the traditional values & teachings of the NW tribes	Number of initiatives developed with culturally rooted evidence based practices and policies during the rating period.	October 2010 to October 2015	Developed & modified multiple training curriculums to be relevant to tribes, tribal organizations & tribal practices Public Health Improvement Program: Supported the implementation of the public health accreditation tribal standards via trainings, TA & outreach
4. To improve tribal awareness about important health topics, the NPAIHB will facilitate community education & public relations efforts by developing social marketing campaigns, cultivating media contacts and by producing press releases & "expert" health articles for placement in		October 2010 to October 2015	Sexual Assault Prevention Project: In collaboration with Project THRIVE developed a Sexual Assault Prevention media campaign that has been distributed & promoted nationwide The Office Manager updates the media list by calling the news agency to get the correct addresses when we send a press release & get email

tribal papers			bounce-backs
5. NPAIHB projects will facilitate regional planning & collaboration by developing & implementing intertribal action plans that address priority health topics and by hosting regional trainings, meetings, webinars and conference calls that produce a coordinated, regional response to tribal health needs		October 2010 to October 2015	Organized 2-day "VisualStory" workshop for NPAIHB/local partners. Multiple trainings were provided on digital story telling in a variety of settings, including for youth and cancer prevention and treatment programs. Public Health Improvement Program: Provided 4 public health accreditation trainings; 1 quality improvement basics, 1 Cherokee Nation Lessons Learned, 2 Digital Storytelling During the reporting period 5 emergency preparedness trainings were held and the Board participated in Cross Boarders Emergency Response Training.

GOAL 5: The NPAIHB will support the conduct of culturally-appropriate health research and surveillance among the Northwest Tribes

1.The NW Tribal EpiCenter will respond to the needs & interests of the NW tribes by obtaining regular feedback & guidance from tribal advisory groups, target audience members & key personnel during all phases of the research process and by conducting an annual survey to prioritize public health topics, capacity building needs & research activities		October 2010 to October 2015	The Projects of the EpiCenter use community-based participatory research methods to ensure NW tribes are involved in the selection of community trainings, media campaign development, research topics, the design of research methods & the interpretation of study findings The EpiCenter annual survey assists with development of priorities for projects. Survey results & other information are used to prioritize data analyses/report development. During this period four surveys have been administered to the Board.
2. The NW Tribal EpiCenter will assess the health status & health needs of the NW tribes by conducting culturally-appropriate research & by accessing new & existing AI/AN health data		October 2010 to October 2015	Project Red Talon & THRIVE: Current research includes: the Native VOICES Study, Native IYG & Texting 4 Sexual Health using the We R Native text messaging service Improving Data and Enhancing Access – Northwest (IDEA-NW): Completed almost 40 data linkages with 18 state data systems in OR, WA & ID and evaluated AI/AN misclassification in these systems. Data systems include: cancer registries, hospital discharge registries, trauma registries, STD/HIV/Communicable Disease systems, birth and death certificates, Medicaid enrollment & child blood lead registry Analyzed linkage corrected data to respond to over 50 data requests, prepared journal articles for publication, prepared data reports/fact sheet

			series & prepare state/local level tribal health profile reports Worked with Indian Health Service, tribes & urban Indian clinics to expand the representativeness of the NW Tribal Registry. Obtained access to IHS EpiDataMart in 2014 through a data sharing agreement with Indian Health Service. Developed regional AI/AN Health Profiles for Idaho, Oregon and Washington States. Obtained/accessed state & federal data sources for analysis (e.g., BRFSS, PRAMS, OPHAT, CHAT) Maintained list of data sources/resources for NW tribes. Provided planning/biostatistician support for specific groups (Adult Immunization project, MCH analyses) Wellness for Every American Indian to Achieve and View Health Equity (WEAVE NW): The WEAVE project was funded by the Centers for Disease Control and Prevention to assist Northwest Tribes in making effective Policy, Systems and Environment Change to enhance health and wellbeing in Indian Country.
3. The NW Tribal EpiCenter will communicate the results of its research, surveillance & capacity building activities to appropriate stakeholders. This information will be designed to: 1) assist the NW tribes in their community outreach activities, public health planning & policy advocacy; 2) share important findings across Indian Country & extend the scholarly AI/AN research agenda; 3) increase public awareness about the function & benefits of Tribal EpiCenters.		October 2010 to October 2015	Project findings are shared with participating sites through meetings & community reports, at QBM meetings, in Health News & Notes & are shared with other tribes at regional & national conferences During this period the Board staff has published greater than 30 articles in relevant publications, including being featured in the IHS provider on injury prevention. Lead development of the cross Tribal Epidemiology Center publication "Best Practices in American Indian Alaska Native Public Health" 2013.
4. The NW Tribal EpiCenter will protect the rights & wellbeing of the NW tribes &		October 2010 to	All NPAIHB, Tribal Epidemiology Center research projects have been reviewed & approved by the PA IHS IRB. Many projects have also required

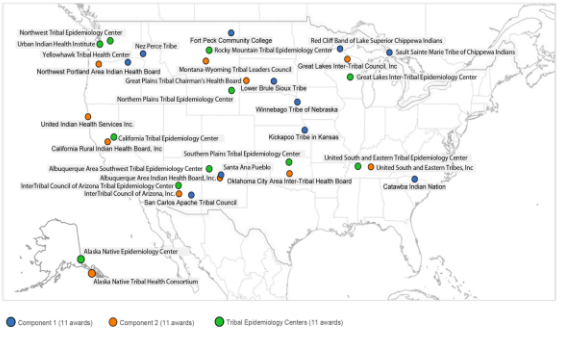
tribal research participants by using and housing the Portland Area IHS Institutional Review Board (IRB). The IRB & EpiCenter projects will recognize tribal research methods & requirements and will work to ensuring tribal ownership of resultant data		October 2015	state IRB approval. Tribes participating in projects at the NPAIHB that involve data exchange have data sharing agreements.
5. The NW Tribal EpiCenter will provide the NW tribes with capacity building assistance (including training, TA & resource development) on epidemiologic skills & research methods		October 2010 to October 2015	The NARCH program has continued to provide Summer Institute Training in research, public health and statistics. Each summer approximately 100 individuals attend this training. The Western Tribal Diabetes Program has continued to provide RPMS/DMS training to NW Tribes and others interested in the DMS system. Consultation is provided annual to all NW tribes requesting such TA, A training has been developed and delivered on understanding and using statistics for non-statisticians as a collaboration between IDEA-NW and the WEAVE Projects Created a "Linkage Resources" on project website

WEAVE - NW

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

WEAVE-NW

Comprehensive Approach to Good Health and Wellness in Indian Country Awards (DP14-1421PPHF14)



Why Policy, Systems, and Environment Focus?

- ENVIRONMENTS where we **live, learn, work, and play** shape health outcomes.
- Policy decisions made by "non-health" agencies play a major role in shaping environments.
- Upstream Approach = Prevention

Policy Change

- Laws, ordinance, resolution, protocols, MOUs, regulation, inclusion of language in mission or value statements, or rule designed to guide or influence behavior

Tribal Health Programs

Systems Change

- Changes made in organizational processes (such as personnel, resource allocation, protocols)
- Systems & policy change often work hand-in-hand

Environment Change

- Physical, observable changes in the built, economic and/or social environment.

Programs vs. PSEs

Health Promotion Programs
- Often one-time events
- One person
- Short term
- Non-sustaining

PSE Strategies
- Ongoing
- Population
- Long term
- Sustaining

Impact Examples

Health Promotion
Diabetes Education Classes → Improved Diet & Physical Activity → Improved BMI

PSE Strategy
Implement a Complete Streets Program → Improved walking and biking infrastructure → Increased Physical Activity → Reduced Prevalence of Obesity

What this means for your tribe!

WEAVE NW Resources & Technical Assistance
- ✓Public health surveillance
- ✓Tribe specific data collection and analysis
- ✓Program evaluation
- ✓Strategic action planning
- ✓Commercial tobacco prevention and intervention
- ✓Capacity development and sustainability
- ✓Best-practices in prevention and management of chronic disease

What this means for your tribe!

Monthly Webinars
- Fourth Tuesday of each month 1-2pm
- Topics vary based on requests and activities

PSE On-line Library
- Launch in 2016
- Requesting copies of any tribal policies you are willing to share anonymously or with your Tribe association

PSE Survey
- Survey Monkey link sent out Wednesday January 13th
  https://www.surveymonkey.com/r/EpiCenter2016

WEAVE-NW Team
Victoria Warren-Mears, Principle Investigator
Nanette Yandell, Project Director
Nora Alexander, Project Specialist
Jenine Dankovchik, Project Evaluator
Ryan Sealy, Tobacco Project Specialist

Northwest Portland Area Indian Health Board
Northwest Tribal Epidemiology Center
WEAVE-NW Email: weave@npaihb.org
Phone: 503-228-4185

WEAVE-NW

Monthly Webinar Series

February Topic:

Native Youth and Tobacco

Date: February 23rd, 2016

Time: 1:00-2:00pm (PST)

Summary:
This webinar will introduce the Northwest Portland Area Indian Health Board's new tobacco project. Overview on what our program can do for your Tribal tobacco program through policy, system, and environment, and cessation. Special guest speaker will be included on youth tobacco prevention!

URL Link:
https://ideanw.adobeconnect.com/r8h90cavin8/

If you have questions, please contact:

Nora Alexander *(Nez Perce)*
WEAVE Project Specialist
Northwest Portland Area Indian Health Board
Phone: 503.416.3253
email: nalexander@npaihb.org

Building a 21st Century Dental Team at Swinomish Indian Tribal Community

SWINOMISH INDIAN TRIBAL COMMUNITY

Swinomish Indian Tribal Community

- The Swinomish Indian Tribal Community is a Federally recognized Tribe, reorganized under the Indian Reorganization Act, with a reservation established by the Treaty of Point Elliott in 1855

SWINOMISH INDIAN TRIBAL COMMUNITY

Swinomish Dental Clinic

- Part of the Indian Health Service system of dental clinics
  - There are 29 I/T/U Dental Clinics in the State of Washington. In 2012, only 55% of Native Americans have access or are accessing these Clinics
  - Clinics are operated directly by the Indian Health Service or by the Tribes or Urban Indian organizations through Contracts or Self Governance Compacts
  - Indian Health Service provides only 22% of current program funding from Dental Program funds –balance comes from the Tribal general fund and 3rd Party billing, mainly Medicaid
- The SITC Dental Clinic is operated by the Swinomish Indian Tribal Community through a Self Governance Compact
- Typical 2015 staffing consisted of 1 Full time Dentist, 1 Part time Dentist, 1 Dental Hygienist, 3 Dental Assistants, 1 Support staff

SWINOMISH INDIAN TRIBAL COMMUNITY

Old I.H.S. Provided Dental Trailer Swinomish Indian Tribal Community

Swinomish Dental Clinic after Self Governance -Exercising Sovereignty

Indian Health Service Overview

- General U.S. Population has an average of 1,000 Patients per Provider/Dentist
- Typical I.H.S Provider/Dentist availability is 2,800 Patients per Provider

Typical I.H.S Provider is expected to service 86% more patients than the U.S. Dental average

SWINOMISH INDIAN TRIBAL COMMUNITY

Medical Care System in the 1970's

- Imagine when Primary Care could only be provided by an MD, i.e. no Physicians Assistants or Nurse Practitioners
- In the 21st Century, the Primary Care System is reliant on Mid-Level Providers
- Dental Practices are operating under the similar model that Medical was under in the 1970's
- Swinomish Medical Clinic has operated with Mid-Levels for 37 years!

