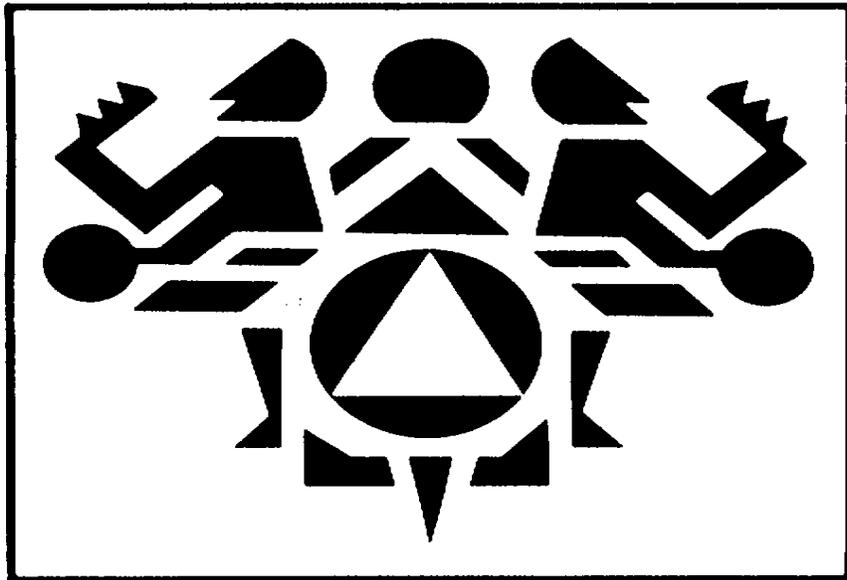


MINUTES

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD



QUARTERLY BOARD MEETING

OCTOBER 27-29, 2015

WILDHORSE CASINO RESORT
PENDLETON, OR

October 2015 Quarterly Board Meeting

Summary of Minutes

<u>Issue</u>	<u>Summary</u>	<u>Action</u>	<u>Follow-Up</u>
Tuesday October, 27, 2015			
Area Director Report	<p>Governing Board Meetings</p> <ul style="list-style-type: none"> • All Six Service Units <ul style="list-style-type: none"> ○ Bi-Annual- Department Best Practices ○ Future Presentations and presence at QBM <p>IHS Directors Listening Session</p> <ul style="list-style-type: none"> • Corrective Action Plan <p>Public Health Service Update</p> <ul style="list-style-type: none"> • Transition of HR Support to Coast Guard system • No new Orders after November 13 – January 1, 2016 • New Commissioned Corps Liaison for PA <ul style="list-style-type: none"> ○ Housed in Alaska Area office <p>Office of the Assistant Secretary for Planning and Evaluation Site Visit</p> <ul style="list-style-type: none"> • November 4-6, 2015 • Site Visits locations <ul style="list-style-type: none"> ○ NARA, Siletz Tribal Health Care Program, and Western Oregon Service Unit <p>Emergencies/Disasters, 2015</p> <ul style="list-style-type: none"> • NW Drought and Wildfires • Roseburg Shooting Incident <p>IHS Actions</p> <ul style="list-style-type: none"> • Tribal inclusion of State and Federal declarations 		

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Summary of Minutes

	<ul style="list-style-type: none"> • Provided technical Assistance, expertise • Critical medical supplies, public and behavior health services and environmental equipment <p>FY16 Initiatives</p> <ul style="list-style-type: none"> • Injury Prevention Projects • Environmental Health Program Capacity Development <p>CHEF Balance Remains at 4 Million as of 10/23/15</p> <ul style="list-style-type: none"> • 59 PA CHEF Cases Submitted • \$2,469,211.33 Submitted for reimbursement • \$1,704,802 funded thus far • New CHEF guidelines will be released mid-November <p>FOIA Data Base</p> <ul style="list-style-type: none"> • Updated <p>Portland Area Facilities Advisory Committee (PAFAC)</p> <ul style="list-style-type: none"> • Develop a Project Proposal the Demonstrates Readiness for Implementation <ul style="list-style-type: none"> ○ Location ○ POR/PJD/Business Plan ○ Tribal Support • Meeting Regularly <p>Fall 2015 Portland Area Clinical Directors Meeting</p> <ul style="list-style-type: none"> • November 5-6, 2015 (NPAIHB Office) • Spring 2016 Portland Area Clinical Director’s Meeting (tentative) 		
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October 2015 Quarterly Board Meeting

Summary of Minutes

	<ul style="list-style-type: none"> • April 7-8, 2016 • Follows Clinicians Cancer Update (4/6/2016) • IHS Essential Training on Pain and Addiction <ul style="list-style-type: none"> ○ Virtual session Nov. 18, 2015 <p>Special Diabetes Program for Indians (SDPI) FY2016</p> <ul style="list-style-type: none"> • Diabetes Prevention and Health Hearts grants have ended • Funding for “Data” Grants” will be an Area-level decision • Funding has been reallocated to existing programs • Selected grantees will be announced in December <p>Portland Area Funds Distributions</p> <p>FY18 Budget Formulation Meeting</p> <ul style="list-style-type: none"> • November 10, 2015 – Embassy Suites Portland Airport <p>Area Office Staffing Update</p> <ul style="list-style-type: none"> • Selected Area Dental Officer – withdrew acceptance • Martha Young retired effective Sept. 30, 2015 • Area Diabetes Officer – expect advertisement with six months 		
<p>IHS Deputy Director</p>	<p>Updates</p> <ul style="list-style-type: none"> • Drought and wildfire response & shooting in Roseburg, OR • July 2015 Listening Session for IHS Portland Area action Item <p>Current Performance Reporting</p> <ul style="list-style-type: none"> • GPRA • GRPAMA <p>New System: Data Mart</p>		

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	<ul style="list-style-type: none"> • Allows Tribes and Urban programs with HER to include their data in national results <ul style="list-style-type: none"> ○ Improves accuracy and completeness of performance data ○ Reports will be available at the National, Area, and Service Unit levels • Automated system built into National Data Warehouse <ul style="list-style-type: none"> ○ Improves timeliness of reporting <p>Launch Timeline for the Data Mart</p> <ul style="list-style-type: none"> • 2015-2016 <ul style="list-style-type: none"> ▪ Tribal Consultation and Urban Conference sessions ▪ Build and test system • 2017 <ul style="list-style-type: none"> ○ Monitor results • 2018 <ul style="list-style-type: none"> ○ Official results available ○ IHS will begin to use results, starting with FY20 Congressional Justification <p>Key Points</p> <ul style="list-style-type: none"> • IDCS allows non-RPMS users to submit data for IHS National Performance results <ul style="list-style-type: none"> ○ Urban programs will be included in reporting • Results will be available at the National, Area, and Service Unit levels • Tribal programs may opt out 		
Executive Directors Report	Strategic Planning coming January Presentation Attached		

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Summary of Minutes

<u>MOTION: Behavioral Health Area Representative, Cheryle Sanders nominated by Andy Joseph, Jr., Seconded by Leslie Wosing. Motion is voted and passed</u>			
	THRIVE/PRT Update <ul style="list-style-type: none"> • We need you here – media campaign released Presentation Attached		
Committee Meeting	Elders – Report Attached		
	Veteran’s – Report Attached		
	Public Health – Report Attached		
	Behavioral Health – Report Attached		
	Personnel – Report Attached		
	Legislative/Resolution – Report Attached		
	Federal Marijuana Policy & State Legalization – Presentation Attached		
Richard Truitt, Director, OEH&E	Regional Specialty Facility Update The Portland Area Master Healthcare Plan <ul style="list-style-type: none"> • Proposes a Network of three Regional Specialty Referral Centers (RSRCs) • Illustrates the RSRCs will expand access to care • PSRCs will conserve PRC funds for higher levels of care • Examples of Specialty Care include: Dermatology, Cardiology, General Surgery, and Tele-Medicine IHS currently Does not provide a mechanism to construct and provide staff for and RSRC The Portland Area Solution: Develop a Pilot Demonstrate the viability of RSRCs		

October 2015 Quarterly Board Meeting

Summary of Minutes

	<p>Current Approach</p> <ul style="list-style-type: none">• Develop a proposed project that demonstrates readiness for implementation<ul style="list-style-type: none">○ Location○ POR/PJD/Business Plan○ Strong Tribal Support <p>The PAFAC is meeting regularly and developing recommendations to strengthen the Pilot Project proposal</p> <p>Positive Developments:</p> <ul style="list-style-type: none">• Two Tribes have expressed strong interest in hosting the Pilot Project<ul style="list-style-type: none">○ Chehalis○ Puyallup <p>PAFAC Members visited both locations on May 14</p> <p>Both Tribes agree with four Core Operating Principles</p> <ul style="list-style-type: none">• Any Federal resources allocated will not be available for individual Tribes to Contract• The network will be Federally operated initially• A Qualified Tribal Organization broadly representing Portland Area Tribes may contract operation of the network• Third Party revenue will be used to improve and expand access to Specialty Care across the entire Portland Area <p>The Area Director made \$110,00 available to support planning and project development</p>		
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October 2015 Quarterly Board Meeting

Summary of Minutes

	<p>These funds are being utilized to update the Interim PAFAC Report to consider:</p> <ul style="list-style-type: none"> • Affordable Care Acts impacts • Comparison of the Chehalis and Puyallup sites <p>The PAFAC will meet October 29 with the Healthcare Consultant OEHE has under contract to update the Report. This will assist the PAFAC in their work to recommend a location for the first of three Regional facilities</p> <p>After the IHS Director’s Listening Session held in Issaquah on July 23, Principal Deputy Director McSwain provided \$150,000 to further the project development</p> <p>Upon completion of the Interim PAFAC Report Update and site selection, these additional funds combined with remaining Area funds will be utilized to develop PJD/POR/and Business Plan for the proposed facility</p>		
	<p>Oregon Washington health Network (OWhN) Presentation attached</p>		
<p>Wednesday October 28, 2015</p>			
<p>Policy/ Legislative Update</p>	<p>Appropriations Update & Continuing Resolution</p> <p>FY 2016 President Request \$460 million increase</p> <ul style="list-style-type: none"> • 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 		

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Summary of Minutes

	<p>Senate provides \$17 million increase for H&C accounts while House provides \$78 million</p> <p>Senate provides \$61 million for Facilities accounts, while House provides \$6 million</p> <p>Congress passed CR through 12/11/2015 for twelve regular appropriation bills</p> <p>CR funds @ 2015 levels; less a .2018% across the board decrease</p> <p>S. 1964 Family Stability and Family Kinship Act of 2015</p> <ul style="list-style-type: none">• 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. <p>Contract Support Cost Updates</p> <ul style="list-style-type: none">• IHS Continues to revisit CSC negotiated amounts using a cost incurred approach more than a year or more later<ul style="list-style-type: none">○ BIA does not follow the same method – why does IHS?		
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Summary of Minutes

	<ul style="list-style-type: none"> ○ IHS advises that it must verify that CSC is being paid on the correct amount and cost-incurred (audit) is the only way to do this ● IHS Past Year’s Claims – Agency want to settle by end of this year ● Revised CSC Policies: BIA has completed a revised policy; IHS should have a draft available soon for review <ul style="list-style-type: none"> ▪ Fixed Rates ▪ OMB should bring IHS and BIA CSC Workgroups together to align the issues and resulting policies ● CSC Appropriations in FY 2016 and potential sequester <ul style="list-style-type: none"> ▪ Congress and Administration have established a policy to fully fund CSC requirements ▪ In event of FY 2016 yearlong CR; or sequester if CSC is not adequate IHS will likely reprogram funds ▪ FY 2016 CR is approximately \$55 million short of fully funding CSC requirements ▪ A potential 2% sequester and across the board cut will result in not enough CSC funds ▪ Administration could request an anomaly for additional funding in the appropriation ● Mandatory CSC proposal <p>CMS 100% FMAP & TTAG Updates</p> <ul style="list-style-type: none"> ● AK & SD Medicaid Expansion proposals to CMS ● AK 100% FMAP request for emergency and non-emergency 		
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Summary of Minutes

	<p>medical transportation and services provided through CHS/PRC referrals</p> <ul style="list-style-type: none"> • SD requests 100% FMAP for telehealth services, specialty services provided through collaborative arrangements, and services provided by community health representatives • CMS has conducted Tribal consultation and expected to issue a decision soon <p>NPAIHB has submitted recommendations</p> <ul style="list-style-type: none"> ○ 100% FMAP for CHS referrals or ○ 100% FMAP for services under contract with I/T/U ○ Without link to I/T there is not incentive for States to work w/Tribes <ul style="list-style-type: none"> • Summary of Benefit Documents for zero and limited cost sharing variations • Referrals for cost-sharing and proper payments • Marketplace Call Center Tribal Scripts • Network Adequacy for I/T/Us – contract issues • Simplify Family Plan Provisions for Indians • Enrollment data for Indians • Transition from Marketplace Coverage to Medicaid coverage (AK) – Could affect Idaho <ul style="list-style-type: none"> ○ New Medicaid eligibles cannot cancel Marketplace coverage ○ NACs and CCIIO have invested much time in this process ○ Results in enrollee not having coverage for some time which has resulted in bills to individuals ○ Complicates Indian cost-sharing for QHP & Medicaid 		
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Summary of Minutes

	<p>HRSA 340(b) Regulation</p> <ul style="list-style-type: none"> • HRSA has proposed 340B Drug Pricing Program Omnibus Guidance, August 28, 2015, makes significant changes regarding individuals eligible for 340B drug pricing • Guidance redefines the required relationship between a provider and a patient & will effect Tribal access 340B drug pricing: <ol style="list-style-type: none"> 1. require that the relationship between a patient and a provider be evaluated on a prescription-by-prescription basis; and 2. that the prescription be issued at a tribal facility. • Will make PRx issued by providers serving tribal health program patients outside of tribal clinic facilities ineligible for 340B pricing <p>NPAIHB Comments clarify standards that should be applicable to Tribal health programs to “permit covered entities” and not focus on facilities and defining patient eligibility under the ISDEAA Presentation attached</p>		
	<p>Portland Area IHS Influenza Action Plan Presentation and plan attached</p>		
	<p>Hepatitis C Treatment - Presentation attached</p>		
	<p>DHAT Project Updates – Presentation attached</p>		
	<p>WEAVE-NW Project Update</p> <ul style="list-style-type: none"> • Year 2 Sub-award Announcement <ul style="list-style-type: none"> ○ Maximum of \$25,000/year or \$50,000 for two years <p>Presentation attached</p>		
	<p>OSHU School of Nursing and the Native STAND Program update</p>		

October 2015 Quarterly Board Meeting *Summary of Minutes*

	Presentation attached		
	Five Year Report on Domestic Violence Prevention Initiative (DVPI) Presentation attached		
	DHAT Project Updates – Presentation attached		
	WEAVE-NW Project Update <ul style="list-style-type: none"> • Year 2 Sub-award Announcement <ul style="list-style-type: none"> ○ Maximum of \$25,000/year or \$50,000 for two years Presentation attached		
	Hepatitis C Treatment - Presentation attached		
	DHAT Project Updates – Presentation attached		
	WEAVE-NW Project Update <ul style="list-style-type: none"> • Year 2 Sub-award Announcement <ul style="list-style-type: none"> ○ Maximum of \$25,000/year or \$50,000 for two years Presentation attached		
	OSHU School of Nursing and the Native STAND Program update Presentation attached		
Thursday October 29, 2016			
Chairman’s Report	Report Attached		
MOTION - Minutes	TABLED – Until October	TABLED	
Resolutions			
16-01-01 Interview Project with People who Inject Drugs <u>[Motion is made by Cheryl Sanders and seconded by Shawna Gavin motion to approve this resolution. Motion is voted on and passed.]</u>		Motion Passed	
16-01-02 Tribal Exemption from the Patient Protection and Affordable Care Act Employer Shared Responsibility Mandate <u>[Motion is made by Cheryl Sanders and seconded by Shawna Gavin, motion to approve this resolution. Motion is voted on and passed]</u>		Motion Passed	

October 2015 Quarterly Board Meeting *Summary of Minutes*

<p>16-01-03 Western Tribal Diabetes Special Diabetes Program for Indians Grant <u>[Motion is made by Cheryl Sanders and seconded by Shawna Gavin, motion to approve this resolution. Motion is voted on and passed]</u></p>		<p>Motion Passed</p>	
<p>16-01-04 Northwest Portland Area Support for Congress to Pass S.1964, Family Stability and Kinship Care Act (S.1964) <u>[Motion is made by Cheryl Sanders, Lummi Nation and seconded by Brent Simcosky, Jamestown, to approve this resolution. Motion is voted on and passed.]</u></p>		<p>Motion Passed</p>	
<p>MOTION Financial Report</p>	<p><u>[Motion is made (by Shawna Gavin) and seconded (by Marilyn Scott) to approve this report. Motion is voted on and passed.]</u></p>	<p>Motion Passed</p>	
<p>MOTION ADJURN</p>	<p>Motion to adjourn by Pearl Capoeman-Baller, seconded by Brent Simcosky motion is voted and passed.]</p>	<p>Motion Passed</p>	

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

QUARTERLY BOARD MEETING

Wildhorse Casino Resort - Pendleton, OR

MINUTES

Tuesday, October 27

[Tribal music.]

MALE SPEAKER FROM THE DRUM GROUP: Welcome everybody! Glad to see you're all here at the Wild Horse Casino and Resort on the Umatilla Indian Reservation. We're the Cayuse Singers. Local drummers from right here on the Umatilla Indian Reservation, and we're honored and glad to be here for this opening ceremony. Thank you.

[Drumming.]

9:00 a.m. Call to order: Andy Joseph, Chairman: Thank you for the welcome. We have -- I'd like to call this meeting to order. We have Chairman, Alan Crawford and BOT Chairman, Gary Burke come to do the invocation and the welcoming.

Invocation: It's good to be here on this day, and it's an honor to welcome you all here to our establishment and our country. I'm glad for the opportunity to say a few words to you. And we'd like to open it up with a song and a prayer so that we may go forward in a good way for the day and hopefully the rest of the time that you're here for your business. Thank you.

[Song.]

Posting of Flags: Tribe Veterans posted the flags.

Alan Crawford: Thank you all very much for helping the day begin with us. Now I'll defer this time to the chairman. Thank you.

Welcome: Tribal Chairman Burke: Good morning. I'd like to welcome you all to the Confederate Tribes Umatilla Indian Reservation, made up of the three branches of the Cayuses, Umatilla, and the Walla-Walla. I'm glad to see that the Indian Health Board is coming here to meet, to discuss all the important issues that needs to be done for everyone's health. Health is very important while we're on this Earth. So today and for the future generations to come, finding those successes that help people live a better life, Umatilla Reservation has a treaty that we still abide by with eleven articles of the law. We also have a constitution and bylaws with eight articles of law. These things that we have, we have to abide by, like any other reservation. But there are some unwritten laws within the other reservations that we all know. And that order that needs to be kept, culture and tradition is what makes Tribes what they are and who they are. Very important to keep those things continuing and pass them down to the next

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generations. They need to know these things. That's how they're going to survive. That's all I have for now. Thank you very much.

[Song.]

Andy Joseph: Thank you for the invocation, the welcoming, and the drums and our honor guard here from Umatilla. Really, really nice to hear the drum and the songs and that great welcoming that we got. I know we've got to have a busy few days here, and so we're going to move on with our agenda. Hopefully if you messed around with the machines out there, they were kind to you. We'll move on with our agenda. Actually I think we have roll call. Shawna will give us a roll call.

Roll Call: Shawna Gavin, Secretary, called roll: Thank you, Andy. And once again thank you to the veterans who are in the room, and those who posted our colors and the drum. Chairman Burke and Chairman Crawford. And thank you all for being here. It's really good to see all your wonderful faces again. Welcome to our beautiful home. I hope you get a chance to go out to see some of our hills and explore a little.

Burns Paiute Tribe – Present	Nisqually Tribe – Not Present
Chehalis Tribe – Present	Nooksack Tribe – Not Present
Coeur d'Alene Tribe – Not Present	NW Band of Shoshone – Not Present
Colville Tribe – Present	Port Gamble Tribe – Present
Grand Ronde Tribe – Present	Puyallup Tribe – Not Present
Siletz Tribe – Present	Quileute Tribe – Not Present
Umatilla Tribe – Present	Quinault Nation – Present
Warm Springs Tribe – Present	Samish Nation – Not Present
Coos, Lower Umpqua & Siuslaw Tribes – Present	Sauk Suiattle Tribe – Not Present
Coquille Tribe – Present	Shoalwater Bay Tribe – Present
Cow Creek Tribe – Present	Shoshone-Bannock Tribe – Present
Cowlitz Tribe – Not Present	Skokomish Tribe – Not Present

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Hoh Tribe – Not Present	Snoqualmie Tribe – Present
Jamestown S’Klallam Tribe – Present	Spokane Tribe – Not Present
Kalispel Tribe – Not Present	Squaxin Island Tribe – Present
Klamath Tribe – Present	Stillaguamish Tribe – Present
Kootenai Tribe – Present	Suquamish Tribe – Present
Lower Elwha Tribe – Not Present	Swinomish Tribe – Present
Lummi Nation – Present	Tulalip Tribe – Not Present
Makah Tribe – Present	Upper Skagit Tribe – Present
Muckleshoot Tribe – Present	Yakama Nation – Present
Nez Perce Tribe – Present	

Mr. Chairman, we have a quorum. Thank you. Again, welcome. [There were 28 delegates present, a quorum is established.]

Andy Joseph: Thank you Shawna. All right, our first agenda item that we have is the Area director report. Dean Seyler, Portland Area IHS Director. Hopefully we have some good news!

Area Director Report

Dean Seyler: I'm always full of good news! Good morning everyone. It's always a pleasure and an honor to start off with giving you an update. On the agenda, I've got 15 minutes. So I'll work through this quickly. We do have Mr. McSwain set to come online at 9:30 to conduct a listening session. So we'll work our way through this. Just want to give an update on the governing board meetings that we're just finishing up, with all six federal search units. The Portland Area to the Direct Service Tribes. We've been working on changing up the format of those governing board meetings. With me is the chair of each of the boards. I split it out to where we have two semi-annual meetings. And one deals specifically with the governance portion. We have the approved bylaws and all the stuff getting ready for their surveys. And the second semi-annual deals more with going over best practices at the Service Units or the departments of the Service Units, to highlight the great changes that they've made and the services they provide.

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We're going to change it up more this coming year, to where I'm going to have just probably two or three departments at each service unit, spend more time developing a PowerPoint presentation to expand further as to details of the changes that they're making, the quality improvement changes. And I'm also going to ask that the Service Units also rotate in at least once or twice a year into this setting, and to share that information here, too. We have some great presentations. Our last one, or second to last was at Colville and I know that I had mentioned to Andy about looking at doing that. So we'll work on that more to come. As I mentioned, there's the IHS Listening session. That happens Back in July. We have a corrective Action Plan that is back in headquarters along with the other eleven Areas that are going through it. Take a look at what they need to respond with. I hope to have that out to all of you soon. I'm just waiting for clearance from headquarters on that one.

Update for those of you who have public health service commission officers, people who are under MOA to you there are some changes come up. I'm not sure whether I shared those with you. There's approximately fifteen or twenty, I think, officers we have on detail at the Tribes or Tribe organizations. And they were notified that their personnel system is transitioning to the United States Coast Guard system. And so with that brings improvement. With that brings some anxiety and some change that we need to work through over the coming months. They are going to shut down the option to be able to generate new orders. I know we have a couple Tribes looking at officers. If we do not get our request in to headquarters by November 13th, then we will have to wait until after the first of the year to request orders. So just FYI, if you have an officer you're looking at, get to me right away. We need to get this going. Because we have our process where we look at that officer ourselves. I need to make sure that this officer is presenting themselves with the appropriate credentials and they have the background that will meet your needs plus my needs if for some reason I have to inherit that officer. For those officers in the room, there will be a new commission core liaison for you to work with. That person is a Commander Martha Wanca, and she will be physically located up in the Alaska Area office. I did talk to her about coming to the Portland Area. And at least hosting the meeting with officers in the future. And of course the commission officers who are effecting supports those of you who began with officers in the Tribes, you really need to take a look at those deadlines and make sure that you assign your officers' reviewing official as their federal supervisor, which would be either Dr. Rudd, Dr. Marrow, Long Wan, and Matt. Does Matt know? Matt Martinson? Those three are the main ones. If they don't know, please have them contact Commander Ann Arnette and she can help them with that.

There's an upcoming visit from the office of the assistant secretary of the planning and evaluation. They first approached me back in August to come out and that's when we had a lot of meetings coming up in September. And I thought "oh great, more department people that we have to ferry around and stuff." But it takes a lot of time and

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a lot of prep work, and it takes away from our busy activities that we're reviewing, and the support to the 43 Tribes. And I tried to get out of it, but then they said "oh, we'll wait." You know, they really want to come to Portland. So their focus is to take a look at the Affordable Care Act and the great changes that's happened here. And they specifically asked for these sites. They've asked for NARA, they asked for Siletz, and Western Oregon. So they're also going to try and set up a meeting with the State of Oregon to talk to them about the Affordable Care Act. So we'll share a little more on that later on. I'll be back in headquarters next week, so I won't be here for that. Terry Dean will be traveling with them.

Just a quick update on the Public Health Emergency Management Support. This past fiscal year, I don't need to go into detail. Those of you who dealt with them know more about it than I do. And that being the Wild Land Fires that the Tribes had to deal with, anywhere from a little bit of inconvenience, my understanding in Yakima, to Wellpinit kind of impacted. Were you guys closed at all, Marcus? One day? Yeah. To Warm Springs had fires where they weren't closed if I remember right, but they had a lot of support from the firefighters and the community, to the worst one of the area was Colville where they actually were closed for about a week, relocated to a Tribal site, Lake Roosevelt. We truly appreciate that partnership, and were able to have a modified delivery of health care to a community. And also my thanks to Mr. McSwain, who added some funds to our budget in order to help offset some of the costs to all the Service Units, and I already distributed that money to them.

This is unprecedented, to have money left over for CHEF. As of last week, the 23rd, a quarter of a million dollars still sitting there. And I know that we had some cases pending yet, that she's been working on, and pretty sure they still have money today. Right? OK. So there's still a balance in headquarters. And there's no guarantee, but chances are high that if you had one pending, you're probably going to get some returns. I think the key to note here is that \$1.7 million has a return back to the products in the Portland Area, to their CHEF, to their PRC money to help deliver more health care to their members. I don't have data of those back that shows what we did prior, for various reasons. But starting this year, starting with fiscal year 15, we're going to track it more and be able to report back to you on how we're doing as far as the amount of money, how many claims that we're able to get back. ICD-10, that rollout happened on October 1st. And it had some minimal impact. We're really not seeing the Dooms Day prediction that we were being told, at the six federal sites at least. If there are some impacts going on with the Tribes, I'd like to hear about it. I know we're fresh in the fiscal year, and that still may happen. To an extent. But so far, things are going fairly smooth. I had that in there twice. My apologies.

The FOIA Database, this is just an update. I've shared this with you guys before, and it has to do with switching the servers over. And so far we've completed 25 sites, and we have three more to go. PAFAC there's going to be a presentation by Rich Truitt this

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afternoon. So I won't go into a lot of detail on this. Just that I need to impress on you guys that now is the time that you must act. We must secure some approvals. Mr. McSwain, who is the head of the agency for at least the next 14 months, is very supportive. We didn't have that support prior to him. But we do now. We're moving forward. We had a meeting Thursday afternoon with PAFAC in Portland. He was working on our business plan, and I need to get this turned in. I know there's PAFAC members who may not be able to make it Thursday afternoon or future meetings, but I'm moving ahead if they're there or not. Because I can't wait. I can't delay. I'll present it to all of you. It's going to be based on what the PAFAC members have contributed so far. But if I wait, we're going to lose out on this window of opportunity. So I'm going to let Dr. Dr. Rudd do this next piece.