SWINOMISH INDIAN TRIBAL COMMUNITY

Dental Health Aide Therapists provide:

- Cultural awareness and understanding of community needs
- Routine and preventive care – dentists can now prioritize more complex cases
- Improved pediatric care
- Cost savings to tribal health systems
- Relief to overburdened IHS system
- A new educational/employment field for AI/AN students

SWINOMISH INDIAN TRIBAL COMMUNITY

Alaska DHAT Scope of Practice

- **Dental Health Aid Therapist (DHAT)**

[----]----------

<50 Billable Procedures

- **DDS**

[----------]

>500 Billable Procedures

Source: Dr. Louis Fiset, BA-DDS-University of Washington

SWINOMISH INDIAN TRIBAL COMMUNITY

Why a 2 Year DHAT Program

- Competency reached with 2 years for the <50 Billable Procedures
- Curriculum fits a 2 year structure
- Training costs lower
- Graduates return to their Communities sooner
- Cost of social commitments for trainees lower

SWINOMISH INDIAN TRIBAL COMMUNITY

Alaska Native Oral Health Solution: DHATS

In 10 years, Alaskan DHATs have expanded care to over 45,000 Alaska Natives!

SWINOMISH INDIAN TRIBAL COMMUNITY

Adding a dental therapist works for the Swinomish Dental Clinic

SWINOMISH INDIAN TRIBAL COMMUNITY

- Procedure review for FY 2012, 2013 and 2014 for Swinomish Clinic showed that over 50% of procedures and services could have been provided by trained dental therapist under the Alaska model
- Analysis shows that the same procedures could have been covered with 50% personnel cost savings by replacing dentist time with dental therapist time
- Analysis shows that dentist time could have been significantly re-oriented to more complex dentist-only procedures, i.e. such as prosthodontic, advanced restorative and surgical procedures, etc.

SWINOMISH INDIAN TRIBAL COMMUNITY

ADA attempts to stop Alaska's success

Litigation against Alaska Native Tribal Health Consortium (ANTHC), individual DHATs, and the State of Alaska

- Alaska Attorney General Opinion supported IHS certification of DHATs for use in Native Villages
- Favorable State Court ruling upholding the right of IHS to certify DHATs to practice in Native Villages without a license from the State of Alaska

SWINOMISH INDIAN TRIBAL COMMUNITY

ADA attempts to stop Alaska's success

After losing its court battle in Alaska to prevent DHATs from providing services to Native Villages, the following language was inserted in the re-authorization of the Indian Health Care Improvement Act (as part of the Affordable Care Act):

Expansion of the Indian Health Service Community Health Aide Program "*shall exclude dental health aide therapist services from services covered under the program…"*

- Unless requested by *"an Indian tribe or tribal organization located in a State (other than Alaska) in which the use of dental health aide therapist services or midlevel dental health provider services is authorized under State law to supply such services in accordance with State law."*

SWINOMISH INDIAN TRIBAL COMMUNITY

Political Road to Sovereignty Solution

- Swinomish worked for 5 years with the Northwest Portland Area Indian Health Board and a coalition of community advocates, public health organizations and dental professionals to pass a bill in the Washington Legislature authorizing dental therapists to practice in Washington in order to meet the requirement of the IHCIA limiting language
- Swinomish worked for the past 2 years to pass a **Tribal Specific DHAT Authorization Bill**
- Neither bills got out of House or Senate Committees in Washington State for the past 5 years, blocked by legislators working on behalf of the Washington State Dental Association
- **Swinomish determined it has the power and obligation to address oral health systems change by exercising its Tribal Sovereignty**

SWINOMISH INDIAN TRIBAL COMMUNITY

Sovereignty in Action: Step 1

Invest in our new workforce model

- Swinomish has entered into an Agreement with the Alaska Native Tribal Health Consortium to provide DHAT Training to Swinomish members
- Swinomish has funded a Tribal Member to attend the DHAT 2 Year Training program in Alaska. Aiyana Guzman started her program in July 2015, and will graduate June 2017
- Swinomish is recruiting a second trainee to start this summer

SWINOMISH INDIAN TRIBAL COMMUNITY

Sovereignty in Action: Step 2

Build Tribal Regulatory Framework

- Swinomish created a Division of Licensing, bringing together existing Tribal licensing and regulatory functions:
  - including licensing/regulating child care services and on-Reservation businesses
  - Swinomish also self-certifies its mental health providers and regulates admission to practice in Swinomish Tribal Court
- Swinomish adopted the first Tribal Dental Health Provider Licensing Code to license and regulate Dentists, Hygienists and Dental Therapists
- This is a quintessential exercise of Tribal sovereignty: regulating Tribal providers who are employed by the Tribe, paid with Tribal funds, working in a Tribal clinic built on Tribal land, and improving the health of Tribal community members

SWINOMISH INDIAN TRIBAL COMMUNITY

Overview of Swinomish Dental Licensing Code

- Establishes Dental Health Licensing Board of five members, with five year terms:
  - Chair of Swinomish Senate's Health, Education and Social Services (HESS) Committee
  - Member of HESS Committee
  - Dentist or other individual with experience in oral health education and training
  - In dividual with education, experience, interest in and commitment to improvement in oral health among Native Americans
  - Swinomish Chief Dental Officer

SWINOMISH INDIAN TRIBAL COMMUNITY

Swinomish Dental Health Provider Licensing Board & Staff

From Left:
Dr. Rachael Hogan
Board Member
Stephen LeCuyer
SITC Staff Attorney
Tara Satushek
SITC Associate Planner
Ed Knight
SITC Director Division of Licensing
John Stephens
SITC Programs Administrator
Dr. Louis Fiset
Board Member
Brian Wilbur
Board Member

Board members not pictured: Ruth Ballweg and Diane Vendiola.

SWINOMISH INDIAN TRIBAL COMMUNITY

Overview of Swinomish Dental Licensing Code

- **Licensing Board duties**:
  - Consult with and advise Swinomish Senate and Division of Licensing on technical and policy matters, and recommend Licensing Code amendments
  - Review and approve Division of Licensing procedures and forms
  - Conduct hearings and appeals from license or sanctions decisions
- **Division of Licensing duties**
  - Investigate license application and
    - Issue license,
    - impose conditions on license,
    - or deny application
  - Investigate complaints
  - Take action to protect public or sanction licensees

SWINOMISH INDIAN TRIBAL COMMUNITY

Overview of Swinomish Dental Licensing Code

- License requirements include:
  - Must meet Tribal minimum standards of character for contact with Indian children or elders
  - Employed by Tribe or eligible for employment when licensed
  - Completed required training and education
  - Satisfied continuing education requirements
  - Demonstrate formal education, training and/or personal or professional experience that would reasonably be expected to result in cultural competence
  - If a Dentist, have experience supervising Dental Therapists or complete an acceptable course on supervision

SWINOMISH INDIAN TRIBAL COMMUNITY

Overview of Swinomish Dental Licensing Code

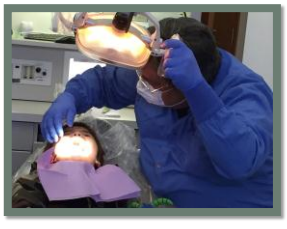
- Robust investigative and appeal provisions to:
  - protect public safety
  - provide due process to license applicants or holders
- Division of Licensing authority to impose range of sanctions:
  - Probation, with regular reporting, limited practice, continued education
  - Reprimand
  - License suspension
  - License revocation

SWINOMISH INDIAN TRIBAL COMMUNITY

Sovereignty in Action: Step 3

Provide services now!

On January 4, 2016, Daniel Kennedy, an experienced DHAT, joined the Swinomish Dental Team in making history by becoming the first Tribally licensed Dental Therapist providing services in the lower 48 states.



SWINOMISH INDIAN TRIBAL COMMUNITY

Sovereignty in Action: Step 4

Secure dental therapy model for all Tribes who want it:

- Continue to build support for legislation in Washington State to allow all Tribes to use their IHS resources towards dental therapy model in their clinics
- Build support in Washington DC to repeal the limitation in the Indian Health Care Improvement Act on expansion of DHATs by IHS outside Alaska, or to amend IHCIA to recognize and respect Tribal as well as State authority to license Dental Health Providers
- Successfully defend any legal, political, or public relations battle that Sovereignty in Action may inspire
- Demonstrate success of program using a regional and national dental therapy evaluation plan being coordinated by the Northwest Portland Area Indian Health Board

SWINOMISH INDIAN TRIBAL COMMUNITY

WE ENCOURAGE YOUR ACTION AND SUPPORT.

Sovereignty in Action is aided by solidarity amongst all Tribes.

SWINOMISH INDIAN TRIBAL COMMUNITY

THANK YOU!

SWINOMISH INDIAN TRIBAL COMMUNITY

VA OTGR Update for the Northwest Portland Indian Area Health Board - Quarterly Board Meeting - hosted by Lummi Nation

January 20, 2016

Office of Tribal Government Relations

VA U.S. Department of Veterans Affairs

VA ~ Office of Tribal Government Relations

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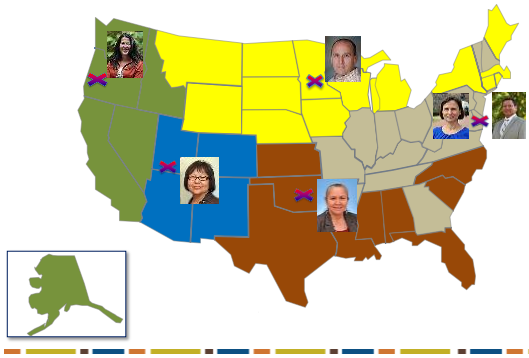
http://www.va.gov/tribalgovernment/

VA ~ Office of Tribal Government Relations



VA ~ Office of Tribal Government Relations

(VHA) Veterans Health Administration

(VBA) Veterans Benefits Administration (compensation; pension; education; insurance; home loan guarantees; vocational rehabilitation)

(NCA) National Cemetery Administration (national cemeteries; burials; plots; tombstones)

4

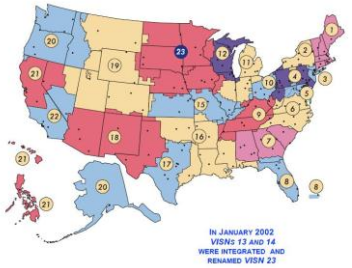
VA ~ Office of Tribal Government Relations

- VHA is one of the largest integrated healthcare systems in the world: **150** VA Medical Centers (VAMCs); **819** Community Based Outpatient Clinics (CBOCs); **135** Community Living Centers (nursing homes); **47** Residential Rehabilitation Programs; **300** Readjustment Counseling Centers (Vet Centers)
- **56** VBA Regional Offices
- **131** VA National Cemeteries / **5** Tribal Cemeteries
- It employs over 21,000 mental health professionals and over 300,000 employees (2nd largest cabinet agency)
- 9.11 M total enrolled Veterans in VA healthcare

5

VA ~ Office of Tribal Government Relations

Veterans Health Administration
21 Veterans Integrated Service Networks



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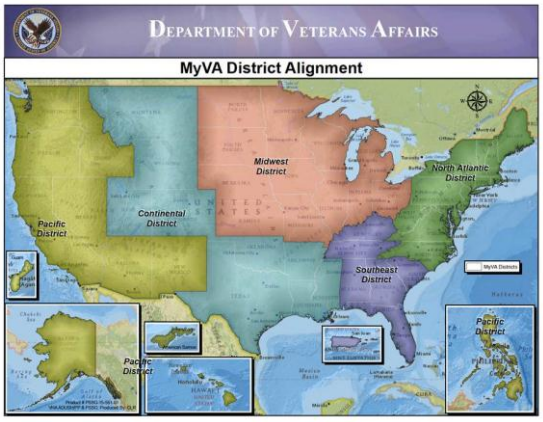

VA ~ Office of Tribal Government Relations
Alaska Native/American Indian Contribution

The American Revolution

Initially, neither side wanted to use Native warriors who they believed did not kill in "civilized" ways. But George Washington recognized their value, stating to the Continental Congress that they could "be made of excellent use as scouts and light troops." In 1776, Congress authorized him to enlist 2000. Eventually, 5,500 (of 250,000 – 2.2%) fought.

The War of 1812

Indigenous warriors again fought for and against Britain and the United States.

The American Civil War

Almost 20,000 Indians served in Confederate and Union forces on both the land and sea. More than 15,000 fought for the Confederates while over 4000 fought for the Union.

World War I

About 13,000 Native Americans served in the U.S. military during the war. 75% were volunteers.