Dr. Rudd: Hey, good morning everybody. A couple meetings that are on the schedule that I wanted to make sure you're aware of. The end of next week, November 5th and 6th, will be the Portland Area Clinical Directors' meeting. It's going to be held in Portland, being provided space gratefully by the Northwest Portland Area Indian Health Board. So that information is going out to your political directors as long as I have their contact information. All are welcome with both federal, Tribal, and urban Clinical Directors for that. Also just to sort of get on the schedule for the Spring dates, we do host our Spring meeting in conjunction with the Health Board's Annual Clinicians' cancer updates. So we're looking tentatively at dates in early April for that. As well, coming up in a couple weeks, last Spring IHS had a series of online webinars on treatment of pain and dealing with opiate addictions. There were approximately ten of these six-hour courses that were provided through the Spring. There have been plans from IHS to make that available through a recorded session that would be available online, but there have been delays, apparently, in being able to get those posted. There's an attempt to make sure that the clinicians that are going through that recorded session would be able to get CME credit for that training. So until that can get resolved, the group that provided the training initially is providing an additional live session coming up on November 18th. And the information is provided there on the slide for your clinicians that may be wanting to go through that. IHS has required all of our federal facilities; any of our prescribers of controlled substances are required to have gone through the training. But I've also encouraged your Tribal clinicians to consider participating. It's actually quite well done. Many of them do have licensure in states that may require a certain amount of pain training to meet their state licensure requirements. Those vary by state. Different than some of the other training courses that are out there. This is really Native American specific. It talks about some of the various cultural issues that may exist for our Tribal populations that do influence how we approach pain and addiction. So it is a particularly good training for your clinicians to make use of.

Also, I wanted to mention the upcoming SPDI cycle that's currently going on. As many of you may know, the noncompetitive diabetes prevention and healthy heart grants have ended. Nationally, those monies were redistributed, the majority of which went into the

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competitive community directed grants. Also there was a decision to stop funding data grants from a national level, but they let that be an Area level decision as to whether or not those would continue. Grants such as what the Health Board has had to assist you with data gathering related to the SPDI in the past. So with the reallocation of the funds, there was a million dollar increase that was given to the urban projects. The urbans sort of act as a thirteenth area related to how those funds are distributed. The Community Directed grants increased by about \$25.5 million. For Portland Area, that translated into about a \$1.2 million increase to the monies going to those community directed grants, so that our total is approximately \$7 million that we'll be distributing in the area. The national funding formula has remained the same, though they did use more recent user population and disease burden data in figuring out that distribution as to how much money was coming to the Portland Area. The selected grantees will be announced in December. At that point, we'll have a fairly short timeline to make the determination about how the Portland Area formula will look, and how much monies will go to each of the Grantees in Portland Area. As per policy in the Area, it will be a decision of the Portland Area funds distribution work group to really determine what that formula looks like for the Area. I will be putting together some preliminary numbers as soon as we have the data on the number of grantees, based on the prior formulas the Area used, which historically going back prior to 2004, that was based on straight user population of that group. But we will also talk about whether or not we would want to try to use any other factors that might influence that. Some Areas will use other things, other than just user pop., such as adjustments for Tribal size. That can help to change those numbers slightly. So as we go into December, for those that are members of the funds distribution work group, we just sort of wanted to have given you a heads up that that will be coming. And then we'll have a short period of time to make some decisions there. Headquarters will need to know those distributions so that by early January, they can get the notices of award out to the grantees.

Dean Seyler: Thank you Dr. Rudd, for those of you in the Fund Distribution work group, once that notice comes out, you'll be hearing that from Commander Arnette. So the fiscal year budget formulation that's to date, came out about a month / month and a half ago. For November 10th, the location happens here at the Embassy Suites at the Portland Airport. There's an agenda that's out. It's in your packet, I assume. We ask you please, if at all possible, to plan to attend and provide your input into that. Andy Joseph and Steve Kutz are still the two Area Reps that will travel back and forth to the national meeting once we have ours all done and submitted.

Quick update on the Area staffing. I shared with you at the last Portland board meeting that we actually selected an Area Dental Officer. And we were excited about this person. And for various personal reasons, he had to withdraw his acceptance. We're working on another candidate. But I can't go into detail about that. That's an HR thing. And as soon as we're able to, I can share the information with you. Many of you have worked with our Chief Contracting Officer, Martha Young. She has retired effective the

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end of the fiscal year, end of September. And we are currently advertising for a replacement. We did get headquarters to up the authorities of the other three contracting officers we have in the Area office, so you should not see any delay, any type of support you get from our Contracting Officer. And then the Area Dental, Area Diabetes Officer, you should expect to see an advertisement in the next six months on that. Dr. Rudd and Jonathan are working on the position description. It most likely will not be another MD. MD's are expensive. And so we're going to have the appropriate person in there, but have it to where they provide the support with all of you.

I think we're going a little over. Does anybody have any quick questions or comments while we dial up the listening session, for me specifically? Sharon?

Sharon Stanphill: Will Dr. Don Lee still be helping us in the interim, for the grants and everything, for diabetes?

Dean Seyler: He's still an Area employee. Intermittent. But his new job is keeping him busy 100% of his time.

Sharon Stanphill: 100%?

Dean Seyler: 100%. That's why we need to move forward and hire somebody else.

Sharon Stanphill: So who's going to do all of our grant reviews and everything? In between now and say six months from now?

Dean Seyler: Give them to Dr. Rudd. I expect that it will be him. He's still on our payroll. We're still paying him. When I say 100% of the time, I'm not lying. It's just dual working like many of us. But until we hire somebody, in fact he's going to help that new person for a little while, learn the ropes. He's running hospice there in Portland. So you know that takes a lot of his time. Any other questions or comments? (A powerpoint presentation was presented)

Speaker: 0:37:39.4 [INAUDIBLE.]

Dean Seyler: Mr. McSwain? *Via teleconference*

Mr. McSwain: Dean, how are you?

Dean Seyler: Pretty good. We've got you on speaker phone here with everybody. Just let me know when you're ready and I'll put the mic next to the speaker.

Mr. McSwain: OK. Let's go ahead and begin. I know you've got a schedule to move through. Let's go ahead and put up the first slide.

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Dean Seyler: OK, it's up.

Mr. McSwain: OK. And I will -- since I don't know what you're doing out there, I will cue you up on each slide. OK. Good morning. I'm pleased to have this opportunity to meet with you today to discuss an important topic. As you know, I sent a letter out asking for consultation. And let me thank all the Tribal leaders and Tribal health directors and all the attendees for making time for this conversation. I particularly want to recognize Joe Finkbonner and the Northwest Portland Area Health Board staff for helping to make this possible. And I would also like to recognize the Portland Area Director Dean Seyler and the Portland Area staff for their contributions. Thank you so much, Dean, for assisting and also for helping to make sure that I can say the right things today.

The listening sessions are another way we're working to strengthen our governance relationship. As you know, this is our number one priority, is to strengthen our consultation through government to government relationship. Today's session provides Tribes with a forum to consult on the implementation of the integrated data collection system datamart. I will say more about the datamart in a moment.

Slide 2.

Here is what I hope to cover today. First let me speak for a moment about region activity. We have been working to provide a coordinated response and to relate to those affected by the dropped conditions and what we are bringing across the Northwest. Many have been affected, with homes and buildings destroyed, people evacuated displaced from their homes. Affected clinics are just now returning to normal operations. We have worked with the state and the federal government agency, and the Tribes and Tribal officials to coordinate a response, including providing staff, supplies, and relief options. Issuing Environmental Health Alerts and helping to ensure the disaster declaration included Tribes. And please accept my condolences on the October 1, tragedy at the Umpqua Community College in Roseburg, Oregon. Like many others, we were saddened by this terrible event. As you may know, I had just employed Behavioral health officers to the Cow Creek Band of Umpqua Indian clinic in Rosenberg to provide grief counseling and emotional support to the Cow Creek community. We were honored to provide this support and continue to monitor the recovery efforts. Our thoughts are with those most affected during this time.

At the last Portland Area listening session in July 2015, several topics were discussed. Those included staffing packages, Joint Venture projects, RPMS, the Methamphetamine and Suicide Prevention Initiative, the Domestic Violence Prevention Initiative, and the Regional Referred Care Center. The Area continues to develop the first of these three regional specialty referral centers, and work is getting underway.

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The Area has begun to evaluate possible sites, develop a Business Plan, and prepare for the Referral Center. I want to highlight that the Portland Area federal Service Units are doing well on performance measures. Portland Area federal Service Units, in total, met or exceeded the goal on all 22 indicators by the close of the GPRA year, showing improvements on nine indicators compared to 2014 performance. Western Oregon and Warm Springs service unit consecutively each met all indicators for the 2015 year. The fourth consecutive year for Western Oregon and the second consecutive year for Warm Springs. This is a real accomplishment, particularly when there are parts of the country that had a real difficult time hitting those targets this year.

On October 1, 2015, IHS Tribal and Urban programs began using ICD-10 medical codes. This updated set of codes for reporting medical diagnoses and inpatient procedures will provide better information about patient care. The Portland Area made IT updates for ICD-10 at six federal, 19 Tribal, and two urban sites. The Portland Area also provided a free training to federal, Tribal, and urban programs. IHS including the Portland Area is deploying improvement to identifying health records that will help patients access their health information and will provide new options for communicating between patients and their providers.

Am I on slide 3? OK. I'm making sure you're on the same page as I am. Let me turn now to the main topic for today. On September 23rd, I wrote to Tribal leaders informing you of a major change to Annual Performance reporting for IHS. Each year, the IHS reports its performance results, also known as budget measures, in the annual president's budget request to Congress. All US federal government agencies are subject to this Performance Reporting. For IHS, this includes reporting of clinical performance results, you may have already heard of the key laws guiding this reporting. The Government Performance and Results Act, or GPRA, and the GPRA Modernization Act are our GRPA models. As you can see here, there are some significant limitations to our current system, including that results are delayed two months or more because of how time consuming it is to manually aggregate all this data. IHS is frequently asked by Congress, the department and the Office of Management of Budget, about the impact of funding on federal and private programs. The participation of those trouble organizations using commercial electronic health records instead of the RPMS, is essential to ensure that the results at every part of the IHS direct service, Tribal and Urban system, are taken into account when the president and his team evaluate performance and make funding decisions.

New Systems DataMart slide please.

This fiscal year, the IHS plans to begin preparations to implement the integrated data collection system DataMart, a new reporting mechanism within the National Data warehouse. The DataMart provides a mechanism for Tribes and urban health programs that do not use the IHS resource and patient management system to participate in

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GPRA and GPRA model reporting. We are making this available because many Tribes that use commercial Health Information Systems have expressed a desire to continue participating in a National Performance Reporting in support of the IHS budget. That is, Tribes that did not use the IHS RPMS want to submit their performance data so their results are counted when the effectiveness of the IHS funding is evaluated. As you can see here, there are a number of benefits. It is very important to me that we do this in a way that works for you. That is why in my letter last month, I requested your input on Tribal council needs and interests associated with this new mechanism. And this is why we plan to spend this time this year and next consulting with Tribes and conferring with urban programs as we develop this system. Let me also say that we appreciate your willingness to consider participation, as it will help ensure more accurate assessment and the outcomes of the program. Results will be available at the National Area and Service Unit levels. Just want to also point out, the secretary is extremely interested in evaluating impact, and if you've heard her talk about it, it's about impact and outcomes.

There will be some specific rules for the information that is submitted, so that the files you send will meet IHS Office of Information Technology standards for national state and information reporting system, referred to as New Systems DataMart. These will enable us to also derive annual user population, estimated from the very same data, that will hopefully lessen the reporting burden for your health programs. You will only have to submit once.

Before I close, I do want to say this is an optional Tribal program. An automated feature in the DataMart will be available for Tribal programs that do not want their data included in GPRA and GPRA model reporting. However, I want to emphasize the importance of this effort. Without data, it is impossible for the Indian Health Service to show improvement or even set targeted goals. We are grateful for your willingness to send performance data, and I look forward to our conversation about the best ways for that to happen.

I'm sure you have comments and possibly questions, and I'll have a chance to cover some of these questions, and you can also get in touch with us after the session using the contact information here. But before I take questions, I believe there are two more technical details to cover. I would like to turn things over to our technical experts from the Office of Public Health Support to describe more of the nuts and bolts of exactly how we propose this will work. Captain Frazier? Captain Frazier on the line?

Well, we had a real great alternate here in the form of Miss Diane Leach, Diane?

Diane Leach: Good morning everybody. This is Diane Leach I'm the national GPRA core leader for the Indian Health Service. There are just a couple points that I just want to go over very quickly, so that we have plenty of time for questioning. What we're planning on doing, is we are moving --

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Dean Seyler: Diane? This is Dean. Can you get closer to the microphone?

Diane Leach: Oh, sure. OK. Can you all hear me a little bit better now?

Dean Seyler: That's much better. Thank you.

Diane Leach: OK, great. What Indian Health Care is doing is we are transitioning our National Performance reporting and our budget from using the clinical reporting system in RPMS to reporting from a national centralized performance database which refer to as the DataMart. We are in the process of building it. We will be building it during 2015 and 2016. In 2017, we will be monitoring the results. And although HHS has not said yet, I'm sure they're going to be wanting to review the 2017 results as we have those. In 2018, we will begin reporting live from the DataMart. And since we do our budget two years in advance, our 2018 reporting will be included in the fiscal year 2020 budget. This DataMart will provide secure, on demand web based GPRA results. We will be using all the data that is stored within NPIRS so we will be using RPMS data, we will be using commercial off-the-shelf data that has been exported to NPIRS. And the data in the fiscal intermediate Area also provides NPIRS will be included. So we will have a much greater data source which will support our budget. This is being done primarily to support the Indian Health Service budget, but it does have many other benefits for the Indian Health System. We want to specify that by reporting from this DataMart, our performance results are going to decrease. We will be moving from the active clinical denominator which is what we use in CRS, it is a smaller denominator. It mirrors more closely the patient profile that providers care for in their Tribal, or in their clinics. And so our results have been based on that over the years. We are using to the user population definition, which is only one visit every three years. It is a larger denominator. And because of that, we have seen decreases in our results in our early look at our measures. There is another reason for moving to the user population denominator. We have heard for years from the Indian Health System across the country that people would like the Indian Health Service to begin using standardized measures for reporting, or substituting standardized measures where we can instead of using our IHS measures that we have devised. Once we report on those standardized measures, we will be using a use pop denominator for those measures. There is no such thing as standard measures at a condensed denominator. So it will be user pop denominator. So we might as well start getting used to these lower results as we transition to standard measures.

The reporting year will change. Currently, the GPRA reporting year runs from July 1st to June 30th each year. And that's so that we're able to have enough time to aggregate data results to national results that can be included in our budget. We are moving to the user pop year, which is the federal fiscal year, so that we can mirror all of the activities for the user population aggregation collection and release of the user population

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estimates. So we are changing to the user population as our denominator, and the reporting year will be the federal fiscal year. It's being built in three different iterations. We have completed iteration one. And OIT put that into full production mode in September of 2015. Prior to this, the federal area GPRA coordinators had an opportunity to actually gain access to the DataMart. They were able to go into the DataMart. They were able to look and see how the reports were, how they looked, they were able to run results on their own areas and compare that to national results. So your area coordinator has already been in the DataMart and has a sense of how it is for iteration one. There are two more iterations that we will undergo before the process is ready for reporting in our national budget.

With that, that's the remarks that I wanted to give you additionally. So Mr. Seyler, at this point, you can open this up for questions from your audience. (PowerPoint Presentation was presented)

Dean Seyler: Thank you, Diane. I see some hands go up and they'll be moving the mics over.

Brent Simcosky: Hello. This is Brent Simcosky with Jamestown Trib. A couple questions. One is -- remind me what we were using for denominator before?

Diane Leach: It referred to the active clinical denominator. And that is within the code reporting systems.

Brent Simcosky: OK. So what's going to be the explanation, because I would think clearly, try these clinics with large urban Indian and patient user populations, they're going to be going way down. Percentages, right?

Diane Leach: We have seen results drop dramatically on some of our measures. Of course, this is preliminary data. We won't know for sure until we have more data. We will be use Tribal data and urban data, and the aggregation and collection of our results. So when we find more adds that other iterations go on, but yes. The performance results are dropping.

Brent Simcosky: And are we coming up for an explanation for when we get to Congress, to why that is?

Diane Leach: The user population will follow the way that we discuss the patient population that we care for in the Indian Health Service. So it will be more representative of that population. Right now, when we report our national results, those are results that are based on RPMS only. And we include all the Federal sites, all the Tribal RPMS sites who want to participate in reporting, and Urban data has never been included in our national results. So when we have our discussions with HHS and OMB,

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we will be engaging with OMB this winter, we will be telling them that the results are more comprehensive of our entire Indian Health System.

Brent Simcosky: OK. And one last question. We don't use RPMS we use EPIC. And they track Meaningful Use. So at one point, almost all the off-the-shelf practices already track meaningful users because they have to, to meet meaningful user criteria. So a lot of them do not track GPRA, which means I have tried to get them to give me a GPRA report that I don't just hand, do I fill out a report myself. At what point are all these reports going to sort of merge together? Because meaningful use is really close to GPRA, and we're getting all these data pulls from the lifetime health records. At what point are they all going to start to merge together?

Diane Leach: The federal sites also report on meaningful use, and so we do have meaningful use reports in RPMS. CMS, as you are probably aware, has the MACRA Act in I think it was April of this year. And it is the next version of CMS looking for quality instead of quantity as far as patient care is concerned. IHS will be looking at that. OPHS and OIP will be working together. And we will be seeing where we can consolidate and use the city measures. And yes, you are correct. The measures are very similar. The one big difference with meaningful use is that those measures are calculated on each provider. So what it does is it takes the particular provider to take their patient panel. Whereas our measure that we use for reporting in our IHS budget are national population results instead of individual provider results.

Cheryl Kennedy: This is Cheryl Kennedy with the Confederate Tribes of Grand Ronde, and I had a couple of questions. First a comment, back in the late probably 1980's, early 1990's, there was an effort by this board, the Northwest Portland Area Indian Health Board, to develop a co-owned Information System with the IHS. The Tribal and IHS. And it was really brought about because of the way CHS dollars were being used to go to a centralized, I think it was Blue Cross / Blue Shield who would take care of all the CHS payments and activities throughout the United States for Tribes. And so a lot of work had been done. So I see that this may be part of that work. I'm not sure if it is. But my question is, in developing this new system, was there a Tribal committee that was working with the Indian Health Service to help develop to where we are at now? And your comments about going to OMB, of course is, you know, to justify why funding is necessary and needed for health care in Indian country. What would be those costs, and how would they be then determined? It might be you're looking at an expanded budget to allow this to happen. So those are my questions, and I'll just finish my other comment. I think that equally, it's important for Tribes to have access to the data that you have, because if there are errors or if there's -- you know, there's always human errors we can assist in correcting those kind of things. And I do understand you're talking about an aggregate national number vs. the independent numbers that would come from each of the Service Units or Tribal operated health centers. But anyhow, appreciate your time.

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Diane Leach: Thank you for your comments. We did not use Tribal competition in building this. This is being built at the federal level to support our budget. And because of that, we have some of the skills of the system internally within the federal side of the house. We are at a point now where we are ready to engage Tribes and Urban partners so that we can get feedback and improve process. And this is what the iteration one did, is the Area Coordinators had access, and they went into the system. They provided 29 recommendations for improvement. They found 10 defects. Nine of those have been resolved. One will be resolved in iteration 2. During the iteration 2, Tribes will begin to have access to the data. Probably sometime in Spring of 2016. When you have access to data, you'll have to go through training in order to get access to the reports. At that point, the service unit data will be available for viewing. In the first iteration, the only data available was at the national level and at the area level. But when the Tribes are going to have a chance to review the data, then the service unit data will also be available for review. One thing about these particular reports is that they are aggregate numbers. There's no PII data. What these reports do is they use the data that has been exported by Tribal sites as well as Federal sites and Urban entities to the national data warehouse. And so that data that is electronically exported and sent to NPIRSs and then uploaded into NPIRS that is the data that is being used. I understand from OIT that sometime in the future, there would be a possibility of having access to look at the straight data, where you could actually look at the data that has been submitted. But that will not occur in 2018. That's probably going to be something that's going to be a little bit later. Because that will take additional funding for that to happen. What I can say right now is that you can work with your area statistical officer, your Area Statistical Officer is one who receives reports from NPIRS when your electronic reports are submitted. So the statistical officer will get a report back from NPIRS with pieces of data about that export. So it will say where the export came from, the facility, how many records were in there, so that that information can be returned to the facility that submitted the report. And at that point, that would be a good time to engage with NPIRS through your area GPRA coordinator if those total numbers that are reported back to your statistical officers did not seem right to you. And so you can begin reporting through your staff officer and NPIRS right away in order to ensure that the data that you have submitted is all there entirely and that it does seem to be appropriate.

Andy Joseph Jr: Good morning. My name's Badger, Andy Joseph, Jr. from the Colville Tribe. I use the information that we get from the GPRA, you know, on different testimonies that I provide. My only worry is that if you have a service and directory like mine that's really active and moving our program, and really doing a good job, we're probably going to get a really high number. My only worry is that if we get a really good score, that the government -- Congress and OMB and whoever is going to think, well, they're doing pretty good. They probably don't need that big of an increase in the budget, when the budget's only a little less than 16% of what the needs based budget

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is. As it is now. And kind of like our facility was built in 1920's or something like that, and we had to build our own buildings, and we had a really good maintenance man that kept that building up so darn good. Well you know, our Tribe was overlooked on facilities because it was well-maintained. So I just kind of worry that we're cutting our own throat by doing some of this real positive work that is happening. You know, to me, our budget is really important. I guess what I would hope is that kind of based on what Cheryl said about having Tribal input on lower scoring, I would hope that there would be some kind of a place in the report that our doctors that work in our clinics could have a place to comment and then possibly that they could use case load numbers to also show how the work is getting accomplished. I always say when you only have a few doctors; you can only funnel so many patients through those few doctors. And if you're a large Tribe like mine that probably should have as many providers and doctors as the Cheyenne River Sioux, that got the full staffing package, if we had those numbers, our Tribe would even do a whole lot better in doing these GPRA measures, because then we'd be able to see possibly every one of our patients. But because of the lack of resources, a lot of our patients don't go to our clinic. So I think there's got to be some way to measure that.

Then I guess I got one more kind of statement for Mr. McSwain. I'm really glad to hear your voice and that you're in that office. I know things are probably getting a lot better for our concerns. I feel a lot more at ease here at the Portland area. What I got to say is about the budget. I kind of worry about how we're going to utilize our lobbying tactics to help IHS. Just a couple years ago, we had to figure out where to come up with \$28 million. And I think it narrowed down to \$16 million, and that was for contract support shortfall. And they took from recruitment retention and some from the Director's Emergency fund. And I guess they took some from third party, what was generated. And then they get the letter in July, I think it was 27th or 29th about the Indian claim for the costs of \$80 million. And for the IHS to say "OK," well we found this money from within, and it came from like third party generation, I believe maybe some of the facilities that couldn't find their staffing for their facilities. But I just kind of wonder for the budget meetings that are coming up, that we need to know how much more pockets of money are kind of put away in IHS in all these different line items. We need to have a full breakdown of those line items and some kind of an audit so that when we do the budget, if we got people dying or need surgeries, that we're going to be able to ask for those funds. Because to me, that was really kind of an upset to me, to have to try to divide money up just not even a year before, and then all of a sudden there's \$80 million that shows up. Kind of makes me uneasy about what I'm doing, when I'm working on the budget. Thank you.

Mr. McSwain: Thank you, Councilman Joseph. And I want to thank you for your leadership on the Tribal Budget Formulation. It's basically your efforts and all your colleagues and such, and I was there when you presented the budget to the secondary budget council and I can tell you, though I can't share all the details in the budget that's

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going forward right now, but I can fully let you know that your efforts were viewed very heavily in the secondary decision on what our budget's going to look like going forward in 2017. And we only have one more hurdle to follow, and that's OMB. I wanted to sort of make an observation for all of you, is that this DataMart initiative is going to enable the ability for all of the data that's out there, and even with the Tribal option to opt out, we will have a clearer picture of what the GPRA measures and GPRA performances are. And I would like to characterize -- you made a comment, Councilman Joseph, about "don't want to look too good." I'd like to believe that what we're really looking good about is what we're using the current appropriation, which is about on the average about 57% of national. And what that means is that's what we're doing with the money that Congress has given us. And then we go from there, and I think the efforts that will go on starting, if they haven't already started, is the consultation and the development of the budget needs and such for 2018 that's now starting in the Area. It's an important piece, and I feel good about the DataMart, in so far as the first time, because I don't know how many years we've heard from all of you, "you're not taking our data." And now we can take your data from whatever source, not just RPMS. And also the EARTH programs. And yet we can also be able to sort the data by those program components of the ITU. And to be able to do some further analysis. I think we've finally arrived. And I think the other things that are going on with the IT system as it pertains to master person index, we can sharply begin to determine multiple visits. And where our patients are actually going. And that's going to be an important dimension going forward. So I think we've reached a good point. And I really -- I've been sort of in the forefront of the Payment of Employee settlements. And we can talk more about that. But I think the bottom line is we've agreed with the unions to pay for those claims for those employees that were either underpaid or not paid for overtime that was due them. And we were able to provide those funds based upon what we found in the accounts. But you raise a great point, Councilman Joseph, and that's an area that we need to move towards transparency about where all of those funds are currently located, and you as a Tribal leader need to know what accounts, in those years for example, that the appropriations for five years, and so there are accounts with balances in those years. Normally we want to just hold funds in those accounts for the sole purpose of any bills that might be pending back then. Because we do have bills that will come due, and we've got to either pay it off, pay those bills kind of like what's happening with Congress right now, about the debt ceiling. We've already encouraged those bills. We just need to pay for them. And so that's essentially what's behind it. But thank you, Councilman.

Marilyn Scott: Good morning, and I guess good afternoon where you are. This is Marilyn Scott. And my animal given name is 1:18:43.8 [INAUDIBLE] and I'm a council member with the Upper Skagit Tribe of Washington State. And I just wanted to raise a concern with regards to the integrated DataMart system that is being developed. And I want to reiterate the importance that Cheryl, comment that Cheryl Kennedy made about Tribal input on the development of phase 2, the next phase or development involvement with the Tribes. But one of the concerns that I want to raise is that currently, there is a

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disconnect between the Tribes' input into the Indian Health Service data systems and the state Medicaid program reviews that are measures that are tracked, and the time we have to submit information that is not in the state system, that is looking at the federal funds that come to the states, and not receiving credit for the services that the Tribes are providing. But there is no current connection between the data systems that Tribes feed into, with the Medicaid funding that we get reimbursed for, sources that we are providing, and the measures. So essentially, we're having to enter into dual systems in order to be able to participate in the measures that are being established by the states and the Medicaid programs. And all of the changes that are happening within the States, with the Affordable Care Act, and purchase within the marketplace, as well as services that our providers are providing. And the record of the services that we are providing. But it's so important that we have input into how we are providing the information, and what information we're actually able to utilize at the Tribal level, when making those decisions about the funding we receive, the funding streams from Indian Health Service, the funding streams, the federal funds that come from the state to the Tribal programs. But there currently is not a way that we are -- you know, there's no incentive for Tribal programs to not be able to connect up those same data systems. But I'm hoping that there is some consideration of looking at there being the capability of connecting out those -- it would give the Tribal programs a better incentive to participate and be able to get the data that we need in order to document the need of our population and the quality of services that we are all providing. So I hope that there is consideration of -- serious consideration with the Tribal involvement of that next phase in this system. Thank you.