8

VA ~ Office of Tribal Government Relations
Alaska Native/American Indian Contribution

World War II

44,000 Native Americans (more than 10% of population) saw active duty and for every one drafted, one and a half volunteered. In some tribes up to 70% of the men were in the military

Korean War

Over 10,000 American Indians served – again at a rate that far exceeded their percentage of the overall American population. Four were awarded the Congressional Medal of Honor

Vietnam War

Over 42, 000 American Indians served – more than 90% of them, volunteers

OEF/OIF/OND

In November 2012, DOD reported that 22,861 were serving in the armed forces.

9

VA ~ Office of Tribal Government Relations

Total Estimated American Indian/Alaska Native Population	154,305
Male	137,335
Female	16,970

10

VA ~ Office of Tribal Government Relations

Key Concerns

Access: Access to healthcare continues to be a major concern.
Homelessness: On a single night in January 2015, more than one in ten homeless adults was a Veteran – 47,725 homeless Veterans. The majority suffer from substance abuse, mental illness, or co-occurring disorders.
Unemployment – unemployment rate for post 9/11 Veterans is 10%, which is higher than the national average of 5.1% - August 2015.

Veteran Suicide - 22 veterans commit suicide every day in the United States.

Military Sexual Trauma (MST) In 2010, over 19,000 sexual assaults were reported in the military - 108,121 male and female veterans screened positive for military sexual trauma.
Substance Abuse: One in six post 9/11 veterans (345,000) has a substance abuse problem.

Veteran Mental Health Disorders - Of the over 2.4 million veterans of the wars in Iraq and Afghanistan, approximately 460,000 (20%) suffer from post-traumatic stress disorder (PTSD) or major depression.

11

VA ~ Office of Tribal Government Relations

Women Veterans

- Serving in higher numbers than ever before – approximately 14% of all active duty soldiers.
- VA is seeing a great influx as a result.
- Women Veteran Program Coordinators are at each VA site to help facilitate care for Women Veterans.
- **Native Women Veterans** proportion is higher than that of female Veterans of other races (11.5% vs. 8.0% respectively)

12

VA ~ Office of Tribal Government Relations

OTGR Update

VA / THP / IHS Reimbursement Agreement: 85 THP Agreements; $30M in reimbursement impacting 6,500 unique Veterans.

2015 VA Executive Summary Report: VA will release in 2016 highlighting the agency's work with tribal governments in 2015.

HUD/VASH Homeless Vouchers Released to Indian Country: 500 Vouchers, approximately $5.9 million dollars distributed to tribal grantees.

Tribal Veteran Representative (TVR) Training: OTGR continues to provide engagement with TVR's and hosted training in September 2015. Another training scheduled for April 2016 hosted by Confederated Tribes of Umatilla.

Veterans Summits: OTGR continues to engage with tribal communities to bring services about VA benefits and services to Indian Country.

National / Regional Engagement: NCAI, ATNI, NIHB, NPIAHB and other boards.

13

VA ~ Office of Tribal Government Relations

Contact Info

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14

VA Access Update and Tribal Health Program Reimbursement Agreements

Northwest Portland Area Indian Health Board Quarterly Meeting

January 20, 2016

National Focus on Access

- **Secretary McDonald's main focus areas:**
  - Access
  - Backlog
  - Homelessness
- **Dr. Shulkin's (new Under Secretary for Health) Five Priorities:**
  - Improved Access
  - Increased Employee Engagement
  - Consistency of Best Practice
  - Rebuilding the Trust of American Public
  - Building a High-Performing Network

Focus on VA Access

Access to Care:

- Increase timely access to care for Veterans patients
- Decrease the number of Veterans patients on the electronic wait list (EWL) and waiting greater than 30 days for their care
- Standardize the process and tools for ongoing monitoring and access management at VA facilities

Choice – FY 16 Changes to Choice

- **Operational Enhancements**
  - **Choice First Phase 2:** NVCC staff will contact eligible Veterans from the 30-day wait group to explain the Veterans Choice Program and offer it as an option to receive care when their wait time for a VA appointment is greater than 30 days (Go Live 10/1)
  - **Outbound Calls:** Eliminate the requirement for an inbound call from Veteran; require Contractor to make outbound calls to eligible Veterans to facilitate care (Go Live Nov 2015)
- **Legislative Changes**
  - **Removal of 8/1 enrollment and combat status requirements**; Veteran must be VA-eligible and enrolled (In process – target completion 10/1)
  - **VA Appointment Beyond Clinically Indicated Date -** To have outreach by VA Care Coordination staff to Veteran offering Choice as an option to receive care when their wait time for a VA appointment is beyond the clinically indicated date (Go Live Nov 2015)
  - **Removal of 60 day authorization limit** - Move to Episode of Care with maximum length of 12 months (Go Live 12/2015)
  - **Expansion of Provider Base** - Expand provider eligibility beyond those providers expressly listed in current Contract eg. Dental (Go Live 11/2015)
  - **40 Mile Expansion** - For Veterans seeking care and the nearest medical facility is a CBOC with Primary Care Physician below 0.9 FTEE (Go Live 10/2015)

VISN 20 Focus on Access:

Progress Toward Achieving Goals

- Electronic Wait List (EWL) for Primary Care in VISN 20 reduced from **3,003** on 9/1/14 to **1,702** pm 9/21/15 and currently at **1,542** on 12/21/15.

Challenges

- Lack of supply in community
- Difficulty in recruiting providers in rural areas

Accelerating Access to Care Initiative - Implementation

- Systematically reviewed clinic capacity to maximize ability to provide Veterans timely appointments
- Identified the resources required to provide timely care
- VA increased the use of care in the community through the non-VA care program (FEE)
- Each facility reached out to Veterans to coordinate the acceleration of their care – either to fee out or reschedule with VA at patients preference

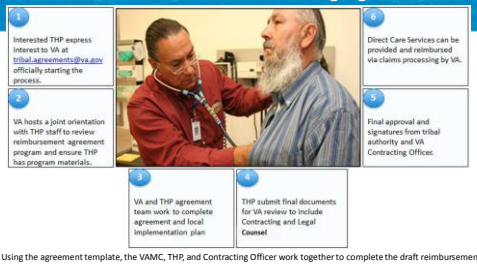
Improving Access for American Indian and Alaska Native Veterans through Reimbursement Agreements

- VA recognizes and values our relationships with Tribes
- Eligible American Indian and Alaska Native (AI/AN) Veterans can choose to receive their health care from the Tribal Health Program (THP) facility and/or VA Medical Center (VAMC)
- Reimbursement agreements with Tribal Health Programs focus on increasing coordination, collaboration, and resource-sharing for eligible AI/AN Veterans

Improving Access for American Indian and Alaska Native Veterans through Reimbursement Agreements

- The agreements promote quality health care through collaborative relationships
- Over $12.5M in reimbursements to date servicing approximately 4,000 Veterans

Basic THP Process for Establishing Agreements



- Using the agreement template, the VAMC, THP, and Contracting Officer work together to complete the draft reimbursement agreement.
- The national template shall always be used.
- Concurrently, the THP works to satisfy local implementation criteria.
- Once the draft is complete, it will be reviewed by VA's Chief Business Office, Network Contracting Office and Regional Counsel, respectively.
- After final signatures, reimbursement for direct care can commence.

Lessons Learned :

- Communication:
  - Initial meet and greet with VA and THP staff
  - Ensure POCs at both VA and THP with direct phone numbers and contact info
  - Ensuring coordinated care between THP and VA
- Education:
  - Ongoing education and sharing with local subject matter experts and POCs about the issues impacting Native Veterans
  - Ongoing education and sharing on the VA processes and any changes for the THP
- Quality:
  - Consistent communication and education between local VA facility, VA payment services (CBO) and the THP ensure our Native Veterans get the best care possible.

Questions Regarding Reimbursement Agreements

- Daniel Kelly, VISN 20 Planner (acting), Daniel.kelly@va.gov, 360-567-4607
- Terry Bentley, Tribal Government Relations Specialist, Western Region, Terry.Bentley@va.gov, 541-440-1271
- VHA Chief Business Office for Purchased Care, tribal.agreements@va.gov

Casey Eye Outreach

Working to eliminate preventable blindness in Native communities

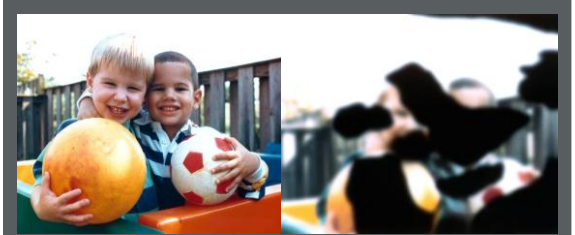
January 20, 2016

Joan Randall, MPH, Research Associate
Verian Wedeking, Outreach Program Administrator

What is preventable blindness?

- "Blindness which could be either treated or prevented by known, cost-effective means"
  - International Agency for the Prevention of Blindness
- 3 main conditions in United States

Diabetic Retinopathy



Images from "Eye disease simulation, diabetic retinopathy" by National Eye Institute, National Institutes of Health

Glaucoma

Images from "Eye disease simulation, glaucoma" by National Eye Institute, National Institutes of Health

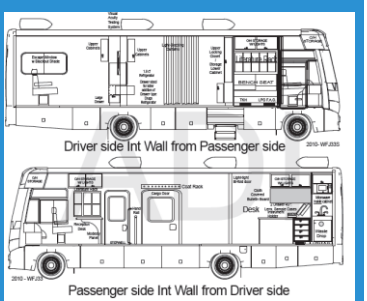
Macular Degeneration

Images from "Eye disease simulation, age related macular degeneration" by National Eye Institute, National Institutes of Health

Why are people in the US still going blind?!

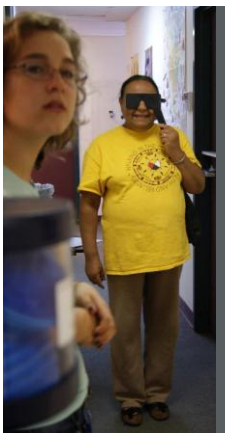
- Knowledge that care is needed/education
- Lack of trust in system or providers
- Access to healthcare
  - Cost/insurance
  - Transportation
  - Maldistribution of physicians

In 2010, Casey Eye Institute *built* a van



Why Native communities?

- Disease prevalence
  - 2.3 times higher risk of diabetes than Whites
  - Higher prevalence of visual impairment and low-tension glaucoma compared with other racial and ethnic groups
- High rates of smoking
- High rates of poverty
- Geographic location



How Native Communities

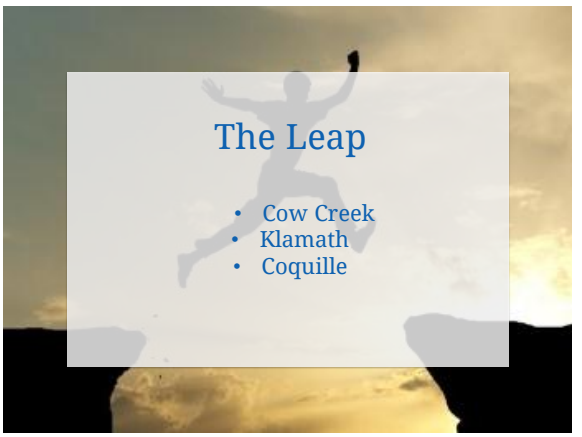
- **We are learning!**
  - Very much guided and supported by our friends at the Paiute, Klamath, Cow Creek, Coos tribes
- Work with tribal leadership – are there unmet needs?
- Listen to each tribe about individual needs; how can we help for the **long haul**
- Collaborate with local providers whenever possible

Casey Eye Outreach Van Medical Director,

- Mitchell Brinks, MD, MPH
  - Burns Paiute Tribe
  - Dr. Miles Rudd, Deputy Director Portland Area HIS
  - Dr. Tom Becker, OHSU Public Health
  - Dr. Steve Mansberger, Legacy Devers Eye Institute
  - Michelle Singer, OHSU NAERG
  - Kerry Lopez, Director, NW Tribal Cancer and Western Tribal Diabetes Projects

Use the existing van model

- Establish partner sites within the communities
- Partner sites identify and invite participants to screening
- Partner sites assist with any follow up that needs to be done based on the screening