Diane Leach: Thank you for your comment. We are beginning to reach out now to Tribes and Urban entities so that as we continue building the DataMart, we can get Tribal input. So that we can try and accommodate some of the things that you need, some of the things that are important to you. It may not be until we have completely finished the build, but it would be in future iterations. As I said it's originally being built to accommodate our IHS budget process. But there are many, many opportunities for the DataMart. Once we have a structure in place, it can be used for running other types of reports, whether it's CMS or whether it's or other types of reporting requirements. Those would not occur during the first three iterations. The funding that we have is for the federal budget. It would take additional funding to do that, and we would probably draw a secure line between reporting the GPRA measures from it or in reporting other types of measures, because we would not be reporting those other types of measures. You would be running those measures and reporting those measures to the appropriate entity. But there is lots of opportunity for expansion of this DataMart beyond just using it to report on the IHS budget. One of the things that I didn't say when I talked first about my remarks, one of the really exciting things about the new DataMart is how quickly we can get the data. Since we are using the data that is coming to NPIRS through exports from sites, what NPIRS does is they take all of those reports. They put those reports into a queue. And once a week they upload that data. So this is probably the closest

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that we will get to real-time data, and this is a vast improvement. I don't think any place in government will have anything that can be responsive this quickly.

Cheryl Kennedy: This is Cheryl Kennedy again. I just wanted to follow up on the remarks that I made earlier about the co-owned information initiative that didn't really come about, but for those Tribes who are Self-Governance, and I assume the Indian Health Service knows that the Northwest was the leader in Self-Governance. Nearly all of the Tribes at that time were all in the pilot project. I think the first 39 that were selected, my Tribe being one of them, and many around this table here, and the idea was to preserve the inherent federal function of the Indian Health Service for what we attributed to the trust responsibility. So I guess I'm reading into the message that headquarters took, that this is an inherent federal function, because Tribes were not included in the development of this important data system, and I guess I'm one that would disagree with that, because in Self-Governance, it also said that one of the reasons for Self-Governance was to remove the administrative barriers. And yet we're now creating another barrier and so in my mind, it runs counter to what Self-Governance was about. And I know you say there's plenty of opportunity to engage after the initial phase is done, but I think the experiences of Tribes here in the Oregon / Washington / Idaho, it has been that if you're not in at the front level, you have a very hard battle to go through. And I know for the state of Oregon, every time there's a change in the health plans, which come through because of changes in Medicaid; they get together and form committees and form authorities and all of these things that affect us. And we try hard to get in to those committees, and it's not been that greatly successful for us. And so we spend years fighting and tearing apart the root of the problem, which is the lack of understanding when the foundation was built. So that's really the basis for my concern, and to have us needlessly put great effort into trying to find where the errors might be, and how it could be better built, if we had been at the table to begin with. So that's just a comment.

You mentioned that there was a cost that was undertaken to get this first stage done. I'd be interested in knowing what that cost was. And then the other piece again is of course, when the DataMart is implemented, will funds be appropriated for all the end users, as I guess, to participate? Or how will that be dealt with? Is that part of, for Self-Governance; is that the Tribal shares piece of it? Or exactly how will that work out?

Diane Leach: Thank you for your comments. We have only completed iteration one. We still have two more iterations to complete before we go live. And when we sent out the Tribal leader letter, it was a fact sheet that had an email address, as well as the 7-page PowerPoint that you were looking at earlier today. And so we are soliciting input through the listening sessions as well as direct comments to HQ_OPHSidcs@IHS.gov. That information is on the fact sheet. And we would encourage that you send comments. And one other comment is I came from the Alaska area. And I was the Alaska statistical officer for eight years and the Alaska coordinator for seven years. And

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one of the main reasons why I took this job here at headquarters is to make this national DataMart work. I've been working on this concept since 2005. And it has been my dream that we have a national performance DataMart where the information will be received by NPIRS so there is not additional work beyond what a local facility is already doing in getting their data exported to NPIRS in order for the IHS to calculate the annual workload user memos as well as establish what the annual User Population estimates are. So this project is very near and very dear to my heart. And coming from Alaska which is all Tribal, I am aware of Tribal input. And that is why we are taking Tribal input before we have completed. We started this because this is an inherent budget function, and that is exclusive to federal employees only. In iteration 2 and 3, there is lots of opportunity for input from other parties so that we can make this a better project. So that we can make it so it has more utility for the user. One thing that, as I said, once we are using this, we will have access to data pretty much at our fingertips, because as data is submitted to NPIRS and uploaded on a weekly basis, that means all that data is there for running reports. So that data can be used as tools by program managers. It can be used by coordinators. So that you can access your data results, and if there are low numbers, you can go ahead and you can plan some kind of activity to increase your numbers, and you could check on it in a month and see if that had occurred. Now as far as working with Medicaid, we will be working with OIP on MACRA, a law that we will see what we can do as far as trying to integrate some of that into our national performance reporting measures, as well as the IPSS [?] DataMart.

Dylan Dressler: Hello. My name is Dylan Dressler and I'm the new Health Services Director for the Lower Elwha Tribe. My two comments I guess I would say for the two more iteration periods, if we could have a way to -- working with GPRA and EPS and the meaningful use reporting measures, they all kind of coincide with one another, but at the same time I've seen agencies and Tribes bend over backwards trying to meet those measures. And they are not with the integrated formulary that is conducive to what is actually done in Tribal communities regarding health, because they only capture chronic disease categories. The colorectal cancer screening and all of that. I know from experience that we've had to subsidize third party revenue to do preventive health efforts such as our Community Health and Wellness program, that are large health efforts like walking, recreation, home visits, and nursing. Those on reporting metrics are not captured by CMS dollars, and it's kind of controversial because for me as a health services director, if I'm going to coordinate the Chronic Disease management reporting systems that IHS and CMS require us to do, that doesn't capture fully the snapshot of health that is happening within the Tribal communities. And I would suggest for your second or your third iteration, to take those into account because the funding that's weighted through all those programs isn't really counted. It's counted as "oh, I'm going to subsidize your third party revenue for that." You don't have to report on your prevention health efforts. So for me, I'd rather see the new formulary come out in those two iterations that have that full snapshot of health activities within Tribal communities, so then that way I don't feel as bad as bending over backwards to meet all the reporting

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requirements. And I can actually see a whole scope of continual health care from prevention to Chronic Disease management.

Diane Leach: I do understand your frustrations. Working as a GPRA coordinator in Alaska, I do realize how difficult it is to meet all these many measures that are required by local facilities, from funding streams that they have received. Initially when IHS developed our measures, we developed specific population measures so that our budget would represent what was being captured and what was being done for the Indian Health Service and for the people that we serve in our budget. And that's why, when we first began GPRA, we concentrated on diabetes measures. We concentrated on immunization measures, and dental measures. And then prevention measures followed as HHS and OMB demanded those of us. But when we first started reporting, we were seeing activities that were very problematic in Indian country. Either in population or it was difficult to get access, usually with dental. And so that was how the Indian Health Service initially geared ourselves and focused for our GPRA measures. And those are incorporated in our budget. And those are things that we were emphasizing in our budget and in our discussions with OMB and with Congress on an annual basis. I am well aware of the meaningful use measures, and to me what they represent is they represent a fairly specialty organizations want to have measures that represent their organizations, and a lot of the meaningful use measures are not quite so appropriate for the Indian Health Service because a lot of those specialties are where we use our PRC dollars. We are sending our patients out for those type of specialty activities that our patients need. Whereas we are focused a great deal on prevention and activities that can be handled at small facility levels where we may or may not have the specialized staff or specialized equipment or lab functions or whatever to perform some of these things that the meaningful use measures are looking at. I absolutely empathize with you, because I went through that also when I was a coordinator in Alaska. And we are looking at these measures. We are trying to harmonize where we can. And we will continue to do so.

Dean Seyler: Any other questions or comments?

Cheryl Kennedy: I missed the cost of it.

Dean Seyler: The Council member Cheryl Kennedy from Grand Ronde asked about the cost. Are you able -- do you have any of that information that you can share?

Diane Leach: We don't have cost information that we can share, and again, speaking as a former GPRA coordinator from the Alaska area, GPRA came about after Tribal share methodology had evolved. And so there are no Tribal shares for GPRA.

Dean Seyler: Does that answer your question? OK. Anyone else?

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Diane Leach: Please, please encourage everyone to use the email to send us so that we can incorporate some of that activity into iteration 2 and iteration 3.

Dean Seyler: All righty. Wait a minute. We have one more question here.

Diane Leach: OK.

Ali Desautel: Hello, my name is Ali Desautel. I'm the Executive Director for Lake Roosevelt Community Health Centers with the Coleville Tribe. My question would be, I heard you talk about weekly uploads and things like that. I'm thinking about my staff. And how easy is this going to be for my IT staff to be -- are they going to be entering data, or is this going to be downloadable, or how is that going to work? Because they're extremely busy as they are. GPRA is dubious and meaningful use is hard data, especially with the RPMS system as it is now, to enter. And I'm thinking I might run right out of the building if I have to have them download on a weekly basis. So I'm kind of worried about that. So if you can answer that question, I'd be grateful. Thank you.

Diane Leach: Certainly. Most of our sites export on a monthly basis, and that is generally what NPIRS sees. Some of the larger facilities may export maybe every 10 days or so. We do have some sites that report quarterly. We do have some sites that report even more infrequently than quarterly, when they're sending their patient registration and their workload data files to NPIRS. So most of the sites submit data on a monthly basis. And when the exports go down, then they will be uploaded. And so if your site exports on a monthly basis, then it would not help for you to be looking at reports on a weekly basis or every two weeks. It would be better for you to look at reports on a monthly basis after your data export had been submitted to NPIRS. As far as additional entry, what the IPSS [?] will do is the same as GPRA. All the data that is entered into RPMS, so there is no additional data requirements, so the care that you're providing to your patients is put into RPMS. Their patient registration is updated in RPMS. And then all that information is queued up by your RPMS site manager on a regular basis, whether it's monthly, to submit those two reports to NPIRS. So there will not be, there should not be additional demand on your RPMS site manager. You will continue business as usual, providing for your patients and caring for your patients. Getting the data about the patients into RPMS. And then that data that is entered into RPMS will be exported to NPIRS and then that data will be used simultaneously for calculating the user population, as will the IPSS [?] reports. And that was one of the reasons for going to a national centralized system, is that we can utilize those exports that are submitted by site for user population calculations. And what this will do is it should actually ease some of the reporting burden, because when it comes to GPRA reporting, somebody in your facility has to go into RPMS and they have to electronically run that national GPRA report, and then they electronically submit it to the area office where that is then electronically aggregated into an area report. So this eliminates the need for that. You will conduct business as usual. You will submit your export file to

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NPIRS and that file will be used for both your GPRA reporting activities, as well as your annual user population calculations. So I'm hoping that this will ease reporting for people out in the field. It will give them access to data more quickly. And I'm just hoping that this is going to be a better pairing for everybody. That's what OIP and I are working for.

Dean Seyler: So it sounds like your staff will be OK, Ali. Great. Let me scan the room here one more time. See if there's any last questions or comments.

Andy Joseph, Jr: I just wanted to thank you for taking the time to explain GPRA and like I said earlier, you can only funnel so many people through the amount of providers that we have. If the Portland area needs to double or triple what their provider levels are, and we're only getting one-third of how the overall GPRA report would estimate our needs to be, so I kind of look at numbers and try to figure out a way where we can benefit from this the most, for all of our creds. Like I said, some of us never get that lottery like Nome, Alaska and Kenai, and Cheyenne River Sioux that got a full staffing package. So if we were all fully staffed, the amount of funds that we could generate and use to really take advantage of this Affordable Health Care Act and Indian Health Improvement Act, we would probably be able to really be a real model program. You know, we're not like the VA or the federal penitentiaries where they're getting all their needs met. We only get 16% of what our real need is on a national level. And that's still somehow got to be calculated into GPRA. So hopefully that we have some more meetings and consultation on just what we're going to score. And I want to make sure that a report that goes in is going to something that will show that we do need the rest of -- what is it? 85% that we're missing out of. But thank you for the time I know we do use the GPRA report and our copy, and we try to help IHS as much as we can using numbers.

Diane Leach: I really, really appreciate your comments. And one thing that I would like to say is that yes, our numbers are going to go down, but when you personally talk to secretary Burwell or when our Tribal people are talking to their congressional staff, then what they can say is that yes, these results have gone down, but these results reflect the actual care that is being received throughout Indian Country. The previous results were reported only through RPMS. So if somebody was not using RPMS, then their data was not included in the final results. And we never included the Urban programs in our final results. So what we will be educating HHS, OMB, and Congress is that yes, our overall national results are going to decrease. But our overall national results are finally representative of care that is being provided in Indian Country, because it will include data from RPMS, from commercial systems, and from the fiscal year. So we will work more on strategy with OMB and HHS. We will provide talking points for when you are talking to Congress, as well as HHS. And I look forward to a great deal of collaboration.

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Andy Joseph, Jr: Thank you.

Bob McSwain: Dean? This is Bob McSwain. I, Chairman Joseph and the Board and Mr. Seyler, thank you for providing time for us to speak to you about this initiative. I'm just thankful that Diane was here. I'm going to have to go find Gavin Frazier. I'm sure he's someplace. But we've, this is an ongoing discussion, Chairman Joseph and as we begin to roll this out and you see the data, there's always an opportunity and I think there were some comments made, about if you'd like to make some changes, and you'd like some thoughts and so forth, and ideas. We're open to those. And also bear in mind, the Information Systems Advisory Committee was central, and they actually are our sounding board for our whole strategy on IT as it moves forward. So that group certainly is Tribal members as well. And we would be remiss if we said that we will continue this consultation. Thank you.

Dean Seyler: All right. Thank you. This is one last thing that I forgot to mention during my update, was that the headquarters is looking for an alternative representative for the Portland area, for many areas, for the Behavioral Health Tribal Advisory Committee. Cassie from Cowlitz -- is Cassie here? No? Cassie is the primary rep for Portland area, but I've asked before. I'm headed back to Headquarters again next week. So it would be good if I had something from the Health Board if you choose to have it. If you don't, that's fine. I'm sure Cassie will be able to cover it. But they're sure getting pressed for a second person, and I thought I'd ask one more time. With that, I'll turn it over.

Andy Joseph, Jr: OK. We got our agenda, we have Joe Finkbonner, our Executive Director, to give this report. And then we'll have our break.

Joe Finkbonner: Everybody doing OK? I can easily switch to break in my presentation if you need to get up and stretch, because I know that was a little long. Is that OK, Andy? If we take a break now and then just start when we come backline 10 minutes? Let's go ahead and do that, because I know it's, you guys have been sitting for a little bit. So.

BREAK.

Joe Finkbonner: Thank you all for coming back. Is Dean here? OK, just very quickly since I wanted to sort of close that loophole that Dean is asking about the Behavioral Health secondary rep from the Board. There's a group of us, I recall that we had nominated Cheryl Sanders as the secondary, and Cheryl remembers that as well. But just for the record, can we just do a quick motion and just to get it out there? And we'll write the letter to Dean so he has the official notification.

MOTION: Behavioral Health Area Representative Cheryle Sanders, Lummi – nominated by Andy Joseph, Colville, 2nd by Leslie Wosing. Motion is voted and

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Andy Joseph, Jr: I guess I'll need some power and a pointer. Thank you.

Executive Director Update

Joe Finkbonner: Good job. That's more efficient. Good morning everyone. Thank you all for being here. Sorry I don't have my sport coat dress up. It's a long story. I had to come back in with this presentation as to why that took place. But this is a standard presentation I do. I'll tell you about personnel and about events in terms of meetings that I've attended. And then upcoming issues or events that we'll be attending as well. New employee Nanette is here. Nanette, can you stand up, introduce -- Nanette just came to us, is working for a WEAVE, as the project director. She's also an epidemiologist. We stole her from CHRIB. If she looks familiar, you may have seen her in July down at the joint meeting. So, welcome Nanette. Also Selena McCray was promoted from a Project Assistant and thrived to the Coordinator Position. So congratulations to Selena. If you see her, please congratulate her. I also wanted to bring up Ryan. Transitioning from the DVPI, Domestic Violence Prevention Initiative to Tobacco and WEAVE project as well. So congratulations to Ryan. Glad you're sticking around with us. Departures: Amanda Gaston left the board. Worked with Stephanie's projects. You remember Amanda did the Ask Auntie campaign. She'll still be working with us just a little bit to do some of that, keep that continuity going until the grant ends. Jenna Charlie who was our front desk person also left for a position that was more compatible with her desired full-time job. And then Elaine Dado, resigned for personal reasons. So those are our departures from the board.

We had our 638 Training at Issaquah. I really, if you've not had a chance to participate in any of these, I encourage you all. It's a great refresh. It's also a good way to just keep in touch with the new folks that are coming up and maybe put a little bit of a Tribal spin in how you've been using your new authority, or your -- it's not so new anymore. But your authority as a 638 contracting- compacting, Tribe to expand your health services. So I encourage you to go. We have our annual meeting in Portland, or actually Tulalip with our Tribal Dental Chiefs and our prevention coordinators. And we also officially announced our -- I'll quit calling it the DHAT project that we are doing with Tribes of Oregon through the private authorizations that's there through state legislation. And then also the Swinomish project that's going on, and I'm sure you're all aware of Brain's efforts to open up a Dental Therapist program at Swin. And he's moving full steam ahead and is telling people to stay out of his way while he's got a head of steam going! So we wish him luck and we're there to support him however we can.

Public Health Accreditation board meeting. You're going to hear a lot more of this, because there's actually a fair amount of activity that's going on in the public health

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accreditation world. The board lost -- didn't lose, but their grant is sun setting. The Robert Wood Johnson grant that helped to sustain their infrastructure. What does that mean? That means that their fees are going to go up. And their fees are going to go up fairly substantially. And per their own bylaws, they have to publish their fees a year in advance. And they're about ready to do that, but in that transition between now and when they're actually published, the Board is trying to develop some new ways to cut costs in the operations of the Public Health Accreditation Board so they don't have to raise the fees the amount that need to be in order to stay afloat. So if you are at all considering, or you're close to applying for accreditation, I would suggest you do that within the next year, because once the fees go up, they're talking about 25 to 35% increase in fees. And for small health departments, they're already kind of healthy for the amount that you have to pay. That's other things that they're trying to look at, is how do they accommodate smaller health departments so it's not such a large impact on their budgets? The larger public health departments can absorb it because they've of course got the infrastructure there.

We had our annual staff picnic at Oaks Park. You are all welcome to attend. The more that we have these, I think we just need to do a better job of getting that out to you in your area. You can show up. It's just a chance that staff can take a little bit of R&R. And sort of decompress and celebrate for a while.

Nike Native Fitness was another huge success. It's what, our eleventh year? Anybody? Twelfth? Twelfth? Thank you Kerri. I can see, I thought that you'd taken off. Thank you Carrie. Another huge success. As always. We're going to continue with that as long as we possibly can. If you haven't had a chance, I'd encourage you to go to that.

ATNI in Spokane and NIHB annual conference, this year was, coincided with the Pope's visit in Washington DC. So traffic was a bit hectic a couple of times, but it really didn't affect the conference goers. We were up at the Hilton. Not the capital Hilton, but the other Hilton up on the Hill near Adams Mark. Adams? Yeah, Adams Mark. And so it didn't impact us as much, but there were a lot of security and military posted around just to make sure that the Pope was well protected. The conference itself was very well conducted. One of the bigger things that is coming out of it, that some of you may have gotten notice about, is the Tribal Public Health Initiative that NIHB is trying to create as a Tribal Public Health Institute. So they're going to be calling some of you up and doing a capacity survey, and they're going to start with the area health boards, but I know it will trickle down to some of the Tribes to ask about your public health capacity. And they're really trying to build up an institute that they can be that clearinghouse of information or that support for you all if you have questions. I'm not sure how we as an Area really feel about it yet. If you look at their strategic plan, it's one of the things that's a little bit off from what their wheelhouse really is. I think that might be better for us to deal with more at the Area level rather than at the National level, because it really would

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be hard to deal with all the different systems that will be in place in terms of whether the states are centralized systems or whether they're decentralized. How many local health departments are you dealing with. So there are a lot more complexities that I think would make it really difficult for NIHB to deal with, with 567 Tribes in the nation, and be able to do that well. I think they'll still be counting on the area health boards and the area Epicenters to provide a lot of that support.

I attended the Washington Dental Services Retreat. One of the things on their agenda was the mid-level practitioner's movement. So the Swinomish movement and others. They were pretty subdued about it. Fairly quiet, but I had a lot of conversations with folks in the hallway, and it's mixed. It's almost evenly split in terms of support. There are a couple of private dentists there that operate their own shops that are looking for ways to integrate DHAT into their model. Those that are looking to do that, really understand that the Medicaid expansion in the state is really that emerging market where they're going to capture more bottom line. Because they're not getting more market share by the regular pay or private pay. They see that their opportunity for expansion is that Medicaid population that's newly insured. And so they're looking for a lower cost way to provide that service. So the business folks are trying to make a business opportunity out of DHAT. There still are some of those folks that are drinking the Kool-Aid from the American Dental Association that's it's a lower quality of care means of providing oral health services to your communities, and I hope you all don't believe that. Because it's absolutely not true. There are enough studies out there that have demonstrated that a mid-level practitioner not only in Alaska and that model, but throughout the world have provided quality care that's on par with how dentists are providing oral health care to your patients now.

Indian Day celebrations, our 10th year. Kudos again to Lisa for really pulling the team together and making it successful. It started out rainy in the morning. I wasn't there. I was up at Washington Dental Services retreat, so I wasn't able to be there. It started out rainy in the morning but turned out very well. And I got one photo at the end of my presentation to show you.

I sit on the Kaiser Permanente charitable fund, and we review grants for the local Portland area, the I-5 corridor. So every once in a while I have a chance to go and review grants, and make recommendations about how those should be divvied out.

The Northwest Indian College Foundation (not fountain. Sorry I missed that). The Northwest Indian College did get a fountain with their new campus, so. I'm kidding. But I sit on the Foundation Board for Northwest Indian College. So we had our quarterly meeting. And also I've been talking with Dr. Freeman. You all know him. Dr. Freeman and his wife have developed the scholarship that's specific for students that want to join the health care arena. And so he's seeking my input not only in terms of how to set that up, but also seeking my input on how to develop some philanthropy in getting that better

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funded so that we have it into perpetuity and not just as long as he and I are contributing to it.

The Centennial Accord Meeting just a week and a half or so ago. It amazes me how those have evolved to what they currently are. Cheryl was there. I saw Cheryl at the front. And it's really a chance for the Tribes to sit down with the governor and the cabinet -- somebody's phone.

And the governor and his cabinet and really address some of, not only the major accomplishments that have been made through the year, but also identify opportunities for a mutual agenda.

NCAI, here's where I'll tell you the story about my sport coat. I was leaving on the last day after Brian was voted in by acclamation. He ran unopposed, and so congratulations to Brian.

So I made a run for the airport, and in so doing, I was trying to catch the flight and jumped out of the rental car and jumped onto the shuttle, got to the airport and remembered that I left my sport coat in the back seat of the rental car. So I called them, they said no problem, we'll put it aside. And I knew that Jim was leaving the next day. So I called Jim and said "hey, can you grab my sport coat at the rental car?" And he said "yeah, no problem." So he was using Hertz, I used Enterprise. So he went to Enterprise, grabbed my sport coat, threw it in the car, went over to Hertz, jumped in, and he left my sport coat in the back seat of the rental car at Hertz.

So it's on its way back from San Diego. And it will be back for the next meeting. But it just went from one hand to the other.

Upcoming meetings this month, first I think it's on Thursday is the Idaho Tribes. Budget formulation in November as well. Our accreditation meeting for PHAB is where we'll actually review some public health departments and either make them accredited or put an action plan for them to improve so they can achieve accreditation. We're going to have our staff retreat. It's been two years since we've had a staff retreat. We'll all reflect back on our accomplishments and prepare us for -- I'll let the bird out of the cage here and that is for strategic planning, which January -- a portion of our meeting in January will be for strategic planning. I think what we'll also do is try to make it a way that it doesn't seem so much like it's that you're the first patient for the DHATS. We'll make it seem like it's getting your teeth work done, but instead we'll try to develop the process that captures the spirit of the input that you want to share with us, what direction you want the organization to go, and helping you. And then we'll have the actual board meeting for the Public Health Accreditation Board that deals more with the policy, and we'll likely take some actions to cut costs to keep the fees at a more reasonable level rather than the proposed 30-something percent.

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This is from Indian Day. This was a great thing. If you all have been to Portland Pioneer Square, you know they have a metal post up with major cities throughout the world, and they tell you what distance that the cities are away. And so we were at a staff meeting at the board and we said "wouldn't it be a great idea if we didn't do that for all Northwest Tribes? And had that down there during Indian Day? So that people can have an idea of how close we are to Portland and Portland's living area." So we had this made. And so we're going to have it at our offices, so you'll be able to stop by our office. But we put it in Pioneer Square, and it was, needless to say it was a big hit. I think a lot of people would come by and look at it. Certainly people, the Tribal community in Portland would stop and they all took pictures with it, so it's -- already it's gotten a few accolades for being there. And I apologize that it's cut off, but that's just the way it imported into the PowerPoint. I think that what we'll do is probably try to make it a little more permanent. The base is just a wood base, and I think we'll sort of polish that up, and regardless of where we end up in terms of -- I'll give you an update on our new building as well, as you know, You all gave me authority to use our contract support cost funding to go after new office space. We met with the bank, and we are starting to put together some pro-formas that we can go to prospective seller and give them a snapshot of what our financial health is like, so that they'll take us seriously if we make an offer on a building. So that's being put together. We have identified a couple of build spots that we think would fit us in terms of square footage, location, and opportunity for growth. One of the -- at least my leading candidate is down on Macadam. The south end of Macadam. It's 30,000 square feet. We're currently in 17,000 square feet, so it lets you know there's quite a bit of extra space there. Likely what we'll do is if we were to enter into an agreement for that building, we would lease out the additional -- it's three levels. We'd lease out 10,000 square feet and there a couple of candidates that we've already been talking to. ATNI is looking for office space in Portland, so that would be easy to accommodate them, even within our current square footage we have now, easy to accommodate. And then also NICWA is, and they're right about that 10,000 square foot level currently, and they're already on Macadam but just further north on Macadam. So those are possible co-tenants with us in that building, and then we'd be able to use the revenue that's generated from the lease to sustain the maintenance and other efforts for the building. So now that we'd be a landlord, we'd want to make sure that we stay a Class A landlord instead of letting it go downhill and have people regret moving into our building.

So I think that's it, unless you have questions for me. Yes, Tim?

Tim Gilbert: I'd just like to do a really quick shout out. Shawna Gavin and myself received today the Umatilla specific data book. I'm going to Data book I'm getting the title wrong. We just received the Tribal specific morbidity/mortality report that we've been waiting for for a long time, and we really appreciate Victoria and staff. That information will be really valuable to us. Thanks.

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Joe Finkbonner: Thanks Tim. Just to let you know, that was the first one that's out. And so we sort of cut our teeth on not only the elements of that report, but also getting all that data put together. It's fairly sizable, too. I think it's a couple hundred pages in length. So we're going to start mining those out to you all as we get them done. But now that we've got the format and just need to populate the information to each Tribal specific, so be looking for those, and be looking forward to talking to you about those. And hopefully that generates some sort of questions for us to push us in a direction that we can help you better. So, thank you for your attention. Yeah, Marilyn?