Cow Creek at Canyonville

Cow Creek at Canyonville

Cow Creek at Canyonville

Klamath at Chiloquin

Klamath at Chiloquin

Klamath at Chiloquin

Klamath at Chiloquin

Coquille at Coos Bay

Coquille at Coos Bay

Other Native Screenings

- NARA – twice/year
- Burns Paiute yearly

NARA July 2015

NARA July 2015

NARA December 2015

Burns Paiute October 2015

Burns Paiute October 2015

Next Steps

- Partner with other tribes

Next Steps

- Partner with other tribes
- Continue/expand outreach of educational opportunities in health careers to Native youth

Next Steps

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- Continue/expand outreach of educational opportunities in health careers to Native youth
- Expand eye health services to the aging

Next Steps

- Partner with other tribes
- Continue/expand outreach of educational opportunities in health careers to Native youth
- Expand eye health services to the aging
- Work with tribes to integrate educational components

Next Steps

- Partner with other tribes
- Continue/expand outreach of educational opportunities in health careers to Native youth
- Expand eye health services to the aging
- Work with tribes to integrate educational components

Contact Verian Wedeking

- caseyoutreach@ohsu.edu, or at wedeking@ohsu.edu
- (503) 418 - 1698

References

1. Engelgau, M. M., Geiss, L. S., Saaddine, J. B., Boyle, J. P., Benjamin, S. M., Gregg, E. W., Venkat Narayan, K. M. (2004). *The evolving diabetes burden in the United States* doi:10.7326/0003-4819-140-11-200406010-00035

2. Indian Health Service. (2012). *Facts at-a-glance.*

3. Centers for Disease Control and Prevention. (2014). *Morbidity and mortality weekly report: Cigarette smoking in the united states.* (No. 63 (47)). Atlanta, Georgia

CASEY EYE INSTITUTE
OUTREACH VAN

Vision Screenings

Tribal communities are typically located in rural areas where eye doctors are scarce. Community members aren't always able to obtain vision screenings which could detect eye diseases that cause blindness. In addition, diabetes disproportionately affects American Indian populations, leaving the community at higher risk for diabetic retinopathy, which can lead to blindness.

Through partnerships with tribal health centers, the **Casey Eye Institute Outreach Van offers free vision screenings on site** at an expanding network of urban and rural locations, giving members of your community the opportunity to be screened for common preventable and treatable conditions related to refractive error, diabetes, macular degeneration, and glaucoma. Participants are examined at no cost, and Casey staff members collaborate with tribal community partners to provide assistance in purchasing glasses or accessing follow-up vision care.

The 33-foot, fully outfitted mobile ophthalmology unit and medical supplies were purchased through the generosity of private donors. A crew of volunteer staff including eye doctors, technicians, interpreters, and assistants provide this incredible care.

For more information about Casey Eye Screenings, please contact Verian Wedeking at 503-418-1698
E-mail: wedeking@ohsu.edu

Cannabis in Indian Country

Lael Echo-Hawk, General Counsel
National Indian Cannabis Coalition
Attorney, Garvey Schubert Barer
lechohawk@gsblaw.com

National Indian Cannabis Coalition

- www.niccdc.com

2

Why Are We Here?

- December 11, 2014 the DOJ released its internal Policy Statement on Marijuana Issues in Indian Country.
- Memo dated October 28, 2014
- Internal policy developed without consultation with tribes.

3

DOJ Policy Statement Regarding Marijuana Issues in Indian Country

- Directs each U.S. District Attorney to:
  - Assess all threats within the District, including those in Indian Country.
  - Consult with the Tribes in their District on a government-to-government basis.
  - Focus enforcement efforts based on that district-specific assessment.
- Invitation to consult – not blanket authorization to legalize
- Guidance only!

4

Cannabis

- Cannabis is derived from the cannabis plant (cannabis sativa).
  - Cannabis has at least 85 active **cannabinoids**
  - **THC** – is a cannabinoid and can cause a "high"
  - Cannabidiol (**CBD**) is one of at least 85 active cannabinoids identified in cannabis.
  - Hemp – variety of Cannabis plant with less than 3% THC
    - Produces higher levels of CBD than THC

5

Across the Country…

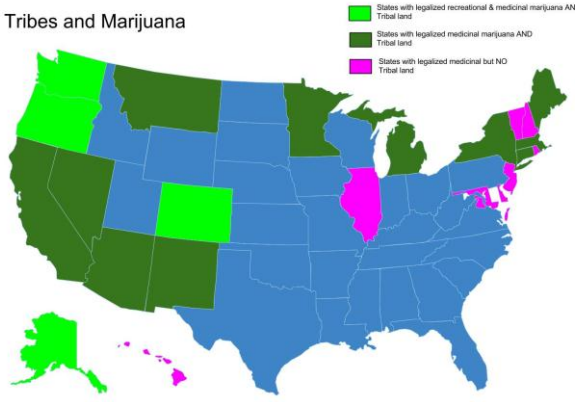
- 23 states, plus WA D.C., recognize and permit the medical use of cannabis
  - 1996: California
  - 1998: Alaska, Oregon, Washington
  - 1999: Maine
  - 2000: Colorado, Hawaii, Nevada
  - 2004: Montana
  - 2006: Rhode Island
  - 2007: New Mexico, Vermont
  - 2008: Michigan
  - 2010: Arizona, New Jersey
  - 2011: Delaware, Washington, D.C.
  - 2012: Connecticut, Massachusetts
  - 2013: New Hampshire, Illinois
  - 2014: Maryland, Minnesota, New York

6

Across the Country…

- 4 states legalized the recreational, adult use of marijuana
  - 2012:
    - Washington
    - Colorado
  - 2014:
    - Oregon
    - Alaska
    - Washington D.C.*

7



Economic forecast - Marijuana

- Legal marijuana grew 74% in 2014 to $2.7B up from $1.5B in 2013.* Arcview Market Research report
- Colorado - $699M total combined sales
  - Taxes - $63M Revenue (36% from recreational)
  - Licensing - $13M Revenue
  - 2.85M edible retail products sold
- Washington – estimated to increase by $252M in 2015*
- AMR estimates $10.8B in national sales by 2019*

9

Economic forecast - Hemp

- Hemp – estimated $500M market for hemp products
  - Renewable energy source?
  - Medical treatment
- Higher rate of return per acre than any other crop except Tobacco. (Congressional Research Service Report for Congress 2013)
- 22 states have passed pro-hemp legislation.

10

Across the Country…

- 13 states authorizing commercial hemp programs:
  - California
  - Colorado
  - Indiana
  - Kentucky
  - Maine
  - Montana
  - North Dakota
  - **Oregon**
  - South Carolina
  - Tennessee
  - Vermont
  - Virginia
  - West Virginia

11

Across the Country…

- 7 states establish industrial hemp programs that are limited to agricultural or academic research programs:
  - Delaware
  - Hawaii
  - Illinois
  - Michigan
  - Nebraska
  - New York
  - Utah

12

Marijuana - Research Steps

1. Submit your study proposal to the Food and Drug Administration for a thorough review of its "scientific validity and ethical soundness."
2. Submit your proposal to a separate Public Health Service (PHS) board, which performs pretty much the exact same review as the FDA.
3 Get a marijuana permit from the Drug Enforcement Administration.
4. Finally, obtain a quantity of medical marijuana via the Drug Supply Program run by the National Institute on Drug Abuse (NIDA), which maintains a monopoly on medical marijuana grown for research in the U.S.

- **June 22, 2015 – Obama administration removed Step 2 – PHS review.**

13

HHS Patent – "Cannabinoids as antioxidents & neuroprotectants"

- Awarded October 2003, filed by National Institute of Health
- "This new found property makes cannabinoids useful in the treatment and prophylaxis of wide variety of oxidation associated diseases, such as ischemic, age-related, inflammatory and autoimmune diseases. The cannabinoids are found to have particular application as neuroprotectants, for example in limiting neurological damage following ischemic insults, such as stroke and trauma, or in the treatment of neurodegenerative diseases, such as Alzheimer's disease, Parkinson's disease and HIV dementia."

14

NIH grants license to KannaLife to study CBD

- 2010 - NIH granted KannaLife exclusivity to develop a treatment for Hepatic Encephalopathy, a disease of the liver and brain that stems from cirrhosis.
- August 2014 - NIH granted the company an additional license on their previous patent to study CTE.
- KannaLife is the only company with licenses on the US-government held patent on cannabinoids. NIH owns patent, but KannaLife has exclusive rights to develop drugs with it.

15

Changes?

- New President, 2016
- Republican controlled Congress, 2015
- New U.S. Attorney General Loretta Lynch
- New U.S. Deputy Attorney General Sally Yates
- Nebraska and Oklahoma's suit against Colorado alleging federal preemption
- Ever-Shifting federal enforcement priorities on tribal land

16

House Tribal DRAFT Legislation

- Draft attempts to provide clarity for tribes wishing to produce, purchase and possess marijuana but concerned that participating in the marijuana industry might put their federal funding at risk.
- This bill attempts to alleviate that concern by prohibiting federal agencies from considering the tribe's participation in the marijuana industry when:
  - Allocating federal funds, benefits, grants, contracts, or other agreement with the United States, determining compliance or evaluating eligibility for federal funding.

17

House Tribal DRAFT Legislation

- National Indian Cannabis Coalition (www.niccdc.org) is providing input on the draft legislation.
  - Include IHS
  - Allow tribes to participate in Hemp initiatives
  - Include tribes engaged in processing and selling cannabis

18

Federal Tribal Legislation

- Keeping out Illegal Drugs Act of 2016 - Senator Lankford (R-OK)
  - "A bill to prevent Indian tribes and tribal organizations that cultivate, manufacture, or distribute marijuana on Indian land from receiving Federal funds."
- **NICC Position** – "In a time where both Congress and the Administration are deferring to individual State decisions on marijuana legalization, this bill would eliminate the opportunity for Tribes to evaluate and make an individual determination regarding the legalization or prohibition of marijuana on their Indian lands."

19

HR 2029 - Military Construction and Veterans Affairs and Related Agencies Appropriations Act of 2015

- Section 246: "**None of the funds** appropriated or otherwise made available to the Department of Veterans Affairs in this Act **may be used** in a manner that would— (1) **interfere with the ability of a veteran to participate in a State-approved medicinal marijuana program**; (2) **deny any services** from the Department to a veteran who is participating in such a program; or (3) **limit or interfere with the ability of a health care provider of the Department to make appropriate recommendations,** fill out forms, **or take steps to comply with such a program."**
- NICC recommending a similar provision be included in this bill providing the same direction to the Indian Health Service.

20

Indian Health Service Position

- IHS Findings issued in June 6, 2011 -"Federal law specifically prohibits the use of marijuana under all but very controlled, investigational circumstances"
- Chief Medical Officer recommends:

  "I recommend that all IHS, Tribal, and Urban programs fully adhere and comply with Federal law by not prescribing, recommending, possessing, cultivating, processing, manufacturing, or distributing marijuana for medical or other purposes."

21

Indian Health Service Position

- **But –** HHS Sec. Burwell Sec. Burwell reported to tribal advisory committee "…that HHS funding would not adversely be impacted if a Tribe operated a medical grow or dispensary on Tribal lands as long as federal funding is not used." (Sept 2015)

22

Washington-Tribal Marijuana Compacts

- HB 2000 – All marijuana "compacts" to address any marijuana-related issue that involves both state and tribal interests or otherwise has an impact on tribal-state relations.
- Compact provisions –
  - Allows tribe to buy and sell to State licensees
  - Protects tribal territory by requiring the State withhold issuing a license to any applicant without express permission of Tribe.
  - Tribal tax must be at least 100% of the State tax (WA = 37% plus sales tax up to 9.5%)
  - Medical marijuana is exempt from tax

23

Oregon

- July 1, 2015 – personal possession and use is permitted
- Liquor Control Commission is tasked with implementation.
- Temporary regs adopted 10/22/15
- License applications will be accepted starting January, 2016

Alaska

- Alaska has historically allowed possession in small quantities
- Rules adopted November 2015
- March 2016 – regulation effective date

24

Logistics:

- Insurance –
- Lloyds of London determines it will no longer support insuring marijuana operations of any kind until the drug is formally recognized by the U.S. government as legal.
- Banking issues – will a bank accept the money?
  - *Fourth Corner Credit Union v. Federal Reserve Bank of Kansas City,* Civil Action No. 1:15-cv-01633, (D.Colo. 2015)

25

Logistics: Gaming & Cannabis

- **Bank Secrecy Act** requires all financial institutions to file Suspicious Activity Reports ("SAR's") on businesses they suspect to be engaged in potentially illegal activity. Under the new guidelines, financial institutions must continue to file the following SAR's on marijuana businesses. These are:

☐ **Marijuana Limited SAR** – on businesses that appear to be operating legally and not engaging in activities that will interest federal prosecutors as detailed in the Cole 2.0.