Marilyn Scott: There was a national behavioral health agenda that is being established. The forum nationally for national for SAMSHA and that was introduced last week at the National Congress of American Indians. I know that in Portland area, for the Board, we had Linda Frizzell consultant that was representing the Portland area with the Behavioral Health and the TTAG before. Do we have a behavioral health, you know I know that IHS has Michelle at the area office as the Behavioral Health, but do we have someone with the Board? Because my concerns about the activities that is going on within Washington State, and the integration of mental health, chemical dependency, and physical health, you know the whole effort that is going on within the state. Kind of the initiatives that are being formed with integration of SAMSA and Medicaid priorities. So I'm wondering whether we at the Board have a representative that will be aware of the national behavioral health agenda and work with us, the Tribes, in an effort that is changing in the states.

Joe Finkbonner: The answer is yes and no. It's never direct. I'm sorry about that. But the behavioral health and substance abuse is one of the areas that is probably the weakest for the board. And we've all talked about that. We had Linda Frizzell for a while. I was working on bringing Dr. Dale Walker, OneSky Center, closed up at OHSU. And we went as far as moving his library down into our offices. And at that point we were going to sit down and talk about pursuing some grants and other activities that would bring Dale into our offices a little more routinely. And as you know, his wife passed away about six months ago or so. And so we've sort of just let him contact us, other than send out our condolences to him and remind him that we still want to have a conversation with him about being engaged with the board a little more routinely. So that's why it's yes and now. I need to renew that conversation with him and see what his thoughts are right now, but also want to be respectful that he's still mourning. Thank you all for your attention. (A PowerPoint presentation was presented)

Andy Joseph, Jr: Thank you Joe. All right. Have some announcements. Umatilla has a staff person offering water aerobics at 7am in the hotel pool tomorrow. And the Silent Auction is in the back corner, see Clarice, back that way. I was thinking I ought to do the water aerobics at 7 tonight. Maybe I'll stay away from those machines. But, OK. Our next agenda item we have our program THRIVE and PTR update. Stephanie

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Craig-Rushing, Suicide Prevention PRT Project Director. There you go.

THRIVE/PRT Update

Stephanie Craig-Rushing: Thank you. Colby Caughlan is actually going to kick us off this morning. And we're going to do-si-do each other here. We're just going to cover some updates on the suicide prevention campaign that was launched mostly throughout the month of September. Some crisis response protocols that the THRIVE project has been working on. Some project and research updates to share. And some next steps in terms of upcoming zero suicide trainings for folks who might be interested in those topics. So, here you go.

Colby Caughlan: OK. So we have been to a few meetings, I think January and October were the -- so a year ago, and then January. We came and we talked to you guys about a new suicide prevention campaign. And ta-daa! We have it here for you today. So we're very excited for this. As Stephanie said, it launched in September for World Suicide Prevention Day was September 10th. And I know a lot of our communities did maybe a walk or a memorial event or an awareness dinner or something within the schools to educate about suicide prevention and awareness. So I'm so glad that all of you were able to do that. With the campaign, we have posters. We have flyers. We have a rack card. We have a temp card. And we have these lanyards that Stephanie is handing out, and hopefully we have lots of extras for everybody at the tables and chairs. And we also have something new. It's the lived experience videos, which we will go over, and we'll have you guys watch one in a couple minutes. And we have T-shirts, radio, public service announcements, and we have flash drives that should be delivered to us on Friday that have downloaded on them already the radio PSA and the Lived Experience videos. And we'll be sending one or two or three, I'm not sure how many we have yet, but we'll be sending them out to all of our Tribes, probably next week.

Let's see. So this is one of our posters. And I'm hoping that you guys remember that we talked about doing this suicide prevention sign, and we really wanted something to show across the generations. And we wanted people to know that it's not just teens that die by suicide. It is across the board. Suicide knows no boundaries whatsoever. But if we really think about our communities and all the people that help us if we're feeling down, it could be anybody. It could be somebody that's 6. It could be somebody that's 76. It does not matter who's there to support and help you. So we have these signs that were created from youth and from folks that work with youth, and parents, and grandmas and aunts and grandpas, and what we came up with -- so the first sign is "you're a gift from the creator. You will pass on our traditions. We need you here." "We know you are in pain. We can heal together. We need you here." "I've been there. We will get through this together. We need you here." And then "my life matters. I am here for a reason. My story has just begun." So you notice this one is a little bit different. And the reason it's different is because we also want people to know that there are

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others in the same position, different reasoning's maybe, but they, you can also work with each other to try to talk about your thoughts of suicide and maybe get through that together. And to really know that people at all levels in their life right now, depending on what's going on, what their situation, and if there's conflict, if there's anything going on at school or at work, and that it doesn't matter who you are, but no matter what, your story has just begun. Or maybe you're continuing it, and we want you to continue so that you can eventually pass on all of your knowledge and all of your wisdom to those generations coming up.

And so far we've gotten wonderful feedback on this. People love it, and they like the fact that we've gone across generation. And again, all of these things came from talking to you folks at this quarterly board meeting, going to youth conferences: the Northwest Indian Youth Conference, the Unity Conference for Youth, I can't even name all the other ones that we've been to.

I do want to show you one of our lived experience videos. So we talked to three native youth within the Pacific Northwest, and they told us that they would be willing to go on film. We got consent forms, everything done. And tell us -- Chris, do you want us to use it through YouTube, or through -- whatever way we want? OK. And so we have three videos. The first video is of the three youth. Just talking about how two of them have attempted suicide, and then the other one has gone through with the passing of his father, who killed himself. And that's kind of a teaser video, and it's just like "hey, we're promoting the fact that we're coming out with two more videos." And all of this can be found on YouTube or on our website. And the link is on your iPads. I don't know if you'll be able to do it with all the people here with the bandwidth, but you can go during lunchtime or something and check out the video again. And then the second video is actually, he's from Nooksack, Hamilton Seymour, and he introduced the First Lady at the Tribal youth gathering in DC this past summer. And he talks about his struggles, that how his culture really grounded him when his dad died by suicide. And then the third video, we're going to show you now. And this is the two gals that have attempted suicide. And then a third adult female who has struggled with suicide throughout her life. And what has helped her. So, enjoy.

2:23:01.9 [Suicide prevention video.]

Colby Caughlan: OK. What did you guys think? I'll just run down here.

Brent Simcosky: I'm not very good with my phone. You text -- ?

Colby: So you text the word "start" to 741741. And what it will do, is it will prompt the suicide prevention lifeline. And they'll start a chat with you.

Brent Simcosky: Oh, a chat.

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Colby Caughlan: Yes. And what you can do with that too, is if you are a person who is concerned about somebody who's thinking about suicide, you can text "start" to 741741, and ask the folks on the other side of the chat "what do I do? What do I say? I'm so scared right now. I don't know what to do." And then it also helps with your own mental health to do that. And then you might feel better equipped to talk to somebody that has been thinking about suicide, especially if you haven't been able to attend an Assist Training or QPR training, that's Question, Persuade, Refer, or Applied Suicide Intervention Skills Training.

Brent Simcosky: Is there any -- again, I have to take my phone to my daughter and program it for me. One of the things I've always heard from counselors who are working with suicide prevention stuff is that when a person is in need, they don't have the number there. It's not on their phone. They don't have the text thing. Is there an easy way, like a hashtag thing that somebody can remember, that if they just needed suicide prevention or something, a number would come up and send them to that chat or something? Because if you're in need and you're thinking "OK, I'd like to talk to somebody," but you don't know what to do?

Colby Caughlan: One easy way is 1-800-SUICIDE. 1-800-273-8255. That goes to the same place. That's 1-800-273-TALK. But a lot of people don't have those phones anymore that give the letters with the number. So if you actually all would like to take out your phones, and program into your phone: 1-800-273-8255. That's 1-800-273-8255. That's the national suicide prevention lifeline number. And if you dial 1 after, so for a prompt, it can go to veteran's line specifically. We've talked to a few folks that have a crisis clinic that picks up calls from the lifeline, and they definitely would love to have, you know dial 2 for American Indian / Alaska Native. But there haven't been enough volunteers to work at those call centers, to volunteer their time at the crisis centers, to be able to pick up those calls to say that every time you press 2, you'll actually get somebody who understands the culture and traditions that are within a lot of the Tribes. So that's something that if we really want that prompt number 2 for American Indian / Alaska Native, we really have to recruit folks to volunteer at the crisis centers within your states.

MALE SPEAKER: I got 800. What else?

Colby Caughlan: 1-800-273-8255. And I don't know, I don't think there's a hashtag for the lifeline. I've not heard about that. I'm sure you could probably search it.

FEMALE SPEAKER: Can you repeat that number again?

Colby Caughlan: Yes. 1-800 --

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FEMALE SPEAKER: You need it on a -- just --

Colby Caughlan: I know. I don't have it. Let me see if the poster has it. I don't think it's big enough. 1-800-273-8255. It's right there. It's very small, though. So it's on your iPads.

FEMALE SPEAKER: And then "start" to 241?

Colby Caughlan: 741. Or text "start" to 741741. You can also do an online chat. So if you go to their website, the National Suicide Prevention Lifeline's website, you can click and start a chat as well. Kind of like AOL if anybody remembers that. Little dialup for you. OK.

So the next thing -- Steph's handing it out right now, we'll hand it out to the folks behind the horseshoe in a second. She's handing out this blank flyer that you see here. And the reason we did something blank is because we wanted something that you could do as an activity with your community, especially with your youth. And #weneedyouhere. Does anybody want to explain what a hashtag does? OK, well I will try. So Stephanie and the rest of the project Red Talon team are amazing with social media. And they were hounding me. "Colby, you have to do a hashtag for the We Are Connected, We Need You Here campaign." And I'm like "why do we need a hashtag? Not everything has to be social media!" Well, it has been amazing. I'll tell you what. It is a great way to promote positive behaviors and healthy lifestyle. So the reason we put the hashtag on this is we want you to draw or write words, write them big. We've got a whole bag of pens here that we'll also pass around. And you write really big any words of hope, wisdom, anything that you think will really help somebody, if you were to look at this as a billboard. They get 3 seconds to look at it and read it. And it says "Dig deep. Paddle hard. Together we'll get through rough waters." If somebody read that, or you read that, you might say "oh my gosh! I want to live. I want to get through this. Somebody can help me get through this." And -- sorry, I'm thinking and doing this at the same time. Multitasking. And so we want you to write your own words of hope on here. You don't have to turn them in. This is just -- can you doodle throughout today and write something awesome or make a really cool graphic or a symbol or whatever you would like to do. And if you have the capability, and want to (it's up to you), you can take a picture of it -- just of the piece of paper itself after you've drawn on it or written on it, or you can have somebody take a selfie, or what is it? You have to take your own selfie. Somebody can't take it for you. I've never done one! I don't know. So you take a selfie with your card, and upload it to your Facebook page if you have one, or if you have a Twitter feed or an Instagram page or anything like that, and then you type within your little comment box "hashtag," so the pound sign to a lot of us, #weneedyouhere. All one word. And what it will do is it will link your photo and your words of hope, words of encouragement, empowerment, to all the other signs that people have "#weneedyouhere." So since early September, people have been doing this. And we

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have over a lot of thousands of them. Stephanie has those analytics. And it's amazing. So I, yes, had to bow down to the rest of the team and say "you were right. We needed a hashtag." It has gone hugely across the country. We've been in Indian Day Today. And it's just very exciting. So please do that. These were some of the ones that have come in, and so this one right here, I think this was one of the first ones that came in. "Place your hand over your heart. Can you feel it? That is called purpose. You're alive for a reason, so don't ever give up." People from ages 10, probably, up to 70 have been doing these. And they've been absolutely amazing. So please take the time to do it if you want. And you can post it in your cubicle or your office or at home. Just for your own empowerment as well. Your own words of hope, to remind yourself why living is so important to be there for others, too. Not just for yourself.

So I'm going to hand it over to Stephanie, who's going to do the analytics now.

Stephanie Craig-Rushing: So the Indian Country Today had a really wonderful sweet article showcasing native youth in the Northwest, and we have 50 youth ambassadors who help support and spread information about the WeRNative website. And they went to their communities, went to these sites and did all the activities. So if you have the chance to check out this article, it just talked about what they were doing in their communities to spread this message. But in terms of overall reach, for us, it's very hard to kind of quantify the media campaigns that we traditionally send out: posters, the tip cards. It's hard for us to know how many folks have seen those materials. So we get very geeky over these online analytics that allow us to capture who is sharing or liking or sharing the materials, and using these hashtags. So we had over 205,000 likes, shares, and comments related to the WeRNative, or We Need You Here campaign. 80,000 folks visited the WeRNative website as a result of the campaign pushing them to those sites for more information about suicide or how to help a friend in need. We had nearly 22% of our folks were returning to the website. And almost 80% were new visitors to the website, which is really exciting for us. Driving new, young people to seek health information from We Are Native. And this breaks down that 205,000 by different media channel that we use. So we have a website, a text messaging service, Facebook page, and most of that viewership was driven on our Facebook page. But also nearly 4,000 of minutes of video viewed from the three lived experience videos, which is really neat to see.

So now I'm going to pass it over to Colby to talk a little more about the crisis response protocol they're working on.

Colby Caughlan: OK. So when we do our presentations, we also like to put you to work. So, I've got something I would like you guys to look at, that's going to pass around. And you can jot down notes on it, or what you can do is shout anything out to us, and Steph will write it down. And I want to let you know that the reason that we're doing a template for crisis response, I know this is actually for Ebola. Don't worry, I'll tell

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you why. Is because -- oh my goodness, maybe three years ago, it was something that was actually brought up at a Behavioral Health committee meeting here, that said "you know what? We don't necessarily have a crisis response protocol that's just a one-pager, that's really easy to use." A lot of us can go to the protocol binder, the binder, and be like "OK, so I do step one, and then there's like A, B, C, D, E, F, G, H. OK, now step 2: A, B, C, D, E, F, G, H." So there's so much stuff in there. So what do you do if you're just front desk, somebody presents suicidal. And you go "uh, uh, I don't have time to do A through G. What do I do?" So we wanted to just do a slab one-pager, can sit somewhere in your clinic -- and this is for clinics right now. We can go through for education and do all of those other departments and those areas later on. But we wanted to at least get one out the door. So we have been talking with you folks I think over the past year and a half at quarterly board meetings, asking what you would want to see on a crisis protocol template, and what we did was we also looked back at some templates that were pretty easy to read, and made sense. So one of those happened to be "What to do when you're presented with the Ebola virus." So that's why this is up here. It's just something that we looked at, and we want to eventually make ours very easy to use, like this.

So Stephanie is bringing around a copy of just a very generic version of our template right now. We do want to pretty it up, but we didn't want to make it so when you're just writing down your own comments on it, we wanted to have white space and places for you to actually comment. But eventually it will look fun and pretty and work for our community. Something like that, maybe. Or maybe something where we just have very few words and a whole bunch of graphics. We haven't decided. So these are kind of just options of what it will look like in the future.

But what I'm hoping that you notice is that if you flip to the backside of the crisis response model that we have right now, there is a resource directory. So we turned it into a two-pager. But you know, you can just flip-flop so you can print it on one piece of paper. And the backside would be for somebody at your clinic to fill out. Numbers, names, and anywhere that you need to contact, anybody you need to contact if somebody does present suicidal, or there was an attempt. This is not for a completed suicide. So, just know that. But these are things that, again, if you're sitting there and somebody's in crisis, and you don't remember the number but you are in the clinic, where do you go for all the places that you could call or talk to if the nurse is in the room with another patient? Oh, well I have this thing that's posted on the wall, and on the back of it, there's a whole bunch of numbers. So, awesome! Let's start with that. So that's why we put that on the back, is to have it at our fingertips.

So for this crisis response protocol template, we've had a few versions of it already. The first version used to be portrait, not that it's that big of a deal, but you can read things better landscape, and you can fit more on the page, to be honest. So as you're reading this, if you notice there's somebody -- a patient walks in, or a friend or a family

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member of the patient walks in to the front desk and they say you know, this person is suicidal. What do I do? Or "I'm suicidal. What do I do?" Or maybe they filled out their depression screening form, and the front desk staff or the people that maybe look at that form, count up those PHQ's, whatever you need to do, and then they say "oh my goodness, this person is suicidal," what do they directly go to? Behavioral Health specialist? Well, in some places, they actually want you to go to the cultural advisor if you have one in your clinic. So there's different options and different ways, and different things that you can put on your protocol. Once we're done with this after having lots of vetting and talking to a lot of people, and talking to you guys, we want -- we would send this out in a Word Document so you would be able to make changes as you see fit in your own clinic. This is something that we want people to make personal to them. It shouldn't be something that us, the Health Board, we don't have a clinic at our office! So we don't know if this is going to work perfectly for you. We just are creating this based on all of the conversations that we have with folks that work at clinics.

So is there anything that you want to point out right now? Or you can take your time and fill it out and we can pick it up after lunch, too. Anything? Oh, I'm sorry. Did anybody -- we printed like 90. So many people are here today!

Cheryle Kennedy: My question is on your response, suicide response model, family and friends. The -- I guess this -- when you talk about clinical depression, which I think many of these lead to suicide, and families, I think that families are aware there's something really, really wrong, but really not know what to do when I think sometimes thinking all they need is rest. And not knowing that also, I guess, deepens the depression. So in the work that you're doing, is that addressed somewhere?

Colby Caughlan: So, kind of like a community level aspect to it? Not right now. Because that can go into a lot of detail, and we wanted to start one place that we knew could have a beginning and an ending. And then we'll go into the education. So people asked about schools. And a lot of people have asked about in the community. What should we do? And unfortunately there are so many things you can do at a community level, and you don't have as many policies and protocols to follow that your clinic has written down already, that could be endless, like I said. But yes, it is something we want to do. It's just we want to start with something with a beginning and end right now, and go from there.

Stephanie Craig-Rushing: And communicating to parents and family members around trying to identify risk that is in the media campaign materials. So if you had families that you wanted to educate, tip cards and the rack cards are information for them.

Colby Caughlan: And also utilizing WeRNative. So there are mental health pages within WeRNative's website. And youth can go to that, and even parents. It doesn't really matter who you are, if you just want to gain knowledge about suicide and also

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self-harm. We have information on that there. And on those pages there are some things that say, I think one of the topics is "I'm concerned about a friend of mine. What do I do and what do I look for?" So the suicide warning signs, and how to talk to them or how to refer them to somebody that they would trust and talk to, and hopefully a health professional, but for some folks that's not the way to go right away. But there are definitely tips on there, and there are some Ask Auntie videos. I know Joe referred to Ask Auntie, and there are some of her videos talking about how to talk to somebody about suicide as well.

Andy Joseph, Jr: Are we going to get a new Auntie on there? Because it sounds like --

Colby Caughlan: Auntie is sticking around.

Andy Joseph, Jr: OK.

Colby Caughlan: She is still working with WeRNative, remotely, just for the We Are Native, Ask Auntie section. She wanted to stay on for that.

Andy Joseph, Jr: Well, that's good. Good news.

Colby Caughlan: Yeah.

Andy Joseph, Jr: Because I refer people to WeRNative all the time. I just think it will save lives and help people ease their stress. Thank you.

Colby Caughlan: And the fact that on that website there are so many different ways to learn information. There's just reading. There's facts sheets, posters, all that normal stuff. But there's also audio and video of people talking about their own experiences with various topics. It's not just suicide, obviously. With physical health and with nutrition. So it goes the gamut of everything that would be considered a healthy lifestyle. And really learning from your peers, which we're coming back to that peer learning model and how important it really is and how helpful it is.

So the crisis response model, let's wrap that up. Does anybody have anything they want to say out loud? Or do you just want to mark it down? Because I know a lot of you, we're luck that we do have Tribal health directors in the room as well. So I know there might be a lot of jotting down notes. And if you have a way to make it pretty, feel free to mark on it that way as well.

All right, so we're going to move forward. Here's my clicker. And Stephanie's up.

Stephanie Craig-Rushing: So this is kind of a good segue. When I was last here,

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providing an update on WeRNative and the work that we were doing, we were partnering and presenting with the Seattle Children's Hospital. They have an adolescent social media research team that looks at similar issues that we work on with youth, and we had been meeting with health educators in the regions who brought up the concern that young people were posting content on social media that was expressing either harm to self or harm to others or things that a viewer might be able to identify the youth as "at risk" and potentially provide some sort of intervention to. So we did a series of focus groups with youth in the region this last summer to get a little more information on was that a true experience for them, are they seeing these and what are they doing in response, what do they need to be better equipped to respond to those sort of concerning social media posts? And just as we kind of anticipated, all of the youth in the room had witnessed these sorts of posts in social media. Many of them were acting upon those messages along, trying to either meet with the friend in person or message them. And many felt that the sort of response that they were providing to the youth was not effective. And so during those focus groups, we brainstormed with the youth what sort of ideal programs would be for them, to help support them when they're seeing this content or have friends or family members who are posting that sort of content. And overwhelmingly, the young people said they wanted an adult to help support them and intervene appropriately. Which isn't very exciting to us. We started working with the health educators in the region. And during the focus groups, the youth also said they were interested in inspirational videos that would help educate them about how to respond appropriately, tips and resources like WeRNative.

But we started asking health educators if they'd seen these sort of posts, and just for a show of hands in the room if you're on social media, have you yourself ever seen that sort of post that would either be kind of either depression expression, or suicidality or something that made you alarmed about the mental health, the health well-being of a friend or family member. Any folks in the room? Yeah? And so many of the health educators that we have been talking with over the summer said they don't feel equipped to respond to those sorts of messages. So right now we're working on media messages to youth through WeRNative's website communication channels that would help equip them. We're also working on a grant with Seattle Children's Hospital that, if it were to be funded, we would be developing some educational tools for Tribal health educators and parents working with those young adults to help support them. So those things, we really appreciate the feedback that the youth in the region have provided in building those materials. And if folks aren't aware, this summer Facebook also released a tool within its system so you can go in and report those sorts of concerning posts, but it's really hidden. Does anybody in the room know about this new reporting feature? See? Nobody knows about this!

So if you, this is Celena, our colleague at work. If you see a message in her, on your Facebook sheet, and you are worried about that message, in the top right corner, there's a little triangle that I kind of like, with a little red dot there. And it allows you to

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report the post. And then if you click that, it's going to ask you why you don't want to see it. And you would have to know to click "I think this shouldn't be on Facebook." That's not intuitive. But you would have to know how to do that. And then it would ask you why, what's wrong with this post? And you could then click the option that says "it advocates violence or harm to a person or animal." And then if you click that option, it will give you the opportunity to direct message the person, or Facebook will follow up directly, providing a mental health counselor to that person, to counsel them through the Facebook communication channels. So it's kind of a really hidden functionality in Facebook, and this is the sort of information that will be important materials for youth around how to access and use these tools within Facebook.

Kind of moving the topic along to another project, Jessica Leston and David Stevens, who have been working on a number of kind of clinical support tools, so clinics will soon be receiving personalized reports on their HIV screening, STD screening, and Hep-C screening. Every Tribal clinic should receive their own report in the next two weeks. So be on in lookout for those. And Jessa can provide really tailored kind of support of your clinic in terms of developing EHR binders or other policy practices if you're interested in improving your STD/HIV/Hep-C screening numbers. And I know that Dr. Rudd will be presenting tomorrow on Hep-C, but we also have some support that we can provide in terms of we can remotely access your Hep-C screening numbers in order to create a staging panel for your Hep-C patients. And this will help you identify those patients that might be in most need of treatment and help kind of your planning around Hep-C in your clinic. So if you're interested, we can remotely help support your clinical develop these panels.

We're also working on a project to better understand intravenous drug use and its impact on Hep-C spread, and so she is working with Oregon branch clinics across Indian Country to do interviews both with community members who inject drugs and with clinicians in that setting to better understand what sort of services and resources are needed to support planning around injection drug use and HIV/Hep-C transmission. So these projects with a resolution around this project that will be discussed at lunch time today.

And she also has a library of educational materials around Hep-C, so if you're interested in those materials, get in touch with us also. We'll make sure you have some of those. And any questions around either of those projects? OK. We're on the last leg here.

Colby Caughlan: So this is exciting! Now we're back to suicide, right? We talk about HIV, hepatitis C, and suicide. We're the fun ones in the room! At least we won't show pictures or anything. Sorry, that actually was totally -- I didn't think about that before. I apologize.

OK. So zero suicide. Has anyone heard of this new strategy? Zero suicide model. All

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right. OK. Well, I'm here to help with that. The zero suicide model is something that came out of lots of folks talking about the national strategy for suicide prevention. Goals 8 and 9 specifically. And also talking with the National Action Alliance for Suicide Prevention, where we do have an American Indian / Alaska Native task force, which we actually just met in person on Friday in DC. And it was a wonderful meeting. We have lots of to-do's for the next couple years. But for Zero Suicide, what it is is just a standard. I think we all really want to get to zero suicide anyway, so they coined it "Zero Suicide" strategy. And it's something where there's a tool kit online, and it just helps you go through steps to talk about focusing on error reduction and safety and health care, and how striving for zero is really the best thing. And if you get down to one or two suicides, and this is within a clinic system, that that's awesome, but we always want to strive for zero when it comes to suicide.

So the two goals from the National Strategy for Suicide Prevention that specifically relate to Zero Suicide, were like I said goal 8 and 9. Goal 8 is to promote suicide prevention as a core component of health care services, and goal 9 and to promote and implement effective clinical and professional practices for assessing and treating those at risk for suicide. Suicidal behavior. The foundational belief of Zero Suicide model is that suicide deaths for individuals under care within health and behavioral health systems are preventable. And it's a relatively new approach, but it's definitely being embraced by large health care organizations as well as Indian Health Service and individual clinics around the country. So it's definitely a priority at the national level as well as regional and local levels, just depending on where you're located. And ZeroSuicide.com is where you can find the framework for this systematic clinical suicide prevention and health care systems. And again, I want to stress that this is for a health care system. This is a system wide change. This is something that will help in a community, but it's not based in the community. It's based at the clinic level. And the reason I do stress that is because there are components involved like your EHR system, that you need to be able to track all of your patients, have they had follow-up, are they being seen for suicidal ideation, are they being seen for depression? Two separate things. They coincide sometimes, but they are two separate things to treat in many cases.

So a great thing to look at would be this model here. So this was adapted from James Reason's Swiss Cheese Model of Accidents. So if you notice, there are lots of holes in Swiss cheese obviously. So a suicidal person could really from the start of patient care to, throughout their entire patient care adventure I guess you could say, they could fall through cracks at really any point in time. So they could present at the clinic and have their first appointment with a doctor for a cut, a really deep cut on their foot. Well, if we're not doing suicide screening for every person no matter what they're there in the clinic for, behavioral health or the medical side, then they might fall through the holes because we're not asking about depression at all, and we're not asking about suicide at all. So they could fall through that first hole. Maybe they go and they have depression

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screening, or they talk to their doctor and their doctor asks them directly, you know, "you seem very down today. Have you ever thought of suicide," and they say yes, well good. They're not falling through the cracks. But then for follow-up, they get a mental health appointment. What if they don't go to the appointment? They could fall through the crack again. So then there has to be protocols in place for real, substantial follow-up, which is very hard to do based on staff time, based on getting ahold of the person. Is the contact information correct? So there's a lot of things that go into the system wide change. And there's a lot of holes that we want to fill so that we don't have patients falling through the cracks. So that's why this is such a great image for Zero Suicide and how it focuses on patient safety and error reduction.

Some things I underlined here that I thought were really important is that current research strongly supports targeting and treating suicidal ideation and behaviors, specifically and directly, independent of diagnosis as well as any diagnosed mental health or substance abuse problems. And the reason that I think researchers have been talking about this and the fact that it has been shown is because there are folks that could have very highs and lows for their depression, and they get that treated and they get that stabilized. But they can still have suicidal thoughts, because their suicidal thoughts may not be completely linked to their depression. It could be things that are going on in their life. It could be a trigger of a loss or a significant change in their life, and that's not always directly related to that depression as a chronic condition. So it just depends, obviously, on the person. But we want to think about it as another option, is to treat people independently of just their mental health diagnosis as well.

And also, that again, I said this so many times. The system wide change. So this is a health -- this model is something that has a premise that systematic approach to quality improvement is very necessary, and with quality improvement obviously, that's patient safety. That's compassionate caregivers. That's filling those holes within the Swiss cheese model.

So what I'm trying to do right now is just give you a really quick overview, and if this is something that you're interested in, you can let us know and we can help you get the documents you need. There are some documents that you would want to do with your work force, and talk to folks about, and see if it's something that you're ready to take on. Everybody always strives for zero suicide of course, and we're doing that every day and all of us care and really try to help patients, but at the same time, this is something that maybe would just be a little bit more structures if you are ready and want to do something like this. But your model may be working that you have in place already. Absolutely. Just another tool.

So there are seven key elements to the Zero Suicide model. You see here lead, train, identify, engage, treat, transition, and improve. So the approach represents a strong commitment to patient safety, the most fundamental responsibility of health care. And

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also to the safety and support of clinical staff who do the demanding work of treating and supporting suicidal patients. So I would go into each of these, but that could take forever, and you know, these are just the core elements. There's little things within each one that are really important, and obviously leadership is the biggest one to start with. I think we all know that.

In the Pacific Northwest, we have three Tribal clinic sites that are implementing Zero Suicide as partners for the Garrett Lee Smith grant, which is a grant that we have for -- we finished year one. We're in year two. So we have four more years if you include this year. And so they're using EHR. Two sites are using Next Gen, and one site is using RPMS. And each has a site coordinator who leads their clinic's efforts. And we provide as much technical assistance to the site coordinators as possible, as does the Suicide Prevention Resource Center. And they're a leader with Zero Suicide as well. And each site receives around \$23 - \$25,000 a year to support their Zero Suicide activities and their site coordinator. And what we did with these Tribes is we did a two-day take-off training. So they had as many of their Clinical Behavioral Health staff as possible, and some folks tried to invite their dental clinic as well, because they want to include, since they're included in their EHR, they might want to do the depression screening and suicide severity screening as well. And we talked to them about Zero Suicide, what it meant. What this whole system wide change could really look like. And we talked to them about how would you see it in your own clinic? What do you want to see? What do you need from us to assist you? And we also had them implement their implementation team or an advisory team, whatever you want to call it. And they're the ones that meet every 4-6 weeks to talk about how are we doing with putting in depression screening and the Suicide Severity Screenings that exist within our EHR. Have we talked to the representative from Next Gen about creating an easier template, an easier screen within our EHR to put that Columbia suicide severity risk screening form in there, so that it's embedded, so you can run a report, so that when you have an upgrade, it's not all of a sudden poof, gone, we have to do it over again. So we're having all those conversations. We're hoping to have meetings with Next Gen in the next little bit. IHS I know eventually will be doing the whole RPMS system because IHS is really taking on Zero Suicide as a whole as well.

There are a couple things that people do to start Zero Suicide. So on here it says an organizational assessment and work force survey. So that's really just to get a baseline of what do people know about suicide from their janitors to your front desk staff, to your grounds keeper to your clinician to your ARNP's to if you're involving dental, to all of those that work in dental, to medical records, finance department, I mean this is your entire work force that has your clinic running. Both sides -- behavioral health, medical. Doesn't matter. As a whole, what does it look like? And then we break that down into a report. And we talk to our clinics about -- OK, this is what we're seeing. There are people that are really uncomfortable talking about suicide. And it tends to be the front desk staff or the medical records staff. So let's focus on the first year training all of your

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staff, and I mean everybody. Everybody that could potentially talk to a patient, even about the cups for the water station. They might talk to that person about that. So everybody getting trained, to feel a little bit more comfortable with suicide prevention.

So it's a really exciting new strategy, and it just really helps put it into perspective that there can be, OK step 1, get your leadership team together. Step 2, let's look at our crisis protocols. Step 3, let's look at what we have for our EHR and what templates do we have to talk about suicide and suicide prevention. So it's not a complete "how-to" model, but it has a little bit of structure that makes people feel a little bit safe with "OK, we don't have to do this on our own. We don't have to make it up as we go." There's something that's created for you as kind of a guide. It's not, you know, do this or you're not part of the Zero Suicide model. That's not how it is.

So coming up, with our new MSPI funding, we don't have enough funding to completely support an entire implementation, but what we do have, and we will be sending out recruitment for this in December probably, is we hope to offer three Zero Suicide trainings, one to two days, in the Spring of 2016, for any of our Northwest Tribal sites that don't currently use the Zero Suicide model, and that don't have MSPI or GLS funding right now. There's going to be a list of eligibility requirements, just things like that: they don't have Zero Suicide already, etc. etc. And then we'll provide post training implementation technical assistance. Again, we don't have enough funding to actually do the implementation completely with you and fund that, but we can absolutely walk you through all the steps and tell you "this form has worked for these folks. This template in HR has worked for these folks." And we can give you all of those options. And then we would want to do quarterly check-in calls to make sure that you're feeling comfortable with your Zero Suicide model.

So again, just look for that coming across to your email desks or emails in December. So that's just in a very quick nutshell of what Zero Suicide model is and how it's really an emerging strategy, and so many folks are jumping onto it because although it's a lot of work at the beginning, it has a lot of payoff at the end. There's definitely been a clinic in -- I think it was in Detroit, and they got down to absolutely zero suicides after their fourth year, within their patient load. So not the entire community, but within their patient load. So it is possible.

And now we are going to -- what time is it? 12:16? So do you want to do a quick We Are Native and then let people eat?

Stephanie Craig-Rushing: So just as a next step for WeRNative, technology changes quickly. Our website is getting a little clunky. And we're finding users are having trouble accessing the mobile version of the website. So we'll be going through and doing a major overhaul of the WeRNative website over the next three or four months. So look for hopefully by the next meeting to see some really exciting changes in the functionality

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of our mobile WeRNative website.

Colby Caughlan: That's it! After lunch, I think the break after that is around 3:15. And so at that time, during that break, if you just want to leave any of the documents, if you wrote on any of them, the crisis protocol document or if you want us to take your #weneedyouhere flyer and you want us to upload it, just leave it on your table towards the front, or leave it on your chair. And we will pick those up during the final break of the afternoon around 3 / 3:15. So again, you can jot stuff down throughout lunch and just after. And does Andy break this? Or -- Andy? Thank you everybody for having us here today. (A PowerPoint Presentation was presented)

[Applause.]

Andy Joseph, Jr: I always like the WeRNative and trying to get as many people looking at it as possible, because there are some really good, positive messages, and the text line, you get a text every week from them, and to me that's really good. You know, some of our young people, the contests for some of the money that some of the kids can get is helpful as well. So thank you, ladies, for your energy and moving the thriving WeRNative. So thank you.

OK, on our agenda, we have our working lunch. It's I see the lunches have arrived, and as for our Delegates to work on the committee that they worked on. The Elders Committee is going to be back in that area with Therese and our Veterans. Where's the Veterans' Committee going to be? OK, it's going to be on this table over this way. Our Public Health, Victoria is going to be over in this area. Behavioral Health, Stephanie, back in that corner. Personnel is going to be right over this way. And then the Legislative Committee is usually up here at this table. So are there any new Delegates that we need to acknowledge or if you need to get an orientation?

LUNCH.

Federal Marijuana Policy & State Legalization

Jim Roberts: I hope you don't have the munchies either, because you're back from lunch. Right? I tried to get this item at the agenda at 4:20 today, but it just didn't get on there. I could keep going on and on and on!

OK. So the purpose of this presentation is that I've had several of you in meetings along the way, either here or at ATNI, ask me to do a session on kind of what the impact would be, federal funding or your IHS funding more clearly, would be if a Tribe decided to get into medical marijuana. And then also you know, what would be -- could medical marijuana be allowed in an IHS facility in light of some of the kind of legalization that's been going on around the country. And I finally, and this is not where I'm an

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expert, but I have heard about presentations and I talked to Lael Echohawk who has done a lot of work around marijuana and presentations about this. In fact, she has loaned me some of her slides to use in this presentation, about what the implications are for Tribes in states where marijuana has been legalized. And then finally I'll just discuss potential issues from a non-legal basis. So just mostly informational.

And I think I pulled together kind of enough Federal policy and some of the statutes that govern the regulation of marijuana in this. So I think it can be relied on, but at the same time I think there's a body of law that's actually evolving around medical marijuana and Tribes in the country right now. And a lot of seminars and a lot of kind of analysis that's going on, still underway right now.

So my disclaimer kind of goes along with what I just said. I'm not an attorney and by no means should this be considered a legal analysis. And this is the most important part I want to make a disclaimer. The fact that I am doing this presentation should not be construed that I am an expert about the use of marijuana. OK? I just want to make that clear.

Now, I was going to start my presentation. You can't ever have a discussion about marijuana without talking about Cheech and Chong first, right? So I hope you're ready to begin. But I wanted to do a little video clip. But as I went on YouTube and the internet to find video clips, I could not find a video clip where these guys were not cussing in some form or another. Because those of you that are familiar with Cheech and Chong movies will know what I'm talking about. They do a lot of the S word, F word, and you know. A lot of wow too. So.

So this slide right here kind of gives a graphic on the states that have legalized marijuana around the country. So you'll see in green, Washington state and Oregon being one of them. And now also Colorado was the first, and Alaska. And also I think DC is in here, too. That allow recreational and medical use. So there's two ways that marijuana is legal. One is for medical use, and the other is for recreational use. So in two of our states, we have it legalized for both recreational use but also medical use. And then yellow or orange are those states that allow medical use of marijuana. So you can see, you know, about 3-4 years ago, there were probably two states that were on here, Colorado being one of them, and California the other. So within three years, this issue is really starting to become rampant across the country with states legalizing marijuana. If you look at Nevada, Oregon, Washington, California, Arizona, New Mexico, Colorado, all of those states, and Montana, all of those states have Tribes in them. So this is going to be kind of a concern for Tribal Leadership in terms of what they do with this.

So across the country, four states for recreational use. 23 States for medical use. So over half of the country. And the reason why this is important for Tribes to begin to look

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at, you know, there's a lot of money to be made here. In Colorado when I was there, they still have it, we had the kicker tax. So if the general fund exceeded a certain percentage, then the state government had to issue a kicker tax or return part of the taxes to the taxpayers. The payments that are going to Colorado taxpayers has been in the \$300 range for, depending on what your tax filing status is. So they're receiving a good chunk of change back in addition to funding a lot of the governmental operations and marijuana.

In Washington State, it's estimated to increase by \$252 million in 2015. So we're talking a lot of money here.

So legalization of marijuana poses several implications for Tribes. And I think a lot of us might think, well, Tribes don't really need to get into this or do anything. But you really do. So your decision not to do anything invokes a process that the Tribe is going to have to do in terms of developing its Tribal courts, its regulations, its statutes. If they're not going to allow it on the reservation. So you're going to have to prosecute folks. Some of them will be Tribal members. Some of them will be non-Tribal members. Will you have jurisdiction to prosecute the non-Tribal members? You're going to have set up interagency or cross-jurisdictional relationships with other law enforcement entities, likely Federal for some of this. You know, an example might be, let's say we've got Joe and Jim are driving across Umatilla. It's legal here in Oregon, and we have marijuana in the car. And I'm a Pendleton Tribal member. A Umatilla Tribal member. So the court here in Umatilla would have jurisdiction to prosecute me, but they couldn't do anything to Joe as a non-Tribal member. So I'm going to suffer the consequences, but Joe gets to go back to Seattle and make another drug run. So how is that fair? So those are the types of issues that Tribes are going to have to address. As well, you're going to have to ramp up your court systems to deal with this. You're going to have to incarcerate individuals. So you might have to set up your jails to deal with this. And this is all going to cost resources. So that's the decision not to do anything, if you want to prohibit it. If you want to make it illegal on your reservations. So it can be legal in the state, but it can be illegal in Indian Country. And I think we actually had signs somewhere around here about marijuana being illegal on the Umatilla reservation. Is it in check-in. OK.

So likewise, if you decide to legalize it and get into the game, then you're going to have to address these issues as well. So there's a lot of work to be done. And no, I'm not looking for another job to get into the marijuana game. I'm just -- so, and these are some of the things that I've talked about. So what must Tribes consider when deciding whether to legalize or decriminalize or prohibit marijuana in Indian Country? There's governmental issues. Effect on Federal programs, depending on how you get into the game. Do you use -- you know, we've heard already at least from HHS that your IHS or HHS funding will not be allocated, and I'll talk a little bit more about this in the presentation. But if you use, if you don't use federal resources. So if you use Tribal dollars, then you should be OK on that. But we haven't seen any official position of the

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agencies on this issue.

So I talked about some of this. Cost of implementation, sales, taxation, licensing, regulating enforcements.

Now about a year ago, the Department of Justice issued a policy statement regarding marijuana issues in Indian Country. So this is referred to as the Cole Memorandum, was issued. And it invoked a lot of kind of sensationalization of the press and media across the country. I read USA Today articles that say, you know, "Indian people -- it's legal for them to use marijuana on the reservations." But that wasn't necessarily the case. But the DOJ policy statement does not legalize or condone marijuana in the Country. It talked about what the priorities were for enforcement from the DOJ's perspective of these issues. So the DOJ statement was supportive of Tribal sovereignty to prohibit or legalize marijuana, and it encouraged consultation with the Tribes to develop the framework and the regulatory framework for how that would be carried out. The DOJ policy statement updates previous guidance regarding federal marijuana enforcement in states that had legalized marijuana, which was initially issued back in August 29th of 2013.

So what is the impact of HHS funding if the Tribe legalizes marijuana? So this question was posed in June by the staff because there were several Tribes around the country that were interested in pursuing medical marijuana go operations. To the Secretary Sylvia Burwell. HHS took that under advisement, and at this past meeting in September, the secretary issued kind of a statement on that. And it wasn't an official policy position of the agency, but it would -- the question was asked "would HHS funding be jeopardized if the Tribe operated marijuana growth or dispensaries on its reservations? Would HHS funding be forfeited or at risk if the Tribe regulated third party growth or dispensary operation on lands?" There are other important questions posed in the staff letter. So we've included this in your packet. So it's in your electronic workbook and I think there are some handouts in the back if you want the paper copy.

But Secretary Burwell reported that HHS funding would not be adversely impacted if the Tribe operated medical growth and dispensary on Tribal lands, as long as federal funding was not used. So I've had email exchanges with several of the Health Directors around that. And I think I sent them the same opinion. But we heard that verbally from the HHS secretary. So I think that's pretty clear, at least with HHS. Whether it applies to DOI or other types of departments within the federal government, I don't know that anything officially has been spoken from the secretaries and heads of those departments. But at least from HHS we got this from Secretary Burwell.

So the next question was "can medical marijuana be allowed in an IHS or Tribally operated facility?" So defining "allowed" means consumed edibles, smoked, prescribed, or other related medical use. So medical medical marijuana and Indian

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health program is complicated. It's not as simple as the state legalizing medical marijuana to have it be able to be used. It would likely require approval from IHS and may need to be included in your annual funding agreement language. Federal funding will likely not be allowed to be used. And the issue that kind of governed whether marijuana can be used in federal facilities is kind of determined by the Controlled Substance Abuse Act that was passed in 1970; the DOJ policy statement regarding marijuana issues in Indian Country; and also a June 6, 2011 IHS -- your Tribal leader letter that was issued by Dr. Carroll on IHS findings of medical use and marijuana in IHS facilities.

So the Controlled Substance Abuse Act. This is probably the first issue that needs to be overcome. So the CSA establishes kind of the regulatory system for recreational drug use and manufacturer distribution and drug stuff in general. But the CSA classifies marijuana as a drug that currently has no accepted medical use. So it's what's called a class 1, I think, substance. Incongruity between federal and state. So incongruity exists between some federal and state laws regarding medical marijuana use. And according to the manufacturer distribution, possession of marijuana is, continues to be a federal crime under the CSA. So that's the first thing, is that even though States have legalized it, it continues to be illegal federally.

So this is the point that I was mentioning. So the CSA schedule 1 substances, which marijuana is, is a drug or other substance that has high potential for abuse. It's a drug or other substance that has no currently accepted medical use or treatment in the United States. There is a lack of accepted state safety for use of the drug or other substance under medical supervision. So in order to get marijuana accepted in the federal facilities, at least IHS -- I'll talk about the VA here shortly, which has kind of taken a different position -- it would have to be reclassified on the CSA. The DOJ policy statement regarding marijuana issues in Indian Country, which is the memo I talked about previously, kind of sets out the Cole Memorandum, explains the enforcement priorities that previously or would continue to guide DOJ enforcement of federal laws or marijuana laws regarding, where it's been passed in the states. Those priorities were restated in the new policy that came out last December or thereabouts. The 2014 DOJ Tribal policy statement clarifies that the federal enforcement priorities for the Cole Memo will still apply to the enforcement in Indian Country. And here are the priorities. I'm not going to go over them all, but the last one is the important one, which is kind of italicized and underlined here.

Preventing marijuana possession or use on federal property. So the CSA issue kind of, I think, with marijuana still being classified as a schedule 1 drug, this issue, as well as the "Dear Tribal Leader" letter from IHS, I think established the basis that medical marijuana use in IHS facilities has a long way to go still and is not likely to happen anytime soon.

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So the "Dear Tribal Leader" letter issue explains that federal law specifically prohibits the use of marijuana under all but very controlled investigational purposes. The chief medical officer recommends that I recommend that IHS Tribal and Urban programs fully adhere and comply with the federal law by not prescribing, reminding, possessing, cultivating, processing, manufacturing, or distributing marijuana for medical or other purposes. So there you have it. I don't think you will be allowed to use medical marijuana in your facilities in the States that have legalized it.

So these are some of the issues that would have to be overcome, and I explained a little bit about this. So marijuana has to come off the CSA as a schedule 1 drug. ISH manual also includes provisions for investigational drugs, but not for schedule 1 controlled substances as a matter of the agency proposal. And these are findings from the position of the IHS findings. There's an attachment to the "Dear Tribal Leader" letter. And these are kind of some items that I've lifted out of there.

The other important point is that a 1981 HHS ruling prohibits reimbursement of unapproved drugs by FDA, and the FDA considers marijuana as an unapproved drug and is ineffective through the drug efficacy study implementation. So FDA you would have to factor into this as well. So FDA would have to accept this on its list of approved drugs.

So this kind of wraps everything up. Considerations for medical marijuana Indian programs. These will all have to be overcome. So the DOJ statement says that preventing marijuana and possession on federal property is a higher priority from them, and this Memo will continue to do that. It has to be reclassified under the CSA. It would also have to be addressed by the FDA in terms of that drug efficacy study that determines whether drugs are effective or not for medicinal purposes and if marijuana is reclassified and approved by the FDA, then IHS would have to reverse its position to those issued in the "Dear Tribal Leader" letter.

So some of the current marijuana activity that's going on. OK, so federal action. So there are a number of bills that are pending in this congress, that move to reclassify marijuana under the CSA so that this would make it -- and it's primarily being driven in those states that you saw on the map earlier. So the Governors and Legislators from them have reached out to the members in Congress. And if you crosswalk the sponsors or the cosponsors on those bills, guess what? They're from the states that are on that map. So the 2014 Omnibus bill also, a couple years ago, that none of the funds made available in this act to the Department of Justice may be used with respect to the states. So it lists out the states that have legalized marijuana in the bill. To prevent such states from implementing their own state laws that authorize the use or distribution or possession of marijuana. So basically, Congress told the Department of Justice, don't use any of the money that we're providing to you in this bill to prosecute marijuana activity in those states that have legalized it.

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This is an interesting one. Now, you can throw out everything I've told you about IHS, but now comes the VA. So the Veterans' Administration has issued a directive that allows veterans to consume marijuana at facilities located in states that have legalized marijuana. So there is a policy that is in VA. It's on the back of the table and it's also in your Dropbox, that is entered into between I think the VA patient and the facility. But the VA cannot prescribe it. They have to get it through their own means or through regular dispensaries that are located in those states that have legalized marijuana. So the VA may not prescribe marijuana in those states, but Veterans who are qualified patients are allowed to consume marijuana they have already obtained.

Some of the current Tribal marijuana activity: Suquamish last week signed their compact with, in Washington State to get in the marijuana business, and it's been sent to the governor. I don't know if Governor Inslee has signed it or not, Leslie. Maybe you have some breaking news there. And then Squaxin Island right now is in the process of entering into their compact and signing their compact. That will be sent to the governor to approve. So the Flandreau Santee Sioux announced a marijuana resort. I don't know what that is. But the state attorney general has asked them to rethink their position and not go forward with the activities that are proposed for that resort. The Passamaquaddy Tribe has signed a deal for medical marijuana operation, and of course other Tribes that you've heard are exploring legalization activities.

So there's been some bad things that have kind of happened. So Alturas Rancheria, Pit River Rancheria marijuana's, they had a medical marijuana, or not a medical marijuana -- marijuana grow operation that was raided by the feds, and they confiscated all their pot and of course several people were arrested. And there, you know, there's been raids at the Pinoleville Rancheria. I don't know where that -- probably somewhere in California. But there's been a raid there too, as well. So that's it. Yeah, video clip would be good end for Cheech and Chong. But happy to ask any questions. I know that we've only begun to touch the tip of the iceberg on this issue. I have reached out to Lael Echohawk who I think is, you know, a subject matter expert on this issue. And she's interested, if you all would be interested to hear a little bit more about this, to come to the January quarterly board meeting to do kind of a more legal kind of overview of the implications for pot in Indian Country.

Brent Simcosky: Yeah, before my question, Flandreau Santee Sioux Tribe. They have a potential to generate \$2 million a month in profit, it says, on their marijuana resort.

Jim Roberts: I hear the executive is looking at holding a quarterly board meeting in that state next year.

[Laughter.]

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Brent Simcosky: What about the directory workplace? We currently test for marijuana, but we've gone round and round about that question about whether we legally can, and whether we should or shouldn't. Because the problem is you know with marijuana, is that you're testing, you could be testing somebody that, unless you get the real expensive test, that was on it two weeks before they even came to apply to work for you. And then you're testing them. Or an employee who does something at work and you suspect them, so you test them and they test positive. Again, on use that was at home, the night before, it's not in their system really in the moment. Is there any word on what's coming out about, you know when we talk to lawyers about that, they all say they're just waiting for the first lawsuit of the employer because get sued or fired.

Jim Roberts: I don't know. Looking at some of our HR folks at the board, if they've heard or know anything about that. So Joe, I know, there you are. Have you heard anything about testing in states that -- is that just a question generally, or does it apply to states that have legalized marijuana?

Brent Simcosky: I'm thinking about the states where they legalized marijuana. Washington. What do I do? I mean, do we have some sort of federal law that state that we still have to be a drug-free workplace and cannot not test potential employees for marijuana?

Jim Roberts: Yeah, that's a good question.

Andra Wagner: It's plugged into workplace policy at this time. So it may be legal. You can say that within your employees and your workplace that they need to be drug free.

Jim Roberts: Yeah, but I would think, just thinking it through, since it's still a federal crime, and what do you call the insurances that you sign in most of your grants and contracts, you have to comply with federal law. So I think as a requirement of that, you would be bound by federal law and not necessarily state law in your programs.

Brent Simcosky: Yeah, we still test for it, but we don't want to have to fire somebody who's used it three weeks ago and then takes us to court.

Jim Roberts: I did hear Ron's going to have you tested when you get back from this QBM.

[Laughter.]

Jim Roberts: Any other questions? Good. Thanks for not putting me -- yeah, Cheryl?

Cheryle Kennedy: It's not about this. But I understand it's most Tribes hesitate

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because banks won't accept funds that are made --

Jim Roberts: Yeah, that was about two years ago. I was back in Denver visiting family. You know, on one of the morning talk show radios, NPR or something like that, they talked about this home invasion scenario that existed in Colorado at the time, because the dispensary owners couldn't open up bank accounts with the drug money, so they were being followed home and either, you know, kind of robbed in their cars or there were home invasions, you know, where people had broken into homes and gotten money that way, or robbed dispensaries. But that has since been fixed in Colorado. They, the state passed a bill that would guarantee, protect banks from some type of insurance. And what it was, was it was an FDIC insurance issue at the time. So if banks accept money from proceeds that are illegal in federal form, that being one of them, then they lose their FDIC insurance. So you didn't want -- you don't want to lose your FDIC insurance because it protects you against bankrupting, you know, and also cases of being robbed and that type of stuff. So the state passed its own version of an FDIC type of coverage for the state, and that solved the problem in Colorado. And I think that will likely be the case in Washington. I don't know if Washington state's fixed that or not. But those are the types of things that Lael could talk about when she does a presentation in January. (A PowerPoint presentation was presented)

Andy Joseph: I always wish that the Federal government would look at the medical part of it and kind of follow along with the VA, you know. I figure that the benefits for the medical part of it, I have a sister that needs it, and she probably wouldn't be alive today if she wasn't on it. You know, her Tribe did referendum vote, and our law kind of mirrors the State's now so, like you said, if a nonTribal person or member from some other Tribe came to my reservation, they wouldn't get cited, but a Tribal member would have got cited as a criminal offense. I'd much rather have our pharmacy and our clinics handing out something that is safe. You know, vs. something that they might get off the street. At least it would be regulated and probably wouldn't be, you know, you never know what's in it if people are dipping it in some other harsher drug that could get them, you know, addicted to other things. So you know, I hear where, see where children use it before it gets that high THC content or before it even starts growing, and that stage, you know, it stops epileptic seizures and things like that, that we never want to see our children going through. But if the government would just take into, I guess, take the studies that are out there and just distribute as they do some of these other more deadlier medications that they have out there, OxyContin, Morphine, and there are other things like that, that are killing our people and our kids get ahold of it and it's killing them. So if the feds would look at it that way, I think Tribes should have some kind of consultation and I guess on a medical part of it. That's all I have to say.

Jim Roberts: OK, Andy. Thanks. You know, in kind of researching the CSA and some of the other pieces, the DOJ and all that stuff, I came across some, you know, there has been some interesting stuff with marijuana and stuff. So they're making cars

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out of it. I didn't know that. And I'm not talking about the car in Cheech and Chong where they go down to Mexico and they drive it back, and remember some of the exhaust fumes light the van on fire and it starts smoking marijuana, and they're just driving through. They get pulled over by a policeman and he looks at the exhaust pipe and, you know, you can tell I watch Cheech and Chong. So but they're also making homes, houses, out of hemp. So there's a lot of good uses for the byproduct hemp and those types of things. OK. Tim, yes.

Tim Gilbert: I think some good information. I just wanted to share, I think we're going to be talking a lot about this before it's all over. But at the CDC TTEC meeting that was held in Spokane this past summer, the CDC actually had some good information both on this and E-cigarettes, which by the way we need to put on an agenda at some point. But I guess what I wanted to share, and on the whole topic of law and jurisdiction notwithstanding, when I ask my providers at our clinic what their feeling is for medical marijuana, and I did this after the TTEC presentation because there was a national cancer program that came and was advocating for the use of medical marijuana in certain cases like chronic cancer pain, etc. Nausea, appetite, and you know, it seems like the low hanging fruit for medical marijuana, and a good use for it. But when I go back to my providers and talk about their perspectives, you know, their response is "where's the data? Where's the evidence-based?" And unless I'm missing something, and they're missing something, there isn't a lot of data out there for, you know, evidence-based data or protocol that, you know, saying that medical marijuana -- I'm just kind of underscoring that as kind of -- and ultimately, they are a Tribe's decision about whether they allow whatever level or not. But from a medical kind of provider's side, it's an area that needs a lot of work in terms of some analyses about the real benefits.