☐ **Marijuana Priority SAR** – on businesses that appear to be in violation of state law or interfering with federal enforcement priorities.

☐ **Marijuana Termination SAR** – where a financial relationship with a marijuana-related business is terminated due to suspected violations.

26

27

Current Tribal Marijuana Activity

- Suquamish Tribe and Squaxin Island Tribe sign Marijuana Compacts under HB 2000.
- Passamaquoddy Tribe inks deal for marijuana operation.
- Other tribes exploring legalization.
  - Omaha
  - St. Croix Chippewa - WI
- ….but
- Alturas Rancheria, Pit River Rancheria marijuana raided by federal and state law enforcement
- Pinoleville Rancheria marijuana raids by State law enforcement
- Flandreau Santee Sioux burned its plants following discussions with DOJ

28

29

Menominee Raid - Warrant

- Issues identified in Warrant –
  - Appeared to be a non-tribal entity and employees operating facility
  - Non-Wisconsin citizens operating grow
    - Jurisdictional authority
  - Public Health and Safety issues
  - Plants tested positive for Marijuana, Hashish, THC and Hash Oil
  - Cannabis farm located in State without any legalized marijuana
  - Menominee has filed Complaint for Declaratory Judgment

30

Why Indian Country?

- Sovereignty as a tool -
  - Less bureaucracy in licensing
  - Lower tax rates
  - Access to land for grow operations – streamlined zoning and permitting processes
  - Blank slate for growing and processing standards.
  - Reasonable regulation
    - Tribes know how to regulate and how to work with feds
  - Foreign trade zones?
  - Banking solution?
  - Medical research?

Questions?

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Website: www.niccdc.org

32

IDEA-NW PROJECT & DATA SHARING AGREEMENTS

NPAIHB QUARTERLY BOARD MEETING
JANUARY 2016

Victoria Warren-Mears, RD, PHD
Director, Principal Investigator
Northwest Tribal Epidemiology Center

Sujata Joshi, MSPH
Project Director
IDEA-NW Project

Historical Context

- Historically, IHS was the source for health care delivery, disease surveillance, and data for Tribes
- 1990s: Expansion of self-governance in health care delivery led to diminished role and capacity for IHS to provide these services
- At the same time, there was increasing recognition that state public health departments were limited in their ability to provide Tribes with disease surveillance and health data.
  - Inaccurate data on race/ethnicity and tribal affiliation (racial misclassification)
  - Data not reported at Tribe-level
  - Limited knowledge and limited consultation with Tribes

Tribal Epidemiology Centers

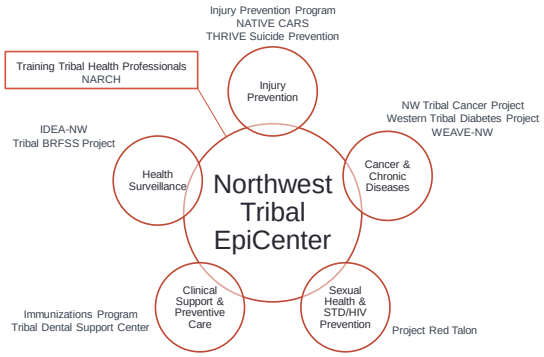
Northwest Tribal Epidemiology Center

Mission: To collaborate with Northwest American Indian Tribes to provide health-related research, surveillance, training and technical assistance to improve the quality of life of American Indians and Alaskan Natives

Goals:

- Assist communities in implementing disease surveillance systems and identifying health status priorities.
- Provide health specific data and community health profiles for Tribal communities.
- Conduct tribal health research and program evaluation.
- Partner with tribal, state, and federal agencies to improve the quality and accuracy of AI/AN health data.

Northwest Portland Area Indian Health Board

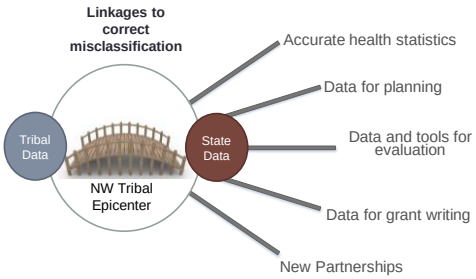


IDEA-NW PROJECT

Improving accuracy of AI/AN health data through record linkages

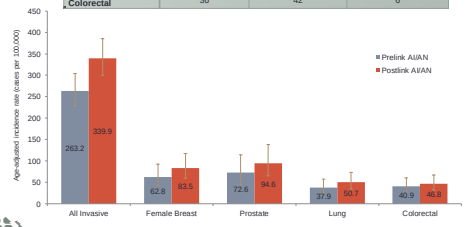
AI/AN Misclassification in the NW

- Misclassification happens when AI/AN are recorded as being another race (usually White) in a dataset
- Ranges from 8-60% of AI/AN records in NW health data
  - Birth and death records have relatively low (8-10%) numbers of misclassified records
  - Cancer registries average at around 30% of records
  - Hospital discharge and trauma registries can have up to 60% of AI/AN records with incorrect or missing race/ethnicity data
- Why does this matter?
  - Small numbers get even smaller
  - Difficult to establish accurate baseline measures
  - Can obscure real disparities experienced by tribal communities



Idaho Cancer Incidence Data, 2008-2012

Cancer Site	Pre-linkage AI/AN Cases	Post-linkage AI/AN Cases	Change in Case Count
All Invasive	243	320	77
Female Breast	35	45	10
Prostate	28	42	14
Lung	29	37	8
Colorectal	36	42	6



Leading Causes of Death for Washington AI/AN, 2009-2013

Rank	Cause of Death	Pre-linkage AI/AN	Post-linkage AI/AN	Change in # of deaths
1	Major Cardiovascular Diseases	1148	1261	113
2	Malignant Neoplasms	902	980	78
3	Unintentional Injury or Accident	543	580	37
4	Chronic Liver Disease and Cirrhosis	250	275	25
5	Chronic Lower Respiratory Diseases	231	260	29
6	Diabetes Mellitus	206	224	18
7	Suicide	147	166	19
8	Alzheimer's Disease	98	111	13
9	Influenza and Pneumonia	69	73	4
10	Other Respiratory Diseases	68	73	5
	Total Deaths	6759	7485	726

Linkages completed to date

Idaho	Oregon	Washington
• Cancer Registry • Birth Records • Death Records	• Cancer Registry • Birth Records • Death Records • Hospital Discharge Records • Communicable Disease Registries • Oregon Health Plan (Medicaid)	• Cancer Registry • Birth Records • Death Records • Hospital Discharge Records • Trauma Registry

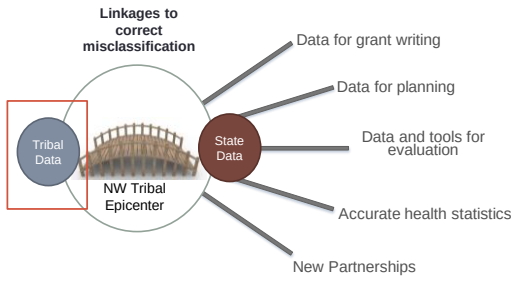
Data Products

- State and CHSDA-level Tribal Health Profile Reports
- Fact Sheets on Cancer, Suicide, Hospital Admissions, and other topics
- Focused reports on NW AI/AN Cancer and Mortality
- Data requests from Tribes
- Manuscripts and Conference Presentations

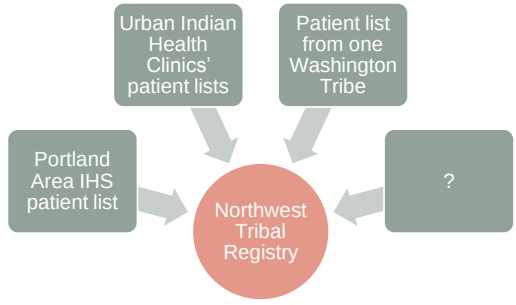
http://www.npaihb.org/epicenter/project/reports

CHALLENGES

Improving the Northwest Tribal Registry



Northwest Portland Area Indian Health Board



Northwest Portland Area Indian Health Board

Data Sharing with Tribes

- Data sharing agreements formalize how, what, when, and with whom data will be shared between individual Tribes and NWTEC.
- Looking forward:
  - Work with Tribes to identify data sharing opportunities for data linkages and other projects
  - Establish or update data sharing agreements with all member Tribes

Northwest Portland Area Indian Health Board

Acknowledgements

NPAIHB

The Tribes of Idaho, Oregon, and Washington, patients and their families

Partners at the Portland Area IHS, Tribal and Urban Indian Health Clinics, and State Health Departments

Funding Agencies: Office of Minority Health and Indian Health Service

Contact

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Northwest Portland Area Indian Health Board

WSU Native American Health Sciences

Overview of who we are & Updates on Recent Projects

Who We Are

Dr. Robbie Paul, Nez Perce

- Director: Robbie Paul, PhD
- Outreach Coordinator: Emma Noyes, MPH
- WSU Native American Health Sciences is housed in the WSU College of Nursing
- We work across WSU campuses and programs to increase the number of Native American and Alaska Native students entering and completing health science degrees
- Big Picture:
  - Increasing the number of Native American/Alaska Native (NA/AN) health professionals dedicated to serving NA/AN communities
  - Eliminating health inequities faced by NA/AN communities

Who We Serve & What We Do

High School Students

- Recruitment
- Na-ha-shnee Native American Health Science Institute
- Near future: Research Internships

na-ha-shnee

Undergraduate & Graduate Students

- Recruitment
- Support Services
- Networking & Mentoring Opportunities
- Scholarship & Research Opportunities
- Offer class in Plateau Tribes Culture and Health

Local Tribes

- WSU MOU with 10 Tribes in the Plateau Region
- Native American Advisory Board for Health Sciences with the Chancellor of WSU Spokane
- Research partnerships and support

Updates on Recent Projects

Graduated 56th nurse last semester!

- WSU Spokane – 2 BSN students, 2 DNP students, 1 Nursing PhD student, 2 Master's level Speech and Hearing students.
- WSU Yakima – 2 BSN students
- WSU Vancouver – 1 PhD student, 1 DNP student
- WSU Pullman – Students on the path to degrees in Medicine, Nursing, Nutrition and Exercise Physiology.

Government to Government Training

- Developing training plan for WSU Spokane administration, Faculty/Staff

Print for WSU Native American / Alaska Native graduates in health degrees

- Art contest to determine print design

21st Annual Na-ha-shnee Native American Health Science Institute

- June 19th – July 1st, 9th – 11th grade, See flyer for more details

Dr. Robbie Paul
509-324-7440
paul@wsu.edu

Emma Noyes
509-324-7215
emma.noyes@wsu.edu

na-ha-shnee

21st Annual Na-ha-shnee Native American Health Science Institute
June 19th – July 1st, 2016

What is Na-ha-shnee? Na-ha-shnee is a 13 day summer program designed to encourage Native American and Alaska Native students to pursue health science degrees and health-related careers. The program is held on the WSU Spokane Campus and housing is in nearby dorms.

Who should apply? Native American and Alaska Native students that are currently in 9th, 10th, or 11th grade. Applicants should have a GPA of 3.0 or above and an interest in health science careers (nursing, medical research, nutrition, physical therapy, medicine, pharmacy, etc.) This year we will be selecting 25 students to attend Na-ha-shnee.