Jim Roberts: Yeah. I think that's the piece where the FDA kicks in, is that first off, you'd have to get it removed off the CSA or reclassified. And then the FDA would have to do what it needs to do to do the evidence-based studies and stuff, you know the research protocols and things like that before they could list it on their drugs as an acceptable form of drug that can be prescribed. And then once that's done, I think the rest of the process -- but you're right. The evidence that's out there, I think at least for medical purposes that I saw, and you know the websites I was looking at, tend to be by kind of private companies that were hired by States or something like that to determine, you know, what are the uses, potentially, for medical marijuana.

Lisa Guzman: Jim, I received an email about, from a clinician that said if I had known about the 502 marijuana monies that are available for treatment programs, and that they had earmarked 15% for, towards substance abuse programs, and 10% for prevention and education.

Jim Roberts: I don't know. Is that the money that's coming through the taxation

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process in Washington State?

Lisa Guzman: I just looked it up, and it is the taxation law. But I didn't know whether they had a distribution formula or anything like that.

Jim Roberts: No, I don't know anything about it. Yeah. There is a plan?

Marilyn Scott: The legislature designated to their state and partner health and the department shared the spending plan, and we sent that out to the Tribes, the American Indian Health Commission sent it out to the Tribes. So we put the requests for funding specifically to the outreach, education, and prevention in our communities. So we're waiting to hear whether Tribes are going to get some of those funds.

Jim Roberts: OK. I'm going to go ahead and wrap it up, but I'm kind of interested. How many, just a sign in your hands, how many of your Tribes are thinking about getting into marijuana or have already gotten into it and done something like Colville?

Cheryl Sanders: For business?

Jim Roberts: Yeah. OK. Need any product testers or anything like that? [Laughter.] We can send around a sign-up sheet. OK. Thank you.

Andy Joseph: All right, thanks Jim. Our next agenda report will be the Regional Specialty Facility update. Rich Truitt, PE OEH&E, IHS.

Regional Specialty Facility Update

Rich Truitt: Thank you Andy, and good afternoon everyone. When I saw the agenda and saw the topic that I was going to be following, I took a deep breath and thought "I'm not sure how I'm going to have anything to the same level of interest as the previous topic!" I'll do the best I can. Thanks for the opportunity to provide an update on the Regional Specialty Referral center. I'm going to, in the time that we have together, I'm going to provide some background for those of you who may still not be familiar with what was involved in this proposal, and then fast forward through some recent events that have happened, and provide you kind of a path forward on this proposed project.

I think probably my sentence to you in terms of where we are is this idea has moved from a concept to a proposed project. And I'll share a little bit about how that's happened and what is lying ahead on the way forward.

So to start with some background, going back about 10 years ago, as you may recall, most of you who were involved in that process, the area participated in the development of a Master Health Plan. It involved nearly all of the Tribes in the Portland area. There

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were a very small number of Tribes who elected not to participate, but the vast majority of Tribes did participate. And from the effort, what developed was the concept of a regional specialty referrals center. The Master Health Plan showed that the user population within Portland area can support a division of specialty care -- that's care above primary level, care that is typically not available in any Federal or IHS or Tribal ordered clinics currently. The plan includes, and this is referring back to the Master Health Plan -- the plan includes a regional network of three facilities located in the vicinity of Seattle, Spokane, and Portland. These locations were chosen because they are within reasonable driving distance for the largest number of users, though acknowledged, not everyone. Not every single user. And because urban areas tend to be more viable locations for recruitment and retention of specialty care providers. Those of you who face challenges in recruiting, primary care providers can certainly understand some of the greater challenges in providing an ongoing recruitment and retention for specialty care. It's a very challenging environment to attract providers in specialties. And the fact that many users are already traveling to these population centers for the referred care that they need.

Individual Primary Care Programs do not have a sufficient number of users to justify stand-alone specialty care. However, through regionalization, combining the user population with the local Primary Care programs provides the number necessary to support on-staff specialists. The regional specialty referrals center expands access to care by providing services within the Indian Health System that are currently paid for through PRC or third party insurance. This concept of providing specialty care on a direct service basis allows the use of PRC funds to be dedicated toward higher levels of care, and preserves the PRC funds for more routine, that otherwise would be used for more routine specialty care.

Examples of specialty care we've identified in the Master Health Plan include audiology, cardiology, dermatology, neurology, ophthalmology, orthopedics, ENT, neurology, general surgery, supported high level diagnostics, CT, ultrasound, MRI, and lab support. Telemedicine would extend the reach of the facility, making routine follow-up care available back at the patient's home primary care facility.

So that's a little background of the concept and how it developed from the master health plan back in 2005-2006.

The current, and here's the rub. The current IHS health care facility program does not recognize this concept, Regional Specialty Referrals. The current priority system for the Indian Health Service allows only a choice between primary care and in-patient facilities. Those are the only two options that are allowed under the current system. So the Tribes in the Portland area with this information began shortly after the publication of the Master Health Plan, began to explore the idea of a pilot project to demonstrate the viability of a regional specialty care referral center. And the goal is to find a mechanism

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to fund the construction, the design, construction, and the staffing for a regional Specialty Referral Center. And it's also very important to note that this effort is predicated upon there being a network of three Regional Specialty Referral Centers within the Portland area.

So from the original stages that were done by the Portland Area Facilities Advisory Committee PAFAC, some very important work was done to develop the concept to be able to persuade folks in leadership positions that indeed this was a viable concept and it was worth leadership of the agency investing and supporting this effort to demonstrate the viability not only for the Portland area but throughout Indian Country. And the group got off to a very good start, put in some very diligent effort and a lot of hard work, and went to Rockville and presented this concept in the hopes of gaining support for moving this concept forward. I won't go into details. Members of the PAFAC wish to share their own perspective on that, or the set of meetings and the interactions. But just suffice it to say that we as partners of the area and the Tribes in the Northwest were not able to gain the traction necessary to move this from a concept to a project.

What has changed is very clearly Mr. McSwain and his lead role for the Agency is very receptive to this concept. He has been for some time, even though he was not in the Director role. He was apprised, he was made aware of this concept from the beginning, and he voiced his support for the idea as something innovative and something that should be explored. As we all know, Mr. McSwain is in the leadership role for the agency. And as you heard in the listening session in July, you heard reference again today, and I can provide some other examples of his support for this project moving forward as we go through the rest of the presentation. With that awareness, that there is a change in outlook at the highest levels of the agency, toward this concept, the folks on the PAFAC and the IHS staff together looked at what it would take to move this from being a nice idea, a concept that is worth exploring, to an actual proposed project. And what you see on this slide are the things that need to be done to be able to tie down this not as a what-if scenario, but rather this is a proposed project that is ready to be funded.

And so the things that needed to be tied down include a specific location, a PJD and POR, and for those of you who are not familiar with those acronyms, PJD is a Project Justification Document. Any new facility that is funded by the Indian Health Service must have an approved Project Justification Document or PJD. And a POR is a Program of Requirements. Again, any new facility approved has to have a Program of Requirements which specifies the size of the facility, the services to be provided, the volume of care that will be provided along with the number of staff that are necessary to provide those services. And last but not least, strong Tribal support.

So with that in mind, the PAFAC has set on a course to address all of those items and to be able to remove any hurdles that might be there, that might stand in the way of this project moving forward. The Area Director has charged the PAFAC to develop

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recommendations to guide the planning. This includes developing recommendations regarding, as I indicated, the location, to assure benefits for all potential users in the Portland area and to assure strong Tribal support for this effort to expand access to care.

Now, moving on to the first challenge, that of identifying location. Two Tribes have expressed a strong interest in hosting the Regional Specialty Referral Center. The first in the network of three. Those two Tribes are the Chehalis Tribe and the Puyallup Tribe. The area director requested the PAFAC members to visit and meet with representatives of both Tribes as part of their work in developing a pilot project location recommendation. On May 14th, both Tribes graciously hosted PAFAC members and Portland area staff. The group toured the building hosting Puyallup's new unique and innovative Salish Oncology Care center, which was established by the Puyallup Tribe. The oncology center occupies a small portion of a building in Fife, Washington, immediately adjacent to I-5. It is owned by the Puyallup Tribe. Puyallup is open to exploring options to renovate other portions of the building to meet the needs of the regional referral center or to consider potential expansion. Following the visit to Puyallup, the group proceeded south and viewed potential properties that the Chehalis Tribe had made available for the construction of the new facility. These properties, several of them, there are several pieces of land that the Chehalis Tribe has identified as potential sites. The 4:08:48.1 PAFAC members visited and discussed and sort of imagined facilities at any one of those particular pieces of land near Grand Mound, Washington. Again, right adjacent to I-5 and in the case of Chehalis, very close to Great Wolf Lodge

On May 15, the area director met with the PAFAC members immediately after their visit, and the PAFAC members advised Mr. Seyler that both locations hold great potential and that they were not yet prepared to recommend one location over the other. They further advised that before additional discussions took place with potential host Tribes, that IHS should inform both Tribes of core operating principles that the Area Director believes are essential to the success of a private project in the Regional Center. And I'll get to these core principles in a moment, but on May 22nd, the Area Director sent a letter to both Tribes indicating what those core principles were and inviting the Tribe to respond if they were, if those core principles were consistent with the Tribe's expectations about how this facility would run.

The four operating principles or core principles are as follows:

- Any federal resources allocated to the regional referral center network will be for the benefit of all Portland area Tribes and will not be available for individual Tribes to compact or contract.
- The Regional Referral Center network will be federally operated initially.

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- A qualified Tribal organization broadly representing Portland area Tribes may be eligible to contract to operate the regional specialty referral network.
- Whether Federally or Tribally operated third party revenue generated by the network will be used to improve and expand access to specialty care across the Portland area.

I do want to comment briefly. These core operating principles reflect a sense of what it would take to be able to gain approval at a national level. For example, the notion of the operation of the facility. If the facility were to be operated by Tribes initially, before the project could be approved, there would have to be in place a firm governance structure, governance plan, all of the details of that would have to be worked out in advance. Whereas if it's federally operated initially, headquarters would have no opportunity to object to that, with the idea that while that's happening, a consortium or group of Tribes, all the Tribes in the area could be discussing how best to set up an operating structure that could be happening on a parallel basis, meanwhile the project would not be delayed. It could proceed with the idea that it would be at least initially operated federally.

To allow us to move forward on this proposed project, to remove those remaining hurdles, the area director made available to this project \$110,000 to support planning and project development. These funds are being utilized now to update the interim PAFAC report, which will include the expansion of the number of patients who would have access to this facility. It will include an update based on expansion under Affordable Care Act. It will do an analysis and a comparison of the advantages of each of the sites, the site in Chehalis and the site at Puyallup. So that the PAFAC will be in a position to take all that information into account and bring forward the recommendation to the area director to proceed.

To indicate one more measure of support for this project, moving forward, after the listening session in July in which several Tribes representatives, some of whom are seated here today, made their voices heard to Mr. McSwain about their support for the Regional Specialty Referral Center. Following that meeting, Mr. Seyler approached Mr. McSwain, and Mr. McSwain responded by making available \$150,000 for the planning for this project. So I think both of those commitments of funding to be able to move through the planning process and remove any remaining hurdles or questions or concerns that Headquarters might have in regard to the project, reflects a commitment both at the area level and at Headquarters level.

I might add that we are just a little bit short of what we need to be able to complete all the planning. And I have a request out to OEHE headquarters for some additional support and we are exploring some other possibilities so that we will have all of the

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funds committed that are necessary to complete the planning process.

So where do we go from here? First of all, the PAFAC will be holding their next meeting later this week in Portland, and the PAFAC will be meeting with the consultant. I mentioned the \$110,000 that the area director made available. With those funds, we have actually entered into a contract with the consulting group that did the Master Health planning originally. It's a combination of a group called BLGY from Austin, Texas and the Anova group from Tucson, Arizona. They are great to work with. We've had some real good, productive discussions with this consulting group. They are experts in the field of health planning. What size population do we need to support this level of specialty care? How far will patients travel to access care? They bring years of experience at doing this kind of planning. They have developed plans for regional specialty referral centers in the private sector that are actually in operation now. So the PAFAC will be meeting with that group later this week to lay out any questions to make sure that the consultant understands what the expectations of PAFAC are, and be able to embrace that and be able to fulfill their requirements under the first scope of work.

The contract has been structured in a way that as soon as the PAFAC and Mr. Seyler are of a like mind in this, we can immediately proceed to award subsequent phases of the contract which will, once a location is identified, then be able to develop the PJD and the POR for that particular location, that size facility, that staffing package. All of the details will be hammered out in some subsequent phases of that contract. So it's structured so there's no further delay. We're not going to get the next report from the consultant and then have to wait for several months before we can go through another contracting procedure. It's set up so that we can immediately proceed the succeeding phases of the work.

Again, our goal is to be able to advance this proposed project in a timely way so that all of the obstacles to funding have been removed, and it will present an opportunity for the agency to support this. Mr. Seyler is committed to, and he has given directions to the OEHE staff involved that we will do everything we can possibly do to have this ready for a request for support from the agency leadership in the remaining time that Mr. McSwain has as the Principle Deputy, as the, in effect the head of the agency currently.

So with that, I want to step back and again summarize and say where this is today is it has moved from a promising concept into a proposed project, and we have a game plan to move forward to address the remaining steps to be able to present a fundable, ready to fund project for consideration by the agency and by others who might be interested in funding this. With that, I'll pause and see if there are any questions. (A PowerPoint presentation was presented)

Yes?

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Pearl Capoeman-Baller: With McSwain's support, does it seem like it will be a priority for facilities in their next 3-5 years or something?

Rich Truitt: I don't know how to put a timeline on it at this point. But what I can say is that the agency's official position, and I'll speak like an OEHE guy, the agency's official position is that there is an established priority list for primary care and inpatient facilities. And if you're on that list, as soon as Congress provides money, you'll be able to move up the list and get your project funded. What this project reflects is a new and innovative way to provide health care. And it is being approached by Portland Area, the Tribes of the Portland Area, and the conversations that we're having with Headquarters as not a project to try to squeeze onto the existing priority list, but rather a pilot project which will demonstrate that this concept demonstrated by an actual project, represents a viable mechanism to provide specialty care. And therefore it should be on future priority lists. So in other words, we are asking for funding for the pilot project which will show this is viable and the existing priority list needs to include this type of facility in the future.

Pearl Capoeman-Baller: So when Dean gave his report this morning, the Portland Area Health Board has already approved the concept that we move forward with this, quite a while ago. But this morning when Dean gave his report, he acted like there was a real urgent need to keep moving on this. Was there some specific action that was needed? Or just ongoing support?

Rich Truitt: I think what Dean was referring to is that there are at least five other areas that are pursuing this concept. There are three that are actively pursuing it. Mr. McSwain has voiced his support for the concept as put forward by Portland area Tribes. And he has indicated that he would like to see Portland's project move forward. So I think the urgency that you heard in Dean's comments refers to the window of time that Mr. McSwain will remain in a leadership position, which of course is likely to be now until the next election, and whoever is in the new administration, whoever is appointed as the director of Indian Health Service at that time. So that's I think the urgent issue that you heard from Dean.

Pearl Capoeman-Baller: Your report wasn't as exciting as Jim's report, but that's good news!

[Laughter.]

Rich Truitt: I tried. I'm sorry. Other questions?

Brent Simcosky: I haven't been paying too much attention to this because I heard Steve talk about it a lot, and the only thing I did hear, it jumped clear to the end and I never saw a business plan or anything, so I sort of wrote it off because it didn't seem

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like it was well thought out. And I still have problems about what is the problem we're trying to fix, or what is the need because of its access? All my patients want to go to the closest specialist, to the best specialist. They're all closer than either one of those two locations. So I'm probably never going to use that Referral Center. And so I mean, shouldn't we have started with going to the Tribe and saying OK, how many referrals do you send out? What type of referrals do you send out? What kind of referrals can you not give? What kind of referrals can you give? I mean, all the data I saw so far was people just guessing. And I think when it comes down to the end, you're going to find out that a lot of Tribes -- I mean, I've really been paying attention to I thought it was something for Eastern Washington where there really is an access problem. But on the two of them in Puget Sound, I mean how many of the Tribes in Puget Sound are really going to send a patient like to a cardiologist that's probably got a two-year rotation at this specialty referral center, vs. Virginia Mason or Swedish that has, you know, the best cardiologists in the world? I just don't know how you're be able to retain and recruit the best specialists for these centers.

Rich Truitt: Thank you for the question. The business plan that is also part of the project development will identify that, and there will be outreach that well quantify the expected referrals to the facilities. There has been some discussion among PAFAC members and others about the question of how will the specialists be recruited and retained. There is talk about sharing, on a contract basis for example, some of those specialists from some of the renowned centers that you're talking about. That is certainly a possibility. If, for example, a cardiologist were to come to this facility one day a week or two days a week and share their services at that location as well as their home base at Swedish or wherever they were located, that's an example of some of the concepts that have been looked at.

Brent Simcosky: Yeah, that would be the best concept. Because quite honestly, all of our local specialists are already aligned with Swedish or Providence or Virginia Mason. And almost every one of those specialty centers are aligned with a hospital. So somehow, you know, you've got to be in that whole network of alignment or your patients aren't going to want to go there.

Rich Truitt: Right. The other factor that is really important, and it will be reflected in the business plan, this project envisions a full staffing package for this facility. So the funding not only for building the facility but the staffing dollars would come with it. So the staff would be paid for. The care that they would be providing would be billable. I mean, there could be reimbursement from that. And so that's part of the business plan, and it will reflect that.

Tracy (Makah): So we're just -- this is Tracy from Makah. We're just down the road from you, Brent, and we -- 65% of our patients are on Medicaid. You can imagine the challenges we have finding specialists like you speak about. And we regularly send our

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patients further away than Puyallup to get the services that we need in a timely manner. So this is something that I, the Makah Tribe would very much support, and we have no problem sending people that far. We have to do it anyways.

Cheryle Kennedy: I have a comment over here, Mitch. Having gone through the process even though we never received one IHS dollar for our facility, we went through the same process, the PJD and the POR which are basically the needs part of exploration of what service you're going to provide. And so that all gets fleshed out in that process. So my question is about if this is supposedly a Tribal, a Portland Area wide initiative, and then you have identified specific areas, what we all, you know, we're kind of in the loop on that. And then to get all of the players, the Tribes who would frequent that facility, I don't know if that's by resolution or exactly how in the process that all works, if it's by resolution and you have your need identified using the examples that you have -- dermatology, cardiology, and it may not be those ones for that specific referral center. But agreement among all of those Tribes who would frequent it. I think the principle we do know is that direct care supposedly costs less than purchased care. So it's to save some monies there. But I don't know, I guess, the idea about whether there would be then a diminishment of those funds because of the specialty, the referral center that we now billed. And then the limitation that it would be run by the federal government, I guess like Service Units and how they all first started. That's what it sounds like to me. So the part that Tribes paid then, play, is really the ground where these specialty services would be located on. So it sounds to me like Puyallup and Chehalis were ones who came forward with ground, with land that says "we have this amount of land for you to use." And so I guess, then, I know that when you have a service right in your area, you probably get the lion's share of who would frequent that building because you're right there. So I don't know if that's being into consideration -- I still think it's a good idea. But the travel costs, I don't know if there's going to be travel costs associated. Andy was just talking to me a little bit ago about Colville and how they would get to Puyallup or Chehalis. Would that be by airport, by plane, or by -- if those are also costs that might be factored in. But I guess it sounds to me like getting this moving forward, in the construction funds, there would be a carve-out specifically? Or would there be a special identified earmark that would go for these three facilities, and is that for 2016 or 17 or a little bit more I guess about that. And for the third one since you only have two there, at what point in time will you be, I guess, calling for a meeting among the other Tribes that would want to do something like this?

Rich Truitt: And your last question relates to the other two locations? OK. Let me tackle that one first. What we envision is if the first project is successful, we would immediately begin efforts toward developing the rest of the network. And so the conversations about potential locations in the Spokane vicinity and in the Portland vicinity, they would begin right away. So that can happen. As far as the question of the funding mechanism, because we don't have a project that's on the priority list, we have been largely shut out. And I know you've spoken to this, I was there once when you

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spoke to the then-Director of the Agency about that. I know Andy has spoken to that many, many times. This is an attempt to get around that by demonstrating an innovative approach that is worth funding. That the agency will support because it is novel, because it is new, because it is innovative. And because it works in the private sector. It's pretty widespread right now. To be able to demonstrate that this is a viable concept that should be supported and move forward. Exactly how that's going to happen, I don't know. I have seen initiatives funded by Congress when they believe that something is worth funding. Yes, it's a challenging fiscal environment. But that's a possibility that someone will grab hold of this and say "this concept needs to be funded as a viable demonstration project." And then move it forward. That's what we're hoping for. But our strategy is to remove all the obstacles that we listed before, so that there can't be any excuse that well, you don't have agreement among the Tribes. You don't have a Government structure. You don't have a location. You know, all of these things that could be obstacles to having this project move forward, we're trying to remove all those obstacles. As far as the government's piece, if the Tribes want to begin conversations right now about how that might be, that's fine. The core principle is not intended to discourage that. It's intended to demonstrate that it's not an obstacle that headquarters can say "well, you haven't done that yet. You don't have a Government structure. You don't have an agreement in place." It's to remove that hurdle. The last question, and you asked several, I believe, all together, the idea of being able to provide the care on a direct care basis, it has several aspects that the PAFAC members have been attracted to and supportive of from the beginning. One would be in a culturally appropriate environment. This would be a facility that was run by IHS and the Tribes, or the Tribes eventually. It would be appropriate to the care and the way care is provided. Secondly, because of the commitment that the Area Directors made, that this will be the first of a network of three, and that it is not intended to just benefit four or five Tribes in the immediate vicinity, it is to benefit all the Tribes, the idea is that the resources that are generated will be utilized to benefit Tribes that are more remote from that. We've heard from Makah that even as remote as they are, they will still refer patients. You know, I have a question whether Shoshone-Bannock would refer patients, or all their patients. They might refer some. But there will be an effort to look at ways to share the benefit of this facility with all Tribes; no matter how close or how far they are from the first facility being built.

Andy Joseph: You know, I always said that every Tribe needs to weigh in. The area kind of drew the map and lines, and I don't know if every Tribe has even agreed to which area they would want their User Population used on, you know, for the different facilities. I still think that that needs to be done, so if you're in the planning phase of any project, you want to know which area Tribes are OK with you using their numbers for that secondary care. If you don't have their numbers and they're not accurate, then I think what we propose to Congress or anybody else would be like all of a sudden this Tribe says "I don't even want to be part of it." You know? And that wouldn't make us look very good. So I still say we really need to make sure that the Tribes that are in the

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proposed project aren't just on the area office thinks is going to be. We need definite numbers if you're going to plan anything. Our Tribe is still thinking about our own primary care. We're one of the biggest districts and still in need of a facility we tried for Joint Venue and just because we had a modular there that was our Tribal health building, we had dental in it. We turned it into, to have IHS use for exam rooms, and that probably scored us low on the Joint Venture, plus across the river there was a hospital on Tribal, and Susan Johnson said that the scoring system actually kind of goes against what a primary care facility would have been used to prevent you from going to the big hospital for secondary care. And she's right. You know? I hope that all of our primary care needs aren't pushed aside so that we're building these secondary care facilities. I know all the Tribes won't have to use so much of their purchase and referred care dollars because this would be a Direct Service health facility. So that's one of the benefits. I guess the more urgent care that would be used by the Tribes for their Purchase and Referred Care dollars. That's all.

Rich Truitt: Thank you Andy. I do want to acknowledge that this network of Specialty Care Centers will not solve all the problems, and as Andy indicated for the community of Omak, which I'm familiar with the needs there, we're still going to work with the Colville Tribes to try to address that as we're working with other Tribes to meet the needs. But this is a view that's an opportunity to make incremental progress on one element of the health care. Yes, Cassie?

Cassie Sellards-Reck: Thank you. My question was just towards presentation. I mean, wanting the Tribes on more, I don't really feel that a lot of us around the table understand some of the details that maybe Dean discussed at the PAFAC. You know, we voted on something seven years ago. We've had lots of turnover at this board in that time, to understand one of the things that I think about that would make it successful is having, I guess I would want to be assured that people who are planning this are actually health care providers and thinking of the future, like how it can be successful and not to be disrespectful, but not just IHS health care providers. The actual practitioners that are working within the communities with good reputations. You know? Quality is one of the biggest concerns that I have in continuity of care. So if you're having a contract with a stellar cardiologist two days of the week, what happens when somebody's sick on the third day, or they got problems? There is a lot that needs to be planned out to make sure that continuity and quality of care is also extremely important, and this project will not be successful if it's not partnered up with a hospital. You can't have surgeons practicing in a facility like this and not think that possibly something could go wrong.

The other piece that I see that if we're going to do something Native, and I think it could be really successful if the right things get put into place and we're efficient, and we have quality of care, is that you need to do it our way. And that means the families that drive these patients here need to be taken care of or have somewhere to stay or have some

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sort of resources. I work at a big hospital. We get people who travel. We have plenty of parking space for those who need to bring their RV's or whatever. We have many different places for families to stay while their loved ones are around. Because these places, if you're asking them to travel six hours, six hours is a whole day, and then they're going to have doctors' appointments and then we want them to go home? That's not how it works. So it could be the potential to do it right and our way. I just have many concerns. I mean, we sent Donni Wilder down to Phoenix because that hospital was so messed up. I'd like to know what happened at that hospital and the lessons learned. What are the lessons learned? Because we could do this really good and it could be really successful, but if the quality of care isn't there and people aren't treated good, and direct care sometimes doesn't save money. I mean, IVC was created for a reason. And there are many places that struggle with efficiency. People want to go, doctors want to go to IHS clinics because they don't think they have to work as hard. I'm just going to say, that's the way it is. At our own clinic, I'll speak for myself because I'm battling at home. Efficiency and taking care of people and doing it right is the most important thing we can do. Otherwise, I want them to go somewhere else. I want that money to go somewhere else, because I want them to have the best. Not "well, this is IHS. You have to go here." I'm tired of people dying that way or not getting the care that they deserve. A lot of these people are veterans, and they choose to come to our clinics because they're treated better. And that's how it should be. Shouldn't have to get second rate, third rate care. We shouldn't have to have, you know, seven patients seen in a day and nobody cares that people need appointments and it's not happening. Those are the obstacles that are in Indian Country right now.

So if we move forward with something new and innovative, what are we going to have in place to make sure that doesn't happen? Because we're still battling that today. So those are just some concerns of having, if we're going to plan this, \$110,000 is not very much. Because we need to make sure that this is top-notch. That this is efficient quality care, that we're not getting just people who want to retire because they don't have to work as hard. We want good people taking care of our people. The best. And I think we can do it. I think it can be better than everywhere else. And then everybody would want to go there. Because the rumor would be out there. I mean, I'm sure you understand, that's how things happen in Indian Country. "I heard that this was a good place. I heard that that person was good. They were treated well there." If they're not treated well there, they won't go. They'll stay home and die. You know? They'd rather do that, because that's something they know. You know? We're asking people to be trusted with some of the most, you know, important things. Important things that, you know, that they're dependent on us. It's very hard for our people to be dependent on us. But the most highest, I mean things that I talked about in the last meeting, and I'll talk about it again, and that is really improving quality care. Really I mean, that's the most important thing. And learning how to judge that we're doing that. Learning how to judge that we can efficiently -- because we know it's possible. And we know it's possible to save lots of money. Because we know the nonprofit hospitals are making

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billions. So it is possible to do it wonderful and save lots of money. But we could also be in a hot mess. And I'd like to know some of those hot mess stories. You know, and how they're being fixed, so that I can have faith that it's going to be done right and that we're going to talk about it and be open.