Where is the application? Applications can be filled out and submitted online. The application will be up-to-date and available in **January 2016**. This application can be found online at: https://spokane.wsu.edu/about/community-outreach/native-american-health-sciences/ (Or google WSU Native American Health Sciences to find it).

What does it cost? FREE! The only cost that we cannot cover is transportation to and from our program.

DEADLINE FOR APPLICATION: 5PM, MONDAY, APRIL 25th, 2016

Questions? Feel free to contact Emma Noyes, Native American Health Science Outreach Coordinator. Phone: 509.324.7215 Email: emma.noyes@wsu.edu Fax: 509.324.7341

This exciting summer opportunity is brought to you by:

WASHINGTON STATE UNIVERSITY – GO COUGS!

Frequently asked questions by parents and applicants:

Where will students be staying overnight and how will they be supervised? Students stay in a dorm on the Gonzaga University campus which is a short walking distance to our WSU Spokane campus. Each student is assigned a roommate and a room on either the female floor or the male floor of the dorm. Students are supervised by "camp counselors", including two staff that are hired specifically to ensure that curfew is kept and students are safe.

Do I need to be enrolled in my tribe to attend? No, you do not need to be enrolled in your tribe to attend. In the application you are asked if you are enrolled or a descendant of a tribe. You do not need to provide documentation of your enrollment.

Can students leave with parents or guardians during the institute (example: attending local events, tournaments, practices, jobs, or family events)? Such a good question! The Na-ha-shnee Native American Health Science Institute involves a full schedule of college preparation, career exposure, leadership development, and getting to know mentors and other students. For this reason the institute is a closed campus program. Students may not miss any portion of the institute.

What if my student needs medical attention during the institute? Our staff includes a registered nurse that is available around the clock to administer prescription medications that students bring with them to camp. The nurse can also provide over the counter medications with parent permission, respond to any sports/accidental injuries, and determine whether further medical attention is needed. If further medical attention is needed parents/guardians will be contacted and student will be taken to the hospital. All hospital fees are the responsibilities of parents/guardians.

What kind of activities take place at camp? Each day is packed with hands-on activities. These include CPR/First aid training, basic nursing skills, creating compounds in the pharmacy lab, working on an artificial tooth in dental hygiene, group games, group fitness, cultural arts, visiting a human anatomy lab, sleep research labs, putting everything that you learn to the test in our simulation lab, and much more!

Northwest Portland Area Indian Health Board

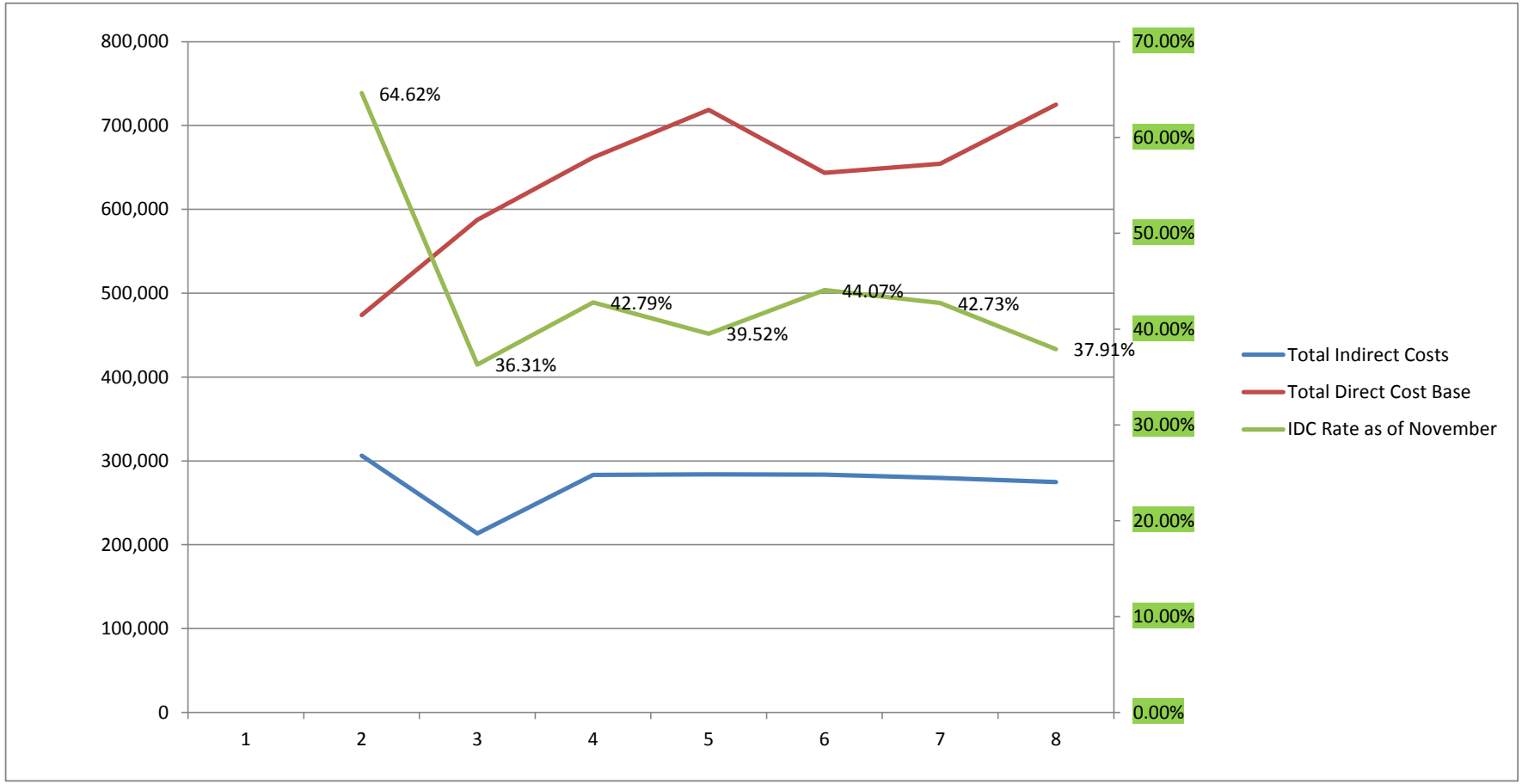
Statement of Revenues and Expenditures - Board -R&E

From 10/1/2015 Through 11/30/2015

	Grants	Unrestricted	Indirect	Total
Revenues				
Program Revenue				
	1,182,395.80	0.00	0.00	1,182,395.80
Indirect Revenue				
	0.00	0.00	253,988.79	253,988.79
Other Revenue				
	0.00	514.59	0.00	514.59
Total Revenues	1,182,395.80	514.59	253,988.79	1,436,899.18
Expenditures				
Operating Expenditures				
Salaries & Wages	339,050.83	0.00	140,340.51	479,391.34
Payroll Taxes & Fringe Benefits	119,377.14	0.00	43,197.97	162,575.11
Prof. Fees & Contract Services	293,463.75	0.00	4,304.08	297,767.83
Rent & Facility Maint.	0.00	0.00	50,073.08	50,073.08
Equipment Lease & Maint.	0.00	0.00	6,804.78	6,804.78
Telephone	5,172.48	0.00	8,508.41	13,680.89
Insurance	0.00	0.00	654.60	654.60
Travel	138,523.89	0.00	16,236.17	154,760.06
Supplies and Equipment	25,173.11	222.65	5,319.19	30,714.95
Postage & Printing	7,145.81	0.00	(644.68)	6,501.13
Other Direct Expenses	500.00	(1,545.00)	0.06	(1,044.94)
Indirect Cost	253,988.79	0.00	0.00	253,988.79
Total Operating Expenditures	1,182,395.80	(1,322.35)	274,794.17	1,455,867.62
Total Expenditures	1,182,395.80	(1,322.35)	274,794.17	1,455,867.62
Revenue Over (Under) Expenditures	0.00	1,836.94	(20,805.38)	(18,968.44)

Indirect Rate as a relationship between Total Indirect Costs and Direct Cost Base Over the Last 6 Years: October Through November

Fiscal Year	2010	2011	2012	2013	2014	2015	2016
Total Indirect Costs	306,205	213,301	283,236	284,053	283,527	279,541.71	274794.17
Total Direct Cost Base	473,856	587,514	661,922	718,752	643,353	654,210.72	724874.55
IDC Rate as of November	64.62%	36.31%	42.79%	39.52%	44.07%	42.73%	37.91%



Northwest Portland Area Indian Health Board
Balance Sheet
As of 11/30/2015

Northwest Portland Area Indian Health Board

Balance Sheet

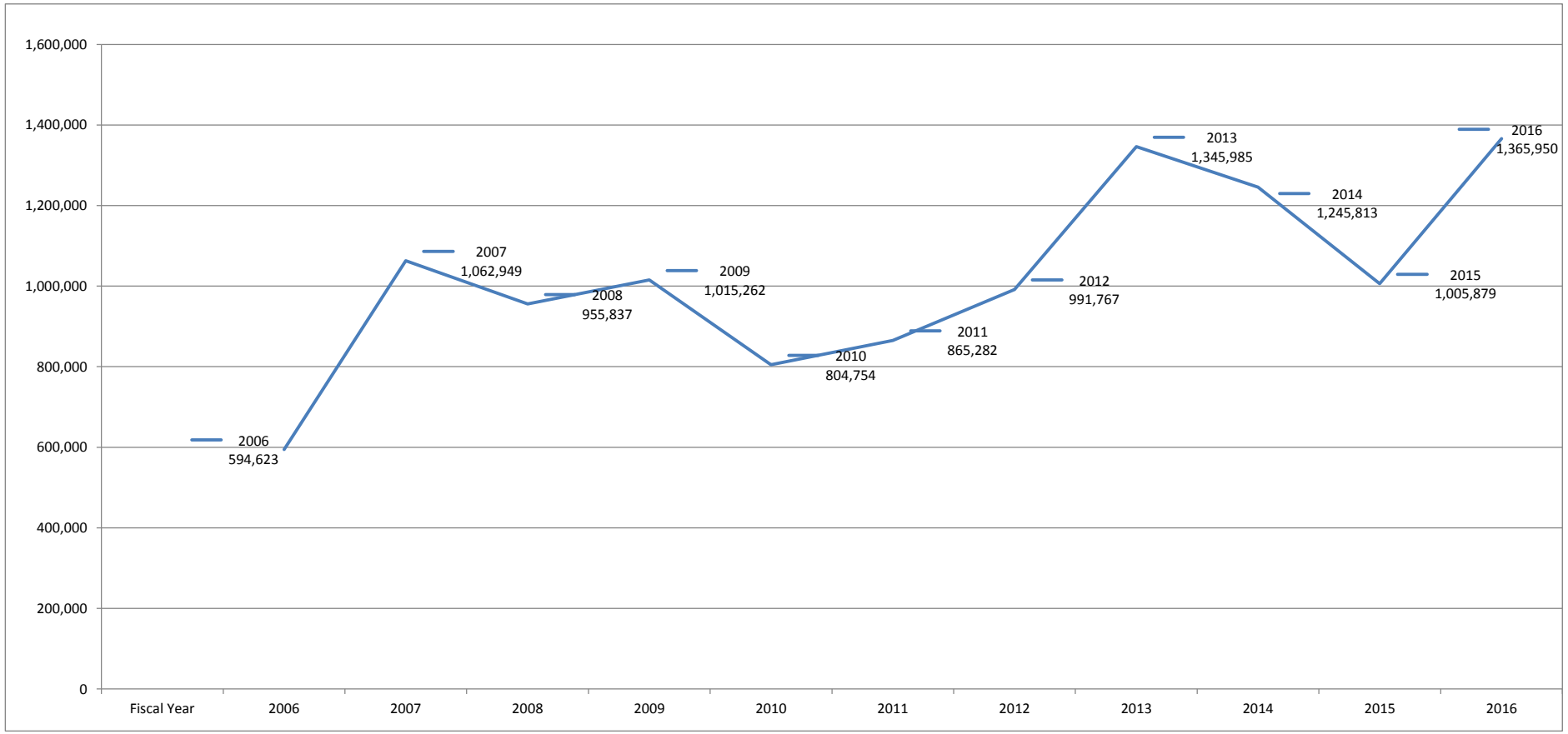
As of 11/30/2015

Assets	
Current Assets	
Cash and Cash Equivalents	**3,902,019.39**
Investments	**208,517.36**
Program Recivables	**(2,558,370.33)**
Travel Advance & Misc Rec	**3,633.99**
Prepaid Expenses	**15,421.60**
Total Current Assets	**1,571,222.01**
Fixed Assets	
Capitalized Fixed Assets (net of accumulated depreciation)	**0.00**
Total Fixed Assets	**0.00**
Total Assets	**1,571,222.01**
Liabilities and Fund Balance	
Current Liabilities	
Accounts Payables	**73,434.86**
Payroll related payables	**47,522.13**
Accrued Leave Payable	**139,673.29**
Total Current Liabilities	**260,630.28**
Fund Balance	
	1,310,591.73
Total Liabilities and Fund Balance	**1,571,222.01**

Cash available for drawdown from Payment Management System: $6,245,441.

Total Operating Expenses (Direct Grant and Indirect expense) over the last 6 years for October Through November

Fiscal Year	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total Operating Expenses	594,623	1,062,949	955,837	1,015,262	804,754	865,282	991,767	1,345,985	1,245,813	1,005,879	1,365,950



NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Schedule of Expenditure of Federal Awards as of 11-30-2015

Grant#	Title	Awards	Expended	Encumbrances	Cash Received	Receivable	Balance
	U.S. DHHS					1200 acct	
	Federal						
100	Health Management Development Program	2,772,653	307,921	303,365	(790,686)	(1,698,016)	2,464,732
110	Epidemiology Center	1,075,302	143,407	137,474		138,817	931,895
111	Special Diabetes Program for Indians	60,000	35,645			220	24,355
114-14	NARCH 7	1,388,695	104,608	304,837		(160,662)	1,284,087
117	WEAVE	1,513,203	97,303	183,809		242,560	1,415,900
118-00-15	Reaching Out Involves Everyone (THRIVE-Suicide Prevention)	999,782	213,949	738,400		120,010	785,834
119	NARCH VIII Tots 2 tweens	693,817	61,305	52,392		11,305	632,512
122	Nat'l Cancer Prevention and Control	273,255	40,211			(146,910)	233,044
128	ASTHO-CDC Consortium	21,089	8,060			(6,915)	13,029
135	Inury Prevention program					(11,397)	0
135-01-15	Injury Prevention Program	20,000					20,000
138	IDEA					(112,938)	0
141	NW Tribal Cancer Navigator					(8,698)	0
142	Child Safety Seat Intervention	714,538	43,141	27,930		(53,206)	671,397
143	Dental Preventative and Clinical Support Centers Program	250,000	18,259	231,741		3,259	231,741
149	ITCM/National Native Network		3,516			21,348	-3,516
152	Public Health Infrastructure		3,895			55,740	-3,895
162	IDEA- (OMH)	225,261	23,379			(41,672)	201,882
	State & Pass Through Funds						0
211	Health Security Preparedness & Response Program (HSPR)	5,971				4,506	5,971
216	TROCD	146,050	2,460			(6,588)	143,590
220	Regional Training Center-UW	37,187	14,283		(1,217)	19,733	22,904
306	U of W Bio-Terrorism	13,471				(18,317)	13,471
921	Texas it's your game				(5,003)	16,042	0
923	ACA Tribal Personal Resp. Teen Pregnancey Prevention	38,330	18,180	19,202	(11,383)	16,090	20,150
927	Oregon Health Ins. Exchange	41,257				(42,476)	41,257
929	NW Health Foundation	7,963				(7,963)	7,963
930	Tribal Org ACA Toolkit	29,138				(23,740)	29,138
932	CMS TTAG AI/AN	28,738				(28,738)	28,738
936	PEW Charitable Trusts DHAT	395,800	3,256	6,500		(34,657)	392,544
937	Kellog Foundation DHAT project	786,610	39,617	70,000		(577,411)	746,993
	TOTAL	11,538,110	1,182,396	2,075,650	(808,290)	(2,555,530)	10,355,714

Elders Committee

Tuesday January 19, 2016
Silver Reef Casino Resort, Ferndal, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	DAN GLEASON	CHEHALIS	360-273-5911 cl
2	Gloria Ingle	Conf. Tribes of Siletz	541-994-5953
3	Andy Joseph	Colville T. Tribe	509 631 1252 andy.joseph@colvilletribes.com
4	Janice Clements	Warm Springs	541-553-1196
5	Patty Kinsue - Davis	Coulitz	360-978-4175
6	Hamen Ides	V-Chair Health Com.	
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Elder Committee Meeting Minutes

January 19, 2016

Silver Reef Casino Resort

Ferndale, WA

Members: Gloria Ingle – Siletz Tribe, Patty Kinswa – Gaiser, Cowlitz Tribe Janice Clements-Warm Springs Tribe, Hamen Ides – Lummi Nation, Andy Joseph-Colville Tribe, Dan Gleason, Chair, Chehalis Tribe

NPAIHB Staff: Clarice Charging

Dan opened the meeting with a prayer.

Patti motioned to approve October 2015 minutes. Janice seconded.

Motioned approved.

Updates:

Warm Springs: Tribe hosted a Diabetic Health Education Fair last quarter that was well attended. Senior Day will May 16, 2016. Warm Springs Casino sponsors exercise class several times a week for elders. The Tribe has changed their statute regarding elder abuse. Family members will no longer be able to petition the tribal court to dismiss criminal charges against the those charged with abuse.

Siletz: Tribe serves elders over a 11 county area. Elders meet once a month at Chinook Winds for elder council meetings. Special interest presentation and decisions on activities are presented. The tribe transports elders to their appointments or provides gas vouchers to family members who drive their

relatives to their appointments. Elders participate in the community garden under the Healthy Traditions program. The clinic medical/pharmacy reach out frequently to elders (reminders for appointments or their Rx is in or due.

Chehalis: Elder program hosted their dinner October 2015 that was well attended. Several area tribal elder programs were also in attendance. Chehalis elders will be hosted by the Cowlitz Elder program February 2016. Elders visited Memphis and Nashville Tennessee touring Graceland and The Grand Old Opry. Elder program sponsors movies and bingo once a month.

Lummi: A board certified family medicine physician was hired part-time to provide physician home visits to LTHC patients. The program initially focused on elders who were recently discharged from the hospital. The Lummi Nation has a senior housing establishment, Little Bear Creek, not tech assisted living. Many of the elders who have been in the home have been residing there for years. The Lummi Nation supports the delivery of Meals on Wheels to assist elders with healthy foods. Lummi senior care programs also support activities including day trips, gatherings, culturally focused activities and participation in senior care conferences. On a monthly basis, there is a senior lunch during visits to local tribes. For those elders that still live in their own homes, support is provided such as wood cutting, community gardens and fitness exercises.

Colville: Elder program has submitted to Tribal Council a budget request for their winter job program. This program hires tribal members to do outdoor jobs (wood chopping, snow shoveling, etc. for elder homes. Colville Tribe is exploring ways to

develop their rest home program in order to add more beds and hiring more healthcare workers for their rest homes.

Elders received the strategic plan and will take it back to their programs for discussion.

Behavioral Health Committee

Tuesday January 19, 2016
Silver Reef Casino Resort, Ferndal, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	MARIE ZACKUSE TRIBAL Council	TULALIP	3609269284 MZackuse-nsn.gov
2	Regina Lane	TULALIP	425-830-0125 Zackuse0655@gmail.com
3	Jacqueline LHB	Staff	
4	Jody Sobel	Stillaguamish	360 631-4314 Jsobolt@Stillaguamish.com
5	Shawn Stanphill	Cow Creek	541-672-8533 sstanphill@cowcreek.com
6	Lisa Guzman	Kalispel	509-671-6311 lguzmana@camshealth.com
7	Wanda Johnson	Burns Paiute	541 573-3088 Wjohnson2011@live.com
8	Elizabeth Buckingham	Makah	360.645.2224 @ ihs. Elizabeth.buckingham gov
9	Caroline M. Cruz Health & Human Ser. GM	Conf. Tribes of Warm Springs	541-615-0146 caroline.cruz@wstribes.org
10	Kevin Collins / Health Director	Stillaguamish Tribe	Kcollins@Stillaguamish.com 360-391-3875
11	Marilyn M. Scott Tribal Council	upper Skagit Indian Tribe	marilyns@upperskagit.com (360) 854-7039
12	cc:		
13	+ Michelle Sobel		
14	+ Jonathan M		
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Behavioral Health Committee

January 19, 2016

Lummi Tribe

Attendees: Marie Zakuse, Tulalip; Regina Lane, Tulalip; Jacqueline Lefthand Bull, NPAIHB; Stephanie Craig Rushing, NPAIHB; Judy Soholt, Stillaguamish; Sharon Stanphill, Cow Creek; Lisa Guzman, Kalispel; Wanda Johnson, Burns Paiute; Elizabeth Buckingham, Makah; Caroline Cruz, Warm Springs; Kevin Collins, Stillaguamish; Marilyn Scott, Upper Skagit.

Meeting Minutes:

- **Discussed action items from our last meeting:**
    - The committee had recommended that the Board hire a Behavioral Health specialist. Someone who can write white papers and stay abreast of mental health/chemical dependency policy change and attend state Addictions and Mental Health meetings.
        - Update: The EpiCenter has identified funding to support this position. We're waiting for approval of carryover funds before opening the position.
    - The committee requested assistance to clarify and streamline data sharing processes between CFR and HIPPA requirements.
        - Currently, data can be shared as long as the patient is made aware that data will be shared...
        - Kevin: This situation doesn't truly solve the problem of providing a fully integrated healthcare system.
        - We would like to see something in writing that clarifies the data sharing protocols for integration.
        - We need to update CFR 42.2 – Let's raise this issue with David Dickenson (SAMHSA, Region X consultant), and loop in the Board's Policy Committee.

- **5 Year Strategic Plan**
    - We need additional workforce development opportunities for mental health providers/counselors that have experience working in our communities

- **We discussed the 2015 grant application process for MSPI/DVPI**
    - NPAIHB's Funding will be used to:
        - Train 3 NW clinics in the Zero Suicide Model
        - And train and support local We R Native Youth Ambassadors

- Question from Caroline: What will be the process for bringing the Zero Suicide Model to the Oregon Tribes?
    - Stephanie will follow-up with Colbie... *Per Colbie:* THRIVE's Zero Suicide training requests can be submitted by Oregon Tribes if they do not have direct MSPI funds from IHS. Unfortunately, IHS will not let us have sub-recipients that have their own MSPI award. THRIVE staff still can provide TA to all NW Tribes if they plan to implement the ZS model in their clinic settings. That TA will not necessarily include funding, but we can absolutely help Tribes navigate the start-up of the ZS model. **If Tribes have any suicide prevention dollars, but they are not MSPI-specific, please request the training if you are interested and can provide the eligibility documents. No requests have come in yet and they are due Jan. 22. After Jan. 22 we will begin to fulfill requests on a first-come-first-serve basis, as long as the ZS documents and buy-in from Tribal council and health directors can be shown.
    - Right now a few GLS grantees based in the state of OR are hoping to host a Zero Suicide Academy for Organizations and Tribes from OR or WA sometime in the fall. Right now, interested partners are looking for funds to host the academy (needing roughly $45,000). If sufficient funding can be secured; the Academy will be by invitation and/or application, based on the training organization's protocols. To attend an Academy, organizations/Tribes/clinics must complete several preparatory steps that take a lot of time and effort by the applicant. Please note: this is all just an idea right now... the Academy is not currently funded and the NPAIHB does not have the funding to bring this to the NW right now – this may not come to fruition. Let us know if you have any funds that you would like to contribute to help co-host the Academy.
- Committee members expressed concerns about the IHS MPSI/DVPI funding opportunity, and the review and selection process...
    - Needs to be more transparent – how and why decisions were made
    - Caroline: The funds were divided between the IHS regions by population, but we would like to see all tribes receive funding, like the SDPI project.
    - Some applications weren't even reviewed
    - We would like to pool our comments and send them to the Area Office.