Rich Truitt: Cassie, thank you for the feedback. If I could address just a couple points in the visit with both Chehalis and Puyallup, the idea of having the partnership with a local hospital was identified. Both of those Tribes gave examples of relationship they have with the adjacent hospitals. In terms of the families and patients that would come and stay, some conversation is already underway in terms of housing folks who do travel a distance to be able to be there. So those are excellent points. I welcome any suggestions you have about how we can get the information to all the Delegates. On the PAFAC there are some folks that are a whole lot more experienced in health care delivery than I am, and I think hearing from them, it might help to answer some of the questions you have in terms of quality of care, in terms of continuity and those kind of things which are being planned for. Other questions? Comments? Yes, Marilyn?

Marilyn Scott: Over the year since the Portland area first started this plan, the health care arena has changed quite a bit. But I just want to state that the idea originally behind this, because the Portland area has not been able, no matter how much work has been put forward in planning and individual Tribes as well as consortiums and Joint Venture applications have not been funded. There's just not enough funding to be able to get a facility of any sort and/or the staffing support for a facility. And originally, a specialty care facility like this was going to be something that was going to be another option available because yes, we may have some Tribal programs that have their immediate referral centers that they have connected with and can get their patients into, but some of us do not have access to those specialty services and specialty providers that will accept our patients when we refer them and in many cases we're having to send them a long distance, and it's costing us our patient referred care program a lot of money to send them to get that specialty care, because we cannot get them in because many of those specialty providers in our local area will not accept our patients.

And so I know that in Washington State, we recently met with the governor in the centennial accord. Almost every one of the Tribes in Washington voiced the concern about the crisis of Suicide and Behavioral Health crisis within our communities within Washington State, and the disconnect for culturally appropriate services that our Tribal programs provide at our members, but disconnect when they had need for specialty care in psychiatric, higher level of care arena. And where the state will not accept the referrals being made by our Tribal behavioral health providers when getting them into those appropriate type services.

So I just want to voice that the arena has changed from when we first started developing this concept, and it's based on the Portland area and the Tribes within the

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Portland area not being able to get funded on the priority list according to the priority list that funding gets funded. Any funds to our area, and so the development of this concept, it was another option. But also many of us, the Tribal programs provide direct services to those other American Indians and Alaska Natives that are living in our service area, and we can provide so much care within our facilities when they have need for specialty care. You know, we don't have nowhere to send them. And they don't have other coverage to pay for that care that they might need, that this would be another option that we could send them to this type of facility that's within our area, as a preventive measure from them expiring in some cases.

So I just want to kind of bring it around to how we started this idea in the years of the development. But I also heard at the National Conference of American Indians last week, the part of the White House Congress that's going to be held next week is the current Administration is wanting to hear from the Tribes across the country, priority list of options that the current Administration couldn't consider within the time that this administration is in office. And so it's been asked of Tribes and Tribal leaders to think about that and put forward at that meeting with the current Administration, things that could be potentially done within the time frame of the current Administration. So hearing the information that the Director is supportive of this type of idea, and moving it forward, that's the first time we've heard that from this -- the number of years that Portland area has put into this concept. So you know, I really believe that with the idea that there would be additional facilities if this does work, that could be available and there are different types of specialty care services in those various locations, it would be a benefit for our area. I really feel strongly that if we can get our foot in the door, I feel we should not risk losing that chance.

Rich Truitt: Thank you Marilyn. Are there other questions --

Bonnie Sanchez: This is Bonnie Sanchez, from Squaxin. I just really agree with her point about the direct care patients that we have who are not our Tribal members. And they're not covered under PRC. And sometimes they don't have insurance. They don't have any other options. And they're all the people in the Urban centers, and there are just a lot of Natives out there who don't live in their CHESDA and don't have coverage and don't really have many options to choose from. So I mean, those Natives, they need health care too. All of our Natives need health care. And I think this will be a good start.

Rich Truitt: Thank you. Any other questions or comments? If not, thank you very much for time to share this with you.

Andy Joseph: Thank you Rich. OK. We have a scheduled break. We'll start back at 3:35.

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Break.

Andy Joseph: All right. If we could get back to our seats, we're going to have our next presentation. The Oregon Washington Health Network, OWHN. Tim Gilbert, from Yellowhawk, Chief Executive Officer, will do his report.

Shawna Gavin: Thank you Andy. As you can see, I'm not Tim Gilbert. Wait, am I? No, I'm not OK. Just checking to see if you're awake! I wanted to take a quick minute here at the beginning of the presentation to thank the Health Commission at the Yellowhawk and the Umatilla Tribe. And I don't see -- I saw Susan Shoeships. Raise your hand, Susan. Susan really helped out a lot with planning the meeting. Cathy Burke was here a little while ago. She's our Vice Chair, JoMarie Tessman, the daughter of Betty McLain, who you may remember, is -- oh. Yeah. I know how to do that. Merina Tubby [sp?] is not here today. And Bob Shipentower helped out with the Color Guard. And he's a Veteran, so he's also our representative from the Board of Trustees. I didn't see you sitting there, Tim. Good thing I didn't say anything! Of course you know I never would.

OK. In 2013, Yellowhawk leadership underwent a strategic planning exercise, and this is the three-year strategic plan for Yellow Hawk. These are the 18 goals that are in the plan, and I will just give you a few highlights from that. I won't read word for word from the slide.

Our number one goals are to address our Chronic Disease disparities. We have several programs that address Chronic Disease, and if you look here -- oh, sorry. If you look here, this is some of the activities that are funded by our CDC Good Health and Wellness grant. And this is one that I'm especially fond of. I have a real affinity for the plant life, and I have to mention after our meeting with the California board, I really enjoy the presentations from the California board on their sharing of their native foods and their medicinal plant use. And so it kind of sparked that in me, because it used to be something I was really all about, and so I've been kind of really bugging everybody about it at Yellowhawk.

If you've looked in the back, you have seen that we have our new clinic plans and designs back there. We're really excited about the new clinic. We have a site selected. It's over by the Government center, so everything will be all kind of together, which is in fact the dream of our Elders, some that are gone. I remember in a General Council meeting when we first started talking about this new clinic and the plans for the Government Center, and she talked about having everything all together and being able to go from point A to point B without having to even walk outside, and I'll never forget her words. She said "in my lifetime, please," and so I'm sorry that we didn't do it. But we're almost there.

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So if you could take some time and those of you who have new clinics, and I know a few of you do, and you have some ideas, please look at our designs and share some of your do's and don'ts with Tim Gilbert, who will diligently take down your thoughts.

This last Friday, we had our second annual Yellowhawk crab feed. And here's some pictures from that. It was a great opportunity to share with the community about the new building. And I think it was also a fundraising effort. And that was pretty much orchestrated by Nancy Curtsy over there. I call her the goddess, but I think her title is Executive Assistant. And before I go any further, I should also introduce Tom Howard, who's our HR director.

So we continue to focus on our GPRA as one measure of quality. And if you look at the red cells here, oh -- I keep pointing at this screen, and you're looking up here. If you look up at the red cells, that's where we still need improvement. I'm sorry. We do need improvement. I wanted to say we were perfect, but we're not. So, sorry.

OK. Moving right along. See? You're waking up.

We've had to focus on improving our maternal and child health program for some time now. And I'm really excited about this one. This is something that most of our current Health Commission members have been really excited about. You might say we nagged a little bit about it, but we've got a lot of really good programs going on at Yellow Hawk. And I'm really proud of that, because I'm a grandma. I know a lot of us in here are grandmas. And we want to make sure our babies are healthy.

We have had a lot of excellent work. I'm sorry, I lost my train of thought there. We do have a wonderful staff. And in this picture, you see Sandy Sampson, and these are the ones that, these are just a few of the ones that we could recognize this year for having some great achievements. I mean, you can't recognize everybody in the building, but I mean it would be wonderful if you could. But these are some really hardworking staff members. And they're from all different departments. I see finance people and behavioral health. Oh, and that's our lab department. We really love our staff. And I will turn this part over to Tim. He will finish. He's got a lot more, you know, technical type of things to share with you. Thank you. Tim Gilbert, CEO.

Oregon Washington health Network(OWhN)

Tim Gilbert: Thanks Shawna. Good afternoon everybody. So we just wanted to share a little bit about the -- we appreciate the people who stayed through the whole day and wanted to spend your afternoon listening to a little bit of what we do in Yellow Hawk. We wanted to just get some highlights. Thank you Shawna, for going through the first part of this. I really do want to underscore one of the things that she mentioned, which is to look at our schematics that we have back here. We're just kind of drawing near to

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the close of our preconstruction phase. We're finishing up our programming, which is to say we're looking at square footage and trying to decide what programs go where. And these four concepts are all one story concepts, about 6,000 square feet. Our current footprint is about 32,000 square feet, and about 5 different buildings. So we're bringing people back into one group and a lot of enforcing growth and adding programs. So for those of you who have constructed in the last few years, we'd be really eager to hear some of the stories you have, the do's and don'ts and avoid some of the pitfalls that people have encountered.

So I'm just going to spend a couple seconds going through these last few slides, and then talk about a unique program that we've had in the last couple years with the development of the rural health network. Strategic build number 7 for us, the last three years has been improving access. And I was sitting here earlier today remembering back when you were here in probably this very room, back in 2012 and we were sharing with you our open access model that we had just deployed in our clinic. We continue to focus on access. We're always looking for ways to improve accessibility to care in both the medical and dental and ancillary departments for our Tribal members. But this just kind of shows you some of the providers that we currently have on staff.

We had -- for my money, we've had more programs and more resources dedicated toward youth and adolescent health than we ever have. We promised one of our program managers that we would include one of his slides up in the very right corner there, is a picture of the youth lacrosse team that has really caught on in our community. That's just, we can't believe how popular it is among youth and how good it is for their health, etc. Down in the little left hand corner is our fun run that we've held every year.

And then finally, we are constantly reminded and also telling our community that -- I know this will resonate with you -- that it's not all about the money in our communities. At the same time, we have to share with them why, every time we come in, we're capturing their demographics and their insurance information. Because that's how we're going to sustain those programs and maybe even expand them. But we're really proud of our revenue team. Over the last 5 years, they've consistently hit home runs and are appreciative, I don't know if Dean's left already, but grateful to the Portland area IHS for recognizing our revenue team for their outstanding achievements from last year.

So I just want to spend a couple minutes, sharing a few notes on one of our strategic goals we felt like was unique. We didn't really expect it to be doing this kind of work three years ago. But I wanted to share with you an initiative that has really kind of grown out of need to do something differently in this really kind of rapidly changing health environment. One of our strategic goals since 2013 has been to work on formalizing business relationships in our community. Us, like the rest of you, if you think back to 2013 when we were sitting at these tables talking about the Affordable Care Act,

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you know, changes that we didn't know in our state here in Oregon, Cover Oregon was still a viable entity. No longer. But those types of threats or landscape is what we were looking at back in 2013. When we were talking with our referral hospitals in our network, and I'll show you the names of those, we realized they were feeling the same pressures, especially if you work with some of those hospitals that depend on Medicare for a significant part of their revenue. They are very worried about the value of a purchasing system and what that might mean in terms of funding reductions.

Again, like probably most of you, recruiting in our area, if you're in a real rural area, has always been a challenge, continues to be a challenge. And frankly our health disparities over time is actually as a county, not just for the CQR Tribal members or American Indians in the country but for everybody, has worsened. In fact, we were showing at the health directors' meeting yesterday that for some health indicators, through a website that's called -- it captures county health statistics, this county is one of the worst in terms of some indicators.

In addition to that, we realized as we sat at Yellow Hawk and figured out how we were going to attain our mission and vision, but we just can't do it by ourselves. We can't do it just with Tribal partners. We actually need those people who are immediately around us. So we thought about that. And we talked with some of our non Tribal health providers and ended up pursuing a HRSA Rural Health Network planning grant, which is really just a one-year opportunity to work with several partners to talk about how we might work together to address common issues. And for those of you that have been in health care for a while, you might remember back in the 90's when managed care was surfaced and was more or less not effective, but about that time, the government made these network development grants available to help rural providers ensure that there was some kind of safety net in place, that it wasn't, that the changes that were happening back then with managed care didn't negatively impact the safety net in rural communities. So that's kind of where they started, and now they're still available. Sometimes for different reasons, but we pursued one of these networking grants and began to work with eight other partners that I'm showing here. Of course, the Yellowhawk Tribal health center was the lead agency. St. Anthony is the hospital that most of our patients get referred to. It's about eight miles west of here. It's a CHR, Catholic Health Initiative Hospital. Good Shepherd Hospital is in Hermiston. You might have passed through if you drove through from Portland. Both of those hospitals are critical access hospitals. The fourth bullet there says the Providence St. Mary Medical Center, which is just north of us, about 40 miles it's in the Providence system. It's kind of a secondary or tertiary facility in part of the greater Providence system, which now by the way is affiliated with CHIH over in Tri-Cities, and Swedish in Seattle.

And then you can see the next three bullets are really county public health departments. I'm going to come back to those in a second. But we realize that for some functions, we rely, in fact we do a handoff to county health departments, so it becomes a certain

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monetary and surveillance activities. And finally we saw the value in adding an institution of higher learning, Blue Mountain Community College is our local community college, and has a nursing track that we do locations with. Saw the value in adding those to our network. And likewise is our Behavioral Health provider here in this region.

So we started working with those guys a couple years ago, talking with them about what their issues were. What were the things that we had in common, that we could band together and kind of work on together in the form of a rural health network? So this map just kind of shows you graphically where those providers are. I don't have a pointer, but the Yellow Hawk Tribal health center is actually -- our service area is actually a two-county area. It's, you're currently in Umatilla County. And if you drove east on I-84, you'd go over the mountains and eventually you'd get to La Grande. And that's Union County. That's also our second that's in our CHSDA, or our service area. But we felt like our patients -- we're thinking out patients come of course some beyond those two county areas, so they come from up north in Walla Walla county across the state line, and over west towards more counties. So this map just kind of shows you where those line organizations are in terms of our rural health network.

Cheryl Sanders: Tim, for trauma where do guys go? Which one of those do you guys use?

Tim Gilbert: The question was what hospital do we refer to for trauma. Both St. Anthony -- all three hospitals, of course, have an ER.

Cassie Sellards-Reck: Providence St. Mary's.

Tim Gilbert: Providence St. Mary's is usually our -- it's up in Walla Walla, I don't have a pointer. It's up there across the state line. It's about a 40 mile drive.

So what we did again, the leadership in those organizations, we started an exercise. I'm not going to go through these data in very much detail. What I want to point out to you is that as you sit down with your neighbors, your non Tribal neighbors and start to talk about what it is that keeps you up at night, what are the disparities, the health problems, there actually is a lot of data and you'll find we have a lot of issues in common. So we look at things like morbidity / mortality rates for different counties. I'm not going to go through these, but we started to summarize that data and look at it as a group as we decided, well, what could be worked on as a rural health network?

This is a little bit more detail, and this is really just for Oregon communities. But began to look at communities and health indicators for different conditions or diagnoses, and of course the areas in both kind of point out where there's higher rates in those communities. And we also looked at utilization. How do our counties, how do our jurisdictions differ? And it's actually, we're not a huge geographic area, but those four

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counties that I just mentioned, Morrow, Umatilla, Union, Walla Walla Counties. But there are some pretty significant access kind of disparities. For example, up in Walla Walla county if you've been there at all, you can see that the second column down where it says one per 825, that's the number of primary care providers per population. Compared to for example in Morrow County where it's one provider per 3700 patients. So even within our own little four-county region, we realized that we have some disparities. And yet we have the same problems in recruiting those types of health professions.

So we began to look at utilization data. We talked with leadership of those organizations, and came up with some areas that we felt like we could work on together. And again, I'm not going to read these to you, but my point is as we sat down to the table over a couple year period, looking at those kind of data, looking at our health statistics, kind of taking off maybe your Tribal hat for a while, or your for-profit hat or public health hat, and just sitting down as health providers and a common community, you'd be surprised at how much commonality there are with your non-Tribal partners.

So this is kind of underscores -- this is the map that shows just Oregon. Doesn't have Washington in it. But the dark county up there in the Northeast corner is where you're sitting today. That kind of underscores what I said earlier, that this particular county has some less than favorable health indicators, and really looking at this data that's maintained by the State, really highlighted the need for us to work together. And I should mention even though we have those nine partners in our rural health network, we also had Emily Hughes with the office, the Oregon office of Rural Health, which is based in Portland. They've attended all of our meetings. And there's another network over in La Grande Oregon called Northeastern Network that we have MOU with.

I mentioned this morning, earlier, that this is hot off the press. We didn't have this when we were looking at all of our data and doing this exercise. But I just want to reiterate that we're appreciative of that. The resource and having Tribal specific data. We'll be looking at that both internally and with our partners.

So with all that, we discussed, we talked about what is a rural health network. What's the benefits? What's the advantages? What's the commitment? You had everything from a community college, the tertiary hospital, the three public health departments, and the little tiny Tribal ambulatory health center. What's in it for everybody?

Over the course of that year and a half, we decided that there was a benefit to all the people that were at the table. So we formed, we developed a memorandum of understanding that would kind of highlight what are the expectations. What we should or couldn't do, and what the opportunities were. Everybody signed. Frankly, I'm kind of really shocked that the participation we get with those meetings -- it's the first time that we've had those particular sets of providers come to the same table, and just kind of

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leave some of their individual items and agendas at the door, and talk about what's good for the people in those four counties. So we ended up with, this is just the cover of a strategic plan that has far too many goals in it, but it was a good exercise. I'm going to share with you just a few of the things that we decided we should work on.

Before I get to that, this shows just a little bit about our organizational structure. So the top box is the nine organizations that signed the MLU. Yellow Hawk remains as the lead agency. I think everybody saw the value in having a Tribal agency submit the grants, because we sometimes get extra points for being a Tribal agency. There's a steering committee that kind of oversees the work of the network. And so on and so forth. And I'll just share with you just as kind of an aside, we early on when we wrote the HRSA grant, this was called the Yellowhawk Rural Health Network. And we were -- we wrote the grant and it was like "we're going to call it this." And we got about a year into it and realized that the world is bigger than Yellow Hawk, and those other eight organizations actually touched our patients and we had things in common, and so we backed away from that and called it the Oregon Washington Health Network. So just a little aside about how we arrived at the name of that network.

So what are we working on? There are actually about 20 strategic goals that we -- you're more than familiar that there's a long list of things that we could be doing in our communities to improve health. These are just a few select things. We've been able to -- part of our grant planning required us to do training, so we identified training for all members of the network as a priority. We realized really quickly that we have an under utilization of telemedicine in that four county area, even though some of our providers -- there's different levels of capacity, the Providence people were furthest along in the use of telemedicine.

One of the areas that came up recently, and for those of you who are from Oregon, this will resonate with you. Our Oregon counterparts, for example the Umatilla County Public Health Department, regards the mental health, behavioral health, substance abuse arena as really a public health crisis in Oregon. The provider panels are closed. Access is just terrible. What we learned at Yellowhawk is that we have probably more resources than some of our non-Tribal partners. So we're actually actively working on how we can address that as a larger network to get some equity for everybody in our service area.

Health professions recruitment is a little tricky. We all identified that as an area of need. We saw the statistics about how many primary care providers there are per population. As it turns out, having a common recruiting effort is a little trickier to do than it is to say, because you're competing for those people. But we still want to work towards that. We realized quickly also that we're, as I said, we exchange patients. So we refer to St. Anthony, St. Mary, and some of our patients end up at Good Shepherd. So we have a specific HRSA outreach grant that's active still, working on outreach and case

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management.

There's a special committee looking at business opportunities among those Board members for things like shared services, things like that. Another difficult one, but really fascinating, is the regional QI initiative. We're at very different levels, nine organizations of how we address quality improvement issues. I personally was intrigued yesterday at the Health Directors' meeting that we heard from Pulse and some of the meaningful use information during that meeting. So we're striving for some standardization of our QI work.

I didn't show the graph, but if you look at our leading causes of death, cancer is in the top two, and we have a lot of work to do in terms of getting some of our fundamental, just kind of basic cancer care improved.

And then finally, out there a ways is the development of a family medicine residency program. Of course, tied to the health professions recruitment. So just to give you kind of a little bit of a flavor of the things that the Oregon Washington Health Network aspire to, just as kind of a close out here, we -- so I mentioned a few minutes ago, people came to those meetings with their own hats on. What's in it for me? Providence sells telemedicine equipment. CHI or St. Anthony's trying to make sure that referrals come to them. Etc., etc. But it's been a great exercise in trying to figure out how you take off those individual hats and think kind of collectively as a large organization with a larger vision. But I'll be honest with you. Yellowhawk started this effort because we had a selfish agenda. For example, in this bottom left hand corner, we heard from a lot of our patients that at some of these facilities, our patients don't get treated as they would hope to as Tribal members. And we learned really quickly that there's been a paucity of cultural awareness, cultural sensitivity training. So that was kind of first and high on our list with our network members, and it was pretty well received.

I don't want to read those to you. But the last year and a half has been filled with identifying kind of the low hanging fruit for training opportunities and how we could help our patients as we work with these non-Tribal providers.

So we wanted to share this with you because we just felt, you know, we still feel as we did three years ago that we can't accomplish our mission and vision in a vacuum. We depend on these non-Tribal partners -- that's even more so. We're talking CCO's and MODA and all these other things the ACA has brought to the table. So what do we gain from it? You know, it's been surprising as I mentioned earlier that the lack of communication that there's been, with organizations that are maybe five miles away, and share patients sometimes. So the communication, I can't tell you how important and valuable it has been to interact with these partners in kind of a more formal way.

As I mentioned as well, when we take up our respective paths, we do have common

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issues, and it's been a good exercise to identify those and have productive conversations about what we could do together to work on them. And in some instances, we have a whole list of funding we're pursuing. But there is value in the strength in numbers when you have a network and collaborators. It's been a real advantage in terms of putting in for funding.

So our next steps really are we're kind of -- you've caught us in between planning. Our planning year ended. We're in the midst, a year or two, of a HRSA outreach grant that is related to evidence based protocols. And some telemedicine work. But next spring we expect the HRSA rural health network development RFP to come out. And that kind of, if we are successful, that helps you lock in some funding for a three-year stint, and you keep going beyond that if your network is effective. We're as we speak deploying -- one of the things we did with our planning was purchase some hardware for all of our partners so that we can actually start doing some telemedicine, but also telemeetings. You all know how you're all sitting here. You know how much time it takes to go to meetings and the cost of that.

And I think I jumped ahead of myself, but the network development grant is on our list. So as I mentioned, we're fairly new. We're currently contracted to have a website developed. But I guess we just want to share, it's interesting, we appreciated Rich's presentation. He used the word network. This isn't that network, but it is a network, a rural health network. And we found it valuable for all reasons I just described, and we think we're going to keep pursuing this as long as there's value for our charter members and the population that we're here to serve. So that is our presentation. Thanks. Appreciate your patience. (Powerpoint presentation was presented)

Andy Joseph: Thank you. That was a really good presentation you both did. All right, now on our agenda we have an executive session. Is there any issues that we need to discuss in executive session? I'm not seeing anything. OK, how about logistics for the dinner? I guess it's just across the hall. And that starts at 6:00, so come and have dinner by the host Tribe here. And I'll see you at 6. Oh yeah, and don't forget about the silent auction. We might have a chance here, we don't have Dan here looking over your shoulder. So you got a chance to bring something nice home.

Recess

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Cheryle Kennedy: The individual who's going to do invocation this morning.

Shawna Gavin: Thank you Cheryl. Good morning everyone. I hope you all rested well and have a little bit heavier pockets today, maybe! I would like to introduce one of our treasured Tribal elders, Tessie Williams, who is going to come up and do invocation this morning. Tessie is a former CHR and a former health commission member. She's a pioneer in the health field. And so much of what we do today in this room is because of some of the hard work that Tessie did. So I'm always very grateful. She's wise and very often very kindly shares with me maybe a direction I might be taking that could be changed. She's very positive, and I'm very thankful to have her here today.

Tessie Williams: [Ringing bell.] We are calling and letting our Creator know that we are all here as his children to take care of the rest of our children. This is wonderful and feels good. Felt good to get up and think of "oh boy, I'm going to work today!" I love my job. I work with the elders. I work with the parents. I worked with the children. And it was wonderful. It was wonderful because they taught me a lot. My people, you go home and take care of your own people, my grandmother said. We are taking care of white people. I lived in Portland for many years, but I came home to take care of our Tribal people. So when you hear some of the things that I pray for, you'll understand it's a wide world today. Very mixed world today. As I look around, when I started, I saw all Indian people. Nothing but Indian people. And I welcome you all here. All souls are beautiful. All souls that belong to the Creator are beautiful. And I want to let you know that we pray today for ourselves. We've got to learn to take care of ourselves because if we don't take care of ourselves in our mind, our heart, and our body, we fail ourselves. So today, I want you to look at yourself. Look at who you are. Where you come from. And who you plan to take care of. Because this is very important. Taking care of people is a wonderful thing. I grew up on this reservation, pristine land without the river. My great great grandmother, she used to deliver babies in her home. She would take care of those babies. She would sing for their life. My family was rich because my Uncles come from the 0:05:05.7 [INAUDIBLE] clan. And they had horses. All kinds of horses. They loved horses. They took care of horses. On the other side of my family, he was a Cree writer. He wrote his name on the Treaty. So when I look at all of these things that my children are going to grow up with, I have three daughters. Three beautiful daughters, gifted me with many, many grandchildren. And I'm proud of those grandchildren. Very proud. So when you look at yourself, you look at your family and what you're doing and what you're doing for -- for your family.

A long time ago, they said you set an example. I didn't understand that. What I did in my lifetime was good and bad. Good and bad. I was normal. So everything we do can be good and bad. But what we achieve from this good and bad is how our family will be. So today, [ringing bell] I ring this bell. Our dear Creator, you are our only one

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Creator that gave us life. That gave us a gift of life. We ask today, dear Lord as we pray for the beautiful helpers that we have in health, not to be judgmental as I was a judgmental person. Not to criticize. Not to look at a person if they did bad, to make them look bad. But to look at them as somebody that's growing up. We have to look today at 0:07:54.2 [INAUDIBLE.] We've got to learn to understand all the medications and our drugs that are being used and abused. For everybody. For everybody. Creator, there are all kinds of sicknesses. We pray for those who carry cancer. We pray for those that are lonely. Very lonely. We pray for those that are alone and have many things to think about. Creator, bless everyone to understand You. To talk to You every day. As I say "give thanks for our land," this beautiful land that we walk on. That we enjoy. That our men can go hunting. That our men can go fishing. That our men can enjoy a life. Give thanks for all the food that comes from this ground. Our traditional foods, the salmon. The deer meat. The roots. The berries. And 0:09:43.8 [INAUDIBLE.] Give thanks, oh God, for our precious water that blesses us every day when we drink the water. That blesses our body so that it can be well and you can stand and say "I am well." Today is a new day. It's a new day when we can 0:10:17.1 [INAUDIBLE] the Creator and thank Him, thank Him so much for what he has given you. Your family. For the precious children that are coming up tomorrow. For the babies that are being aborted. We're sorry, dear Lord, we have to be that way. Those are the things that we see that are not right. We pray for them. We pray for the deceased that are gone, that set many examples for us to follow. The good steps. That wonderful trail that we have. Today, we bless our service men. We bless our service men that fought for this land. That are still fighting for this land. So, today we are thankful for the Creator. And as we go, we are not alone. Never, ever think you're alone. 0:11:42.6 [INAUDIBLE.] [Ringing bell.] [Singing.] [Ringing bell.]

I talk very seriously because I love my work. There were many times when I'd tell my children "put your belt on." Some of them would look up at me and say "what's the matter, don't you know how to drive?" There were other times when I'd go visit people, they'd tell me what they did that day. There was one couple. "Oh, I could have beat up my husband. I just could have beat up my husband. We were driving down the road, and I told him, I said stop! Stop! What for? Let's fight. Let's fight. Let's get out and fight." That's how precious they were. There was one time when I followed through with my patient 0:13:29.9 [INAUDIBLE.] And I always asked the question, every day, some were personal, one man he told me "why are you doing this to me? Why are you doing this to me?" And I told him, and I explained to him and I explained to him, and one day he saw me walking across the street. He said "hey, doc! Doc! Doc! I 0:13:56.2 [INAUDIBLE] twice today!" Told me he went potty twice that day. So my life was wondering. Thank you very much. Have a good day.

Cheryl: Words of wisdom from one of our Umatilla elders. I used to work with Tessy, I don't know how long ago now. Maybe 35 years ago. And she said "and you're still working?" I said "yeah, I'm still working." But I remember when I worked for the Burns

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Paiute just about 200 miles from here, I was in charge of the health services there, and started their clinic and all of their health service there. And they had a water system that the Indian Health Service -- a tower thing that they put up. And we didn't have staff that knew how to take care of the water. And so I went to training, and the training here from Umatilla. So I had to make sure that the water system was running. And one time our pump went out. So I thought "oh, we have to have water." So I called the engineer here and he put me on the phone and he said "well, this is what you do." And so I had to take that pump apart and put it back together again. And it worked. I was so surprised! And then of course, fluoride was kind of hitting the 0:15:59.5 [INAUDIBLE.] And we had to put fluoride in. And it was a manual system. It didn't have the paddles or anything like that, so I had to mix all the reagents and stir them into the water, and I thought "oh my gosh, I hope people's teeth don't fall out if they get too much!" But it was really a learning experience, and I really appreciate the Umatilla people, and for the good work that Tessy did for -- and continues to do. I work with her and Elizabeth Jones, both CHR's, and I really value the time that I spent with them and learned from them. And it's true, every day we need to grow. The main thing is to turn our eyes into ourselves, not into others, and see how they're doing things, because we can only change ourselves. So I appreciate you, Tessy.

So at this time, we're at the policy and legislative update that will be given my Jim Roberts, our famous policy analyst. So, jim -- I invite you to the podium.

Policy and Legislative Update

Jim Roberts: All right. I accept the award! Thank you Cheryl. OK. So let's get started here. Who watched the baseball game last night? Brett's a Royals fan. He truly is a Royals fan! I asked him to name five people who were on the 1985 World Series team, and he could do it! Although he didn't know Steve Balboni. Yeah, I got him on that one.

OK, so I'm going to talk a little bit about appropriations update and the CR that's underway right now. Contract support cost updates, Indian health legislation updates. There isn't too much happening, again, in this congress with health related issues all stemming from Congress' kind of -- I don't know what, -- impasse over the Affordable Care Act. So not too much stuff happening with respect to this Congress which is controlled by the republicans, to change things in the Affordable Care Act or do anything much health related, with the exception of VA. They're doing some veterans types of bills.

Pending proposal in the white paper that was released yesterday, I sent out to the health directors on 100% FMAP. Some TTAG updates. HRSA 340-(b) regulation, and then also I didn't include it on here, but a veteran's "Dear Tribal Leader" letter that was sent out for Tribal consultation about the veterans' budget and choice act, something to that regard.

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So on the CR, we're under a continuing resolution right now, as you all just kind of to recap or summarize, the president submitted a budget request of \$460 million which was really a grandiose kind of pie in the sky budget request, and you know, really kind of political jockeying in some ways, because we didn't really think that we'd get \$460 million out of this Congress. So this at least gives the administration, it's kind of what Tom Daschle used to do the same thing about 15-18 years ago, where he would submit a budget request for \$700 million through the budget resolution, and realizing it would never see the light of day, but then he got to go back to South Dakota and pound the gavel and say "look what I did for you all." But you know, it's respectful and this administration has been very positive for increased the IHS budget in a couple given years. There was one bad year of sequestration.

So as the bills move through the appropriation process, the House bill included 315 less than the president's requests, so they included a slight increase of 3%. And then the Senate bill was \$324 million less than the president's request. About a 3% increase. The difference between the House and the Senate mark is about \$8 million, with the House budget being a little bit more.

The Senate provides more funding for facilities accounts. It funds facilities construction, maintenance improvement, and some of the facility line items that would be beneficial for the Portland area, but it continues to fund -- it requests an increase for the health facilities construction priority system. The House marks, I think, are really good. And given this tight deficit control and the whole kind of budget environment that we're after, I think the House bill ended up being a pretty good bill to 3% increase, with most of the increases directed to agency, CHS. So the health service account line items and some of the prevention activities. So the CR that's underway holds spending to the same amount that you all received last year, with a slight decrease across the Board cut decision of 0.2%. And we'll see. We expect that after probably the elections in November, that Congress will come back and pass, I anticipate another CR that will get them through the Christmas break until they reconvene the second session in January. And then they'll take up probably an omnibus. And there's some speculation that the agency, or the government could be under a yearlong CR. So I don't like to have those kinds of conversations this early in the process, but I think eventually an omnibus will evolve.

Questions about the budget?

I think Mr. McSwain reported yesterday that I think Andy had an interaction with him around a question about the 2017 budget request, which is the request that the president will send to Congress next February. He reported in a meeting in Washington, DC a couple of weeks that OMB has really taken the Tribal recommendation to heart. And he indicated that we would be quite happy with the

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funding for the behavioral health program. So I do anticipate some decent increases for the mental health services line items, and also for the alcohol / substance abuse line item. It's possible they could put more money into the domestic violence and meth suicide prevention initiatives. We'll just have to see. He can't share too much of the budget details, but he can kind of give us a high level overview. And I think this is good news for the behavioral health programs and indicating that there will be sizable increases for both behavioral health and suicide prevention.

Legislative bills in the 114th Congress. Like I said, there's not a whole lot going on. But this bill, Senate bill 286 is the Department of Interior Private Self Governance Act of 2015. It was introduced by most of the committee sponsors on the Indian Affairs committee. Senator Barrasso was the primary sponsor with cosponsors including Tester, Murkowski, Crapo from Idaho, Schatz, and Franken. But this amends title 4 of the Indian Self-Determination act, which is the DOI programs. Title 6, if I recall right, if I have it up there right, is the department of Health and Human Services. But there are certain things that are included in the Health and Human Services title 6 that allow Tribes greater flexibility and authority to develop programs, streamline administrative types of elements like reporting, and that type of stuff that the DOI portion does not include, title 4. So this bill would align many of those administrative efficiencies with title 6 and title 4 so that the DOI programs would benefit from the same types of opportunities that are included for Health and Human Services programs.

This bill did pass out of the Senate under unanimous consent. It's been sent over to the House. So on the House side, the title 4 task force which is this group of Tribal representatives from the self-governance advisory committee, are trying to find a sponsor that can champion the bill on the House side before moving it through any of the committees over there. Senator McCain, when this bill was going through markup, did bring some amendments to amend the whole self-determination act. Mostly around this whole ID alert to Tribes on the use of third party revenues. So some of you may have remembered three years ago -- two years ago -- OIG said something which is really unusual for OIG to do, but they set down an alert. And they explained to you all that the use of third party revenue under the Indian Health Care Improvement Act and the provision in our -- or in the Indian Health Care Improvement Act explains that you have to use your third party revenue to put back into meeting facility accreditation or certification for participation in Medicare, Medicaid, and CHIP. The programs that you actually built to generate the revenue in the first place. But the provision goes on to say -- it includes some very permissive and flexible language that allows you to, if you do meet those requirements, you can put it into Health Services. And Health Services is broadly defined. Health Services could be -- in my view, could be facilities construction. It could be health promotion and disease prevention type activities. It can be -- you know, it's pretty broadly defined there in terms of what Health Services mean.

So McCain did not -- he offered the amendments and then withdrew them. And it just

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caused a little bit of consternation as this bill was going through the Senate. But it did eventually pass out of the Senate under unanimous consent.

Cheryl Sanders: Jim?

Jim Roberts: Yes?

Cheryl Sanders: Can we have 0:26:28.4 [INAUDIBLE.]

Jim Roberts: Yeah, there were many opinions by many of the Tribal attorneys. So Hobbs, Straus, Dean, and Walker, Dorsey, all of those firms issued opinion memos to many of their Tribal clients. And our in-house general council with Hobbs, Straus, Dean, and Walker, and likewise we had a general memorandum on that provision as well.

So a couple of bills have been introduced to exempt the Indian health programs and BIA programs from sequestration under the budget control act. So there's a process right now to get an administrative kind of action to do this. So we're asking OMB and the administration, and this will be an issue that will come up at the White House Nations building -- uh, meeting next week. But there's also a couple of pending bills that have been introduced into Congress. So Senator Tester and Senator Udall from New Mexico have introduced a bill on the Senate side that would exempt IHS, BIA, and HUD programs. There's other programs that are included in there too. I just, you know, didn't name them all here. But there's ANA programs. There's Indian child welfare programs. So there's kind of a menu of different programs and authorities that are funded by match and there's some SAMSA programs in there. I did cross reference all of the citations that were included in the bill, but it's pretty broad on the Senate side. And then on the House side, there's a companion bill that's been introduced by representative Don Young from Alaska with cosponsors Raul Ruiz from California and McCollum from Minnesota who is really -- how many of you were at the National Indian Health Board conference? Representative McCollum was there, and I really like -- you know, we had a meeting with her about some, you know, preparing for the project up in Swinomish, kind of a preemptive informing meeting with this representative from Minnesota, where they have authorized dental health aid therapists in the state. Just to provide some cover for the Swinomish project in the event that the ADA runs to Congress and tries to do something there. But we met with her and her staff, and she's really really cool. I like this representative. And then she was at the National Indian Health Board meeting. And I really like the things that she said. She really is supportive of Tribal sovereignty. She really supports Indian health. She's just really a neat person.

So this bill here is on the House side. Both bills have been referred to the budget committees, where I think, my prediction is they will die in committee. I don't think

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there's been any political will to do anything around the budget control act, let alone sequester -- grant exemptions from the sequestration process. I think this republican Congress is really intends to keep the heat on the administration. And it's not up to Congress to sequester. So really, the process works like this. The administration submits a budget that are over the caps that are included in the budget control act. Then Congress, or the administration, has to decide to do a sequestration across the Board. They can decide how to do that. It could be directed for, you know, maybe we'll do it for HH, Labor H and interior appropriations. We might do something for DOD. But in the end, the final result has to comply with the budget control caps. But the way they did it a couple years ago was they did an across the Board cut of 5%. And that's when we lost \$185 million out of the IHS budget.

So likely the best chance to avoid sequestration for Indian programs is language included in specific appropriations bills too, so there's -- we've got a legislative strategy to do that as well.

This is an interesting analysis that I came across when looking -- how many of you went to NCIA? This was in your NCAI books, so I'm going to come across and see this. I can't remember if this has the -- a pointer? It doesn't have a pointer? So the -- this just shows budget growth in the different IHS programs. So you'll see -- oh you got one? Thank you. Here we go. So comparison of budget ratios based on constant dollars from 77 to 2016. So you'll see like the federal budget non-defense. They've grown about 3% over this time. National resources, DOI budget authority has actually gone down. NCAI's analysis shows. Office of OST BIA, Office of special trustee. That's right. Trying to get rid of that office, I thought. The BIA construction's down. Then when you look at HHS budget authority, you can see that this is the growth, and that blue bar is from 2000 to 2016. And this bar here is from 77 to 2016. So it looks like it measures the last 5 years and kind of this duration here. When you look at the health function, which is a 550 account in the budget process, you can see the growth here during the same times. Now you look at IHS services and you see at least the services over kind of the longer term from 77 to 2016 have grown at about 3%. So they've kept up with the IHS budget authority. But they haven't kept up with the health functions that are included in the national budget. That's Medicaid, Medicare, CHIP, DOD, VA and that appropriations process; they combine all of these health functions and stuff. So -- Eric, you had a question?

Eric: You just answered it.

Jim Roberts: OK. So that's the 550 account, those of you that are familiar with the overall budget. Then you look at IHS facilities, 2.8%. And you know, here. One of the questions I have for NCI is at times when people do budget comparisons, they'll lump services in with facilities. And one of the things I think it's important to do is to separate out facilities from the health components, because there's cost of construction. In some

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budget years, we saw really good budgets in IHS. One year when IHS, about 20 years ago, had \$185 million increase for the facilities construction program. There was a span of about five years when we saw about \$125 to \$150 million on an ongoing process for facility construction. So I thought that was a pretty interesting graph. And as you go to the NCI website, they have these details in their budget handout or their books from the NCI conference that was there.

There are a couple of bills also in Congress that are underway right now to exempt Tribes from the employer mandate. So this is what they call the employer shared responsibility payment. Basically, it's a tax. But the administration doesn't like the term that's used in the statute, the mandate, because it's just not politically or from a public relations standpoint -- to mandate something. And so they changed the name of it to a shared responsibility payment in the regulation. It's kind of like doing chores. Maybe if you tell your kids, you know, "I'm mandating that you do your chores," but maybe you could call them "chore responsibilities," that our kids would be better prompted to do them without a lot of fuss.

Anyway. We could try that at the Board too, with some of our employees, right? "We don't like to travel, so maybe if we say it's a shared travel responsibility instead of a travel mandate."

These bills are referred to as Tribal Jobs, Employment, and Protection Act. And the reasoning for the name is that if the Tribes have to pay this penalty or provide health services, then they're taking resources away from things like economic development or health programs or roads programs or law enforcement, that are used to create jobs on reservations. So that's the reason for the term, the Job Employment Act. So on the Senate side, Senator Daines from Montana has introduced a bill that's cosponsored by Crapo and Thune. You'll notice all republicans. And then HR30-80 has been introduced by Representative Noem from South Dakota, Cole, and also Zinke, again republicans. You can see again, anybody's -- the R's are trying to whittle away the Affordable Care Act. And although this is one that I think is true, because why should Tribes have to take their resources out of services of providing jobs and put it into something to provide health care, when there's a Federal Trust Responsibility of the United States to provide health care for us? So it kind of abrogates the Federal Responsibility for them to do what they should be doing anyway, and makes the Tribes do it, and pay a penalty if we don't.

Consideration for this might be addition of the Cadillac Tax. So that's the most benefit rich health plans that are over a certain amount, you have to pay a 40% Cadillac Tax. I understand there have been a couple of Tribes that have done an internal analysis that they would have to pay this tax, and the penalty is quite steep for some of those. So this tax does not kick in until 2018. So if you want to know about this, see me after the presentation. I can get you some background information and get you in touch with

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Laura Bird who really understands the implications of this Cadillac Tax. And she can help or work with your Tribes to kind of -- you should be doing your internal analysis now if you haven't already done it. Because then you'll have a chance to kind of change some things that would not result in you having to pay this tax.

Cheryl Sanders: Jim?

Jim Roberts: Yes?

Cheryl Sanders: Thank you. I know that NACO is doing a lot of training on this also for the Tribes. You can go to their website. I think they just had a webinar last week on the Cadillac Tax. To take a look at it. But I don't know if everybody gets that information. So I just wanted to share that.

Jim Roberts: Yeah. The -- we use kind of a payroll processing kind of consulting firm or outsourcing firm called the ADP Automatic Payout Processing I think is the term. So they do our payroll, but they've got some really good stuff in doing this analysis on their website, and what companies are doing to change the mix of benefits so that they're not hit with this tax implication. But in that -- in those materials, they show surveys that they've done. And less than 15% of the -- what they call medium sized companies, and this has nothing to do with the way that small and large sized companies are measured inside the ACA, but medium sized are 50 to 100 employees. But they said that less than 15% of small to medium sized companies have done their internal analysis about this. And the large sized companies, those companies that they say are over 100, or the ACA measures large employers, anybody over 50, but in any event, they say that about 40% of large sized companies have done their internal analysis. But the challenge is, you're negotiating benefits for -- let's see, we're going into 2016. They're -- you need to start changing things for 2017 now. So if you wait till next year, guess what? 2018 will be upon you already. So you almost, when it comes to health plans and employer related types of benefits, you should be negotiating or working on those things at least 18-24 months out. Tim?

Tim Gilbert: Good morning Jim. I share with you informally last night that you were telling us and looking closely at this, and the impact of the Cadillac Tax self-insurance Cadillac program, as we speak in the midst of converting to FAHB and not just the clinic but the Tribe and casino and all the Tribe's entities. So just an FYI.

Jim Roberts: Yeah. How many of you know what the Cadillac Tax is? This is a tax where -- it's intended for benefit rich plans, but Joe and I have looked at this, and we -- the thresholds on this thing are really not set that high. I don't really think it's a Cadillac Tax. They should call it -- I call it a Corolla Tax. And then Joe called it a Pinto Tax. But the way it's done is I think the thresholds if I recall, are \$12,500 for an individual, and for a family it's \$24,000. So the logic goes like this. If the premiums provided by you or

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your company -- so the premiums of both of you, along with other health benefits that are provided to an employee, in the regulation, they're asking for comments on programs like Employee Assistance Programs. Which aren't very high. I don't know what we pay at the Board for our EAP. But generally those are around \$10 to \$15 per employee. Those aren't very significant. But you run the math of that for a year, and then flexible spending accounts included in there. So if you have, you know, your employee contributes \$2500 to his or her flexible spending account. You sum up the total of these different health premiums, and if they're over the amounts that I mentioned earlier, so if they're over the \$12,500 on an individual basis, or any amount that's over that, you pay a 40% excise tax. So you know, these things -- and like I said, they're still under consideration. The IRS is developing the method in which they're going to do this. You know, and there are some plans that are grandfathered, too. So if you're one of the grandfathered plans, and many of your Tribal self-funded plans have come in under the ACA as grandfathered plans, but if you change anything in duration, scope, or benefit design, of any significance, that's -- you know, there's a whole body of regulation that defines what that is -- you lose your grandfathered status and you have to comply with some of these requirements of the ACA. Brent?

Brent Simcosky: Yeah. If I so I haven't been paying as much attention, but she says there's some issue over what number that gets used for the basis of how much you spend, that you can use a COBRA amount, and your legal COBRA specified amount is more, which almost everybody's is, you're going to be under the threshold. But she's a little unclear about whether that's right or wrong.

Jim Roberts: Well, yeah. There's -- you know. You can -- there's still some kind of interpretive things that are going on right now. Just to kind of -- in terms of the regulations how this is ultimately going to play out, the IRS in March of this year issued a kind of guidance or regulatory kind of informative thing, saying "here's what the statute is, here's what we're thinking about implementing." It's kind of like the process before an NPR is issues. The notice of proposed rule. And then in September, last month, they published a second notice, which is the actual notification, notice of proposed rule. So now the comment making process on that has closed. And we expect that probably sometime in, you know, the beginning of next year, they'll issue their final rule on how this will be developed. So some of these things are still under consideration. And that's one of the things that she's talking about. That's Diane? Yeah.

Another bill that's included is a Senate bill 1964, which is a Family Stability and Family Kinship Act of 2015. This bill was introduced around a lot of the child health and welfare issues that are going on across the country. I forget, baby -- what was her, Veronica? In North Carolina? That issue. Currently, under current law, the system incents the states, because of the way that they're financed to remove Indian children out of Indian families. Because if the state can get them into their foster care system, then that's tied to federal funding. So there's a disincentive for them, in some ways, to work with

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Tribes, and an incentive for them to break up the family because of this resource allocation issue and how the states deal with this. So Senator Wyden from Oregon, along with cosponsors Bennett, Brown, Cantwell, Casey, Kilbright, Scott -- this bill has a lot of support. Reforms the federal finance system supporting Indian child welfare services. It funds some services that are intended to provide kind of prevention and education around family counseling types of services. So that children -- there's more of an incentive to keep the family together and keep the child within the family network. Encourages child welfare systems to forgo alternatives to break up the family, like counseling, trauma recovery, mental health, etc. Different types of counseling. So I'm sure that the Indian Child Welfare, National Indian NICWA, is working hard on this issue. This one really, you know, other than kind of being supportive of NICWA, being supportive of the bill, we haven't really taken an official position. But we might consider resolutions for this legislation at the January meeting.

So, legislative issues, and I should have put "second session" of the 114th Congress. So in the legislative committee yesterday, we kind of defined what our priorities are. I think it's consistent with some of the items here. There were some additional things that came up during the legislative committee that I haven't included in here. In terms of -- each year, we do a legislative plan that we prepare with the Board. It's adopted by resolution, by this body and also ATNI. And at the January meeting, we'll come forward with that updated legislative plan for the second session of the 114th. The items that I think we'll include in there, along with some of the IHS budget issues and things that have always been kind of mainstays in the plan, the employer mandates, so the exemption issue about the bills that I talked to you earlier about. Advanced appropriations. We're in an advanced appropriations situation right now, and this advanced appropriations for some of you that may not understand that, is any time you're under a CR, you are loaned money against your yearlong amount that you would normally receive, had a regular appropriation passed. So in this case, the CR runs three months? Or thereabouts? You'll receive 90 days funding for your programs, and what that does is it makes it difficult for managers, administrators of health programs, to kind of forecast their activity over the course of a year. And health operations are very complicated. It helps to know what your financing is, what your revenue is, your expenditures, those types of things, so that you can plan your budgets, plan your program, and do your staffing and that type of stuff. So advanced appropriations would fund the Indian health programs on a 2-year basis. So you would always be receiving funding at an appropriation for two years, and this year as an example, we wouldn't have to worry about the CR, because we would have received the money for this year, two years ago. And the process keeps rolling, so there's adjustments that are made in that second year so, you know, if you were given a budget let's say in -- where are we at? 2015, 2016, you know what you're going to get for -- 2016 would fund 2018. And then the 2017 next year, you would make adjustments to the 2018 budget, and the process just continues like that. So you're always working a year ahead of time. There are a couple of other agencies. The VA receives advanced appropriations for certain

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line items in its budget. I don't know if the entire IHS appropriation would be subject to advanced appropriations, but certainly the key health care line items like health services, prevention accounts, are conducive to a two-year appropriation.

SDPI reauthorization. We continue to receive extensions of the program. We have an extension for two years right now that we'll be getting the first year on. So that's a priority. There's a group of us that are starting to develop Indian Health Care Improvement Act technical amendments. So if you've got some things, and I've talked to the Health directors about this, that aren't working for you, you know, we should talk about what those issues are so that we can get those on a technical amendment list. The problem, and for those of you, I did a presentation at NIHP about this issue, is that when we were moving the Indian Health Care Improvement Act, we always had a list of issues from the act that were prioritized, that we could attach to a legislative vehicle that was moving at the time. So the entire Indian Health Care Improvement Act wasn't passed as part of the Affordable Care Act. Everybody thinks that. But there were key component of the Indian Health Care Improvement Act that were passed during the Medicaid Modernization Act, Medicare like rates was one of those.

Cost sharing exemptions and not managed care protections in Medicaid, those were passed in the Stimulus bill, the R-bill in 2009. There were some items that we got into DRA, which I can't remember right now. Billing authority for Medicare Part B. We didn't have full billing authority for Part B. So we got that in the DRA. But there were different bills that we identified important issues in the Indian Health Care Improvement Act and we attached them to those legislative vehicles that were moving at the time. If Congress was to come to us and say "hey, what are your top five priority issues," I don't know that we could do that, and they might be different across every area. I'm pretty sure we could do it in our area. But whether they would be consistent with the priorities of other areas, so we would create this competing interest issue, and it's better if, I think, we identify the technical amendments, have national dialogue on those amongst the area health Boards and private health programs, and we get an agreement on what those are so there's consensus around those issues when we get Congress, and we're not all advocating for our issues over somebody else's issues.

Medicare like rates for Outpatient Services, I think the only way to get this done continues to be legislate it. I don't believe that the current proposal and regulations that have been developed by IHS are conducive to accomplishing the objective of this. And of course, if you saw the regulations which basically were kind of a nuclear clause, which was "you cannot spend any of your CHS money unless you use this regulation," would kind of block access to care with CHS referrals that are not associated -- that are not facility based.

Contract support cost mandatory funding and reconciliation language, I'll talk about this a little bit more on the contract support cost slide that I have. But I think probably the

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agencies created this kind of reconciliation process where they keep your agreements open for a certain amount of time, vs. closing them out after each fiscal year. And you have to go back and demonstrate your costs incurred so that you can justify the actual contract support process they've given you. It's inconsistent with the statute. It's inconsistent with the IHS contract support cost manual. And I think the only way that we're going to be able to address this with IHS is if we legislate it. This is not the practice that is being used in the BIA. Despite IHS telling us that this is what we're going to have to do.

So contract support cost update, this is the issue here. Yes?

FEMALE SPEAKER: Can you just go back -- maybe I'm not awake. I didn't -- on the care like ratings for allocation, because I recently had someone from another Tribe call me and she was new to contract health, and said that she was repricing everything because she was told outpatient, she would be paid for it, I said no, that I would ask at this meeting. But I didn't catch that. I said "Well, good for you, but I think somewhere you're going to get some balance bills back."

Jim Roberts: Facility charges that are associated with an outpatient visit are reimbursable under the current Medicare like rate regulation. So the current Medicare like rate regulation, just to kind of recap that, it requires all Medicare participating hospitals, and there is not a hospital -- well, there might be a couple, in the United States that can stay in business without participating in Medicare, so this makes it a requirement for them to accept your CHS referral. And when they provide that service, all the charges that are associated with the hospital, facility based, are subject to Medicare like rates. Whether they're inpatient or outpatient services.

FEMALE SPEAKER: Right. She was talking about just outpatient facility.

Jim Roberts: Yeah. So provider, you know, those services that are disconnected with the facility, like physician fees, labs, radiology, and those types of things, those are not subject to Medicare like rates.

So the contract support cuts. So this is, you know, IHS said there is a "Dear Tribal Leader" issue, the middle of this year, and essentially it lays out that IHS is going to continue to use this cost incurred approach to kind of determine that the amount of contract support costs that they provided you were adequate, and that based on the program dollars that you spent, they haven't either overfunded you or underfunded you. So it works both ways. But that's not the way the statute reads. And that's not the way that the contract support cost manual was developed. Moreover, it's not the way the BIA is doing it. So if the BIA is not doing it, why does IHS have to continue to do it? So I expect that there's probably going to -- this is going to be the next area of litigation if Congress doesn't step in and fix this issue. But you know, so that's an issue, and there

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are some other letters that are on there. Andy and I have worked on this issue with contract support Work Group. It's complicated. You know, I don't want to overexplain it or lose you in the technicalities of it all. Sometimes I start talking about it and I confuse myself and then I lose track of what I was talking about! In any event, the contract support cost issues are very complicated. We're working on this issue. And there was legislation last year that was introduced by Begich to address this issue. Unfortunately, Senator Begich wasn't reelected, so you know what happens. Generally, most members' bills that are introduced in Congress, if you don't win the reelection, guess what? No one wants to pick up your priorities and champion them for you. So those bills are pretty much dead, for the most part. But there is likely that Lisa Murkowski will introduce legislation or get behind Begich's legislation to address this.

Past year's claims. You know, the agency has really, has to be commended, I think, for their effort to settle the past year's claims. I think this part is kind of a priority for the administration. More so than the agency. But I think they have worked almost \$800 million has been settled in outstanding contract support cost claims. We estimated that at one time, the outstanding past year's contract support cost claims were in the neighborhood of \$3 to \$4 billion. So you know, I think the agency is doing a remarkable job of trying to get these. At the TSAG Technical Work group meeting two weeks ago in DC, IHS reported they want to try to have all IHS claims settled by the end of this year. I don't know that they'll be able to do that, but I think it's an optimistic timeline, and a positive commitment on behalf of the agency. So you know, we at the Board, we've settled, I think Joe's reported in a couple of meetings that we've received our settlement. And plans are underway for the use of the I think Joe showed you that the Board is looking at purchasing a building for the Board, and so I think a lot of the Tribes in the Portland area have also settled their claims.

Revised CSC BIA has completed a revised contract support cost manual. IHS indicates that it should have a draft available for review by the technical work groups soon. It will include a proposal or a section for fixed rates so that if you want to fix your rate over a course of time, you can do that rather than renegotiating your indirect rate