- **Speakers at upcoming QBMs:**
    - We need an update on "retaining shares" and what services are provided by IHS and what process should be used to get technical assistance on treatment referrals (Perhaps from Johnathan Merrill or Michelle Sobel)
        - We all have different interpretations of "shares"

        - It would be helpful to support communication between the Area Office and treatment providers (maybe through a joint meeting at a QBM), to better coordinate referrals and clarify referral processes.
    - Along this vein, we should also invite someone from NARA (maybe Jackie) or the Healing Lodge to attend.
        - Caroline: NARA received funding to provide youth treatment services and will be going through a year-long planning process

Action Items:

1. Stephanie will follow-up with David Dickenson and the new NPAIHB Policy Person (when hired) re: updating CFR 42.2
2. Stephanie will follow-up with Lisa to invite Michelle Sobel and Jackie Mercer to provide an update at the next QBM
3. Stephanie will follow-up with Colbie to get an update on the Zero Suicide Academy in OR. (Done – Notes included above)

Report: Marilyn Scott, Upper Skagit

Veteran's Committee

Tuesday January 19, 2016
Silver Reef Casino Resort, Ferndal, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Cathy Davidson Minority Veterans Coordinator	VA Puget Sound Health Care System	253-589-4147 cathy.davidson2@va.gov
2	DON HEAD NTDB SPEC.	NPAIHB	dhead@npaihb.org
3	DAVID JEFFERSON LUMMI TRIBAL VETS REP.	LUMMI VETS	360-758-9999 davidj@lummi-nsn.gov
4	FRANK GEDEON SUQUAMISH	VETS	
5	Ronda Metcalf	Sauk-Suiattle	rmetcalf@sauk-suiattle.com
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January 19, 2016 Veteran's Committee Meeting

In attendance:
Ronda Metcalf, Sauk-Suiattle Tribe
Cathy Davidson, VA Puget Sound Health Care System
David Jefferson, Lummi Tribe
Frank Cordew, Suquamish Tribe
Don Head, NPAIHB staff

The notes from the October 2015 meeting were read, and two issues came up. At the October meeting, there was a request for training regarding IHS reimbursements from the VA, since there seems to be some confusion about it. Cathy said that tribes that have an MOU with the VA also have a list of VA personnel in the area that they can contact for technical assistance for reimbursements. The VA Tribal consultation was discussed in October, and if there was an explanation or plan to put it into place. Cathy said that the VA Office of Tribal Government Relations has a website that addresses tribal consultation, and that Terry Bentley would be the person to talk to about consultation. Don Head was charged with getting clarification from the participants of the October 2015 meeting, about what training and consultation was discussed, so that the committee can address the issues satisfactorily.

Cathy Davidson will be retiring in July as the Minority Veteran's Coordinator. A transition plan for the incoming coordinator was discussed, as well as the requirements for filling the position.

There is a Joint American Indian Veteran's Advisory Council (JAIVAC) meeting on February 3, hosted by VISN 20 in their Vancouver, WA offices. The JAIVAC meets quarterly, and recruitment for the meetings was discussed. The NPAIHB staffer and delegate were sent invitations to attend.

Recruitment was also discussed for the NPAIHB Veteran's Committee. For future QBMs, Don Head will contact the delegates of the tribes hosting the QBM, in order to inform veterans in the community about the committee meeting and the opportunity to connect with VA personnel.

Meeting adjourned

Public Health Committee

Tuesday January 19, 2016
Silver Reef Casino Resort, Ferndal, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Victoria Warren-Mears	NPAIHB - NWTEC	
2	Danna Drum	OHA - Public Health	971-673-1223 danna.k.drum@state.or.us
3	Jim Steinruck	Health Administrator Tulalip	(360) 716-5610 jsteinruck@tulaliptribes-nsn.gov
4	Shawn Jackson Health Planning & Ed Dir.	Klamath Tribal Health & Family Service	541-882-1487 ext 220 sljackson@klamathtribes.com
5	Tom Weiser	PAO - IHS	tweiser@npaihb.org
6	Judy Hottowe	Lummi Health Commiss	—
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10	Andrew Shogren	Quileute Nation	
11	Kelle Litten	Coquille Tribe	
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Public Health Committee Meeting
January 19, 2015
Ferndale, WA

In attendance:

Victoria Warren-Mears
Bridget Canniff
Danna Drum , OHA – Public Health
Andrew Shogren –Quileute Nation
Jim Steinruck – Health Administrator Tulalip
Shawn Jackson – Klamath Tribal Health and Family Services
Tom Weiser – PAO-HIS
Judy Hottowe – Lummi Health Commission
Kelle Little – Coquille Tribe

I. Introductions of all in attendance

II. Business:

Emergency Preparedness Conference – A save the date was distributed to the committee. The Tribal Emergency Preparedness Conference will be held May 3 – 6, 2016 at the Northern Quest Resort and Casino in Spokane, WA. May 3rd will be the Pre-conference workshops and May 4 -6 will be the conference sessions. You can obtain more information at: https://www.surveymonkey.com/s/TPHEP2016 or contact Luella Azule at lazule@npaihb.org

Training Update – The Board will be working with Red Star Innovations to sponsor a national tribal public health and accreditation forum. The date is to be announced. It will be held at Northern Quest in Spokane, Washington. Please watch our weekly mail out for additional information.

Northwest Injury Prevention Coalition Meeting – We are revitalizing the Board's injury prevention coalition. The injury prevention coalition will meet here on the 20th of January at noon. We welcome new attendees; please let Bridget know if you would like to join this meeting for lunch count. The purpose of the meeting will be to do planning and outreach.

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Epidemic Intelligence Service Officer

Dr Weiser announced that the EpiCenter matched for EIS officer with CDC. We will have new EIS officer joining us in August 2016 for two years. Our match is Sarah Hatcher who has a PhD in Environmental Health.

Hepatitis Questions: There is a possibility to participate in IHS Project Echo telemedicine; learning and case management program. Provider can register at project Echo and present their case. They use the Zoom platform in partnership with the University of New Mexico. Infectious disease specialists are available to consult with rural providers.

Dana Drum spoke about the state of Oregon's vision for public health services. The state has verbalized an intent to include tribes in the planning for foundational capacities in public health. The state has expanded their vision to include much stronger tribal focus where previously the focus has been on health departments.

The State of Oregon has released a new document on population metrics related to marijuana use.

Emergency Planning Information on the NPAIHB Web Site -
Based on recent requests, we anticipate having increased emergency planning information on the Board's web site. Our new website will roll out later this year.

Meeting adjourned

Action Items:

1. Provide information to tribes on Public Health Accreditation meeting as soon as it is available.
    a. Responsible: Bridget Canniff
2. Provide aggregate of tribal priorities to committee as soon as it is available.
    a. Responsible: Victoria Warren-Mears

Personnel Committee

Tuesday January 19, 2016
Silver Reef Casino Resort, Ferndal, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Andra Wagner HR Coordinator	NPAIHB	awagner@npaihb.org
2	Shawna Gavin Lee Comm	CTUIR	Shawnagavin@ctuir.org
3	Bonnie Sanchez	Squaxin	bsanchez@squaxin.us
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Northwest Portland Area Indian Health Board
Quarterly Board Meeting
Personnel Committee Meeting Minutes

January 19, 2016

Start Time: 12:30 pm

Members Present: Shawna Gavin, Bonnie Sanchez

Members Absent: Cassandra Sellards-Reck

Staff Present: Andra Wagner

- Personnel update was read by Andra Wagner
    - 0 new hires
    - 1 temp hire
    - 1 promotion
    - 1 resignation
- CPR, AED & First Aid training is scheduled for February, 2016
- NPAIHB won 2015 Oregonian Top Workplaces Award
- No employee relations issues
- Program Operations Manual Revision to Temp Employee Sick Leave

Program Operations Manual Revisions

January 2014 Revision:

***TEMPORARY EMPLOYEE*:** An employee, hired for less than six (6) months on either a full-time or part-time basis. Temporary employees are not eligible for annual leave, ~~sick leave,~~ health or disability insurance, retirement benefits, holiday pay, or in-house preference for employment. All temporary employees who have been employed with the Board for ninety (90) days and have worked at least two hundred and forty (240) hours will accrue one (1) hour of sick leave for every 30 hours worked.

January 2016 Proposed Revision:

***TEMPORARY EMPLOYEE*:** An employee, hired for less than six (6) months on either a full-time or part-time basis. Temporary employees are not eligible for annual leave, health or disability insurance, retirement benefits, holiday pay, or in-house preference for employment. Temporary employees are eligible for sick leave.

Legislative/Resolution Committee

Tuesday January 19, 2016
Silver Reef Casino Resort, Ferndal, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Jim Petrowitz	NPAIHB	
2	Leslie Wosnig	Suquamish Tribe	360-394-8466
3	P.C. Baller	Quinault	360-276-8211
4	Cheryl Rafaar	Swinomish	360 466 7268
5	Greg Abrahamson	Spokane	509 458 6507
6	Kim Ziltyett	Shoalwater Bay	360-267-8138
7	Joe Finkbonner	NPAIHB	503-228-4185
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Legislative Sub-committee meeting: January 19, 2016

Attendees: Jim Roberts, Leslie Wosnig, Pearl Capoeman-Baller, Cheryl Rasar, Greg Abrahamson, Kim Zillyet, Joe Finkbonner, Andy Joseph, Jr.

One resolution was considered – We R Native: Text 4 sex Ed.

The resolution is asking for approving for We R Native in the EpiCenter to apply for funds from the National Campaign to Prevent Teen and Unplanned Pregnancy.
Motion made by: Swinomish – Cheryl Rasar
Second by: Shoalwater – Kim Zillyett

Motion approved

There was discussion regarding the resolutions from Tribes that need to be amended in order for the Board to pursue a planning grant from the IHS for the assumption of some Area Office activities.

Delegates will be contacted and provided the suggested amended language for their councils to approve. NPAIHB will also follow up with Tribal leaders at ATNI during the February meeting.

RESOLUTION

We R Native: Text 4 Sex Ed

WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS, the NPAIHB is a non-governmental "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the Board's NW Tribal Epicenter manages *We R Native* -- a website, social media platform, and text message service that serves as a sexual health resource for Native teens and young adults. Our campaigns, interventions, curricula and services have been shown to reduce sexual risk-taking and promote protective behaviors; and

WHEREAS, American Indian and Alaska Native youth are disproportionally impacted by higher rates of teen pregnancy and sexually transmitted infections, compared to non-Indian people; and

WHEREAS, *We R Native* is authorized to carry out goals and objectives that coincide with The Innovation Next Awards funding opportunity, founded by The National Campaign to Prevent Teen and Unplanned Pregnancy, to develop innovative, technology-based interventions to prevent teen pregnancy; and

WHEREAS, the specific goals of The Innovation Next Awards initiative are:

- 10 teams of three will be selected to receive $80,000 in funding. During the second stage, 5 of the teams will be awarded up to $325,000 to further develop their innovation.
- The total time for the entire process, if our team is selected for the second stage, is 22 months.
- They are looking for a killer team of thinkers and doers with varied perspectives on teen pregnancy prevention. The magic is in the makeup of our team, and we are looking for other individuals who share our passion and commitment for teen pregnancy prevention in Indian Country.

WHEREAS, in 2014, *We R Native* sent a series of text messages to American Indian and Alaska Native youth, designed to promote condom use and STI/HIV testing. Improvements in condom use attitudes and behavior were retained at least 3 months post-intervention. Building off of this success, we are hoping to design a text messaging service that generates tailored messages (based on age, gender, or risky sexual behaviors) while building in content from our other successful digital campaigns/curricula, including Native VOICES (a CDC-endorsed HIV Prevention Intervention) and Native STAND (a peer education healthy decision-making program for Native youth); and

WHEREAS, the goals of this initiative are consistent with the goals and objectives of both the NPAIHB and the NW Tribal EpiCenter; and

THEREFORE BE IT RESOLVED, that the Board endorses and supports efforts by staff of the NW Tribal EpiCenter – We R Native -- under the guidance of the Executive Director, to pursue funding through The Innovation Next Awards funding opportunity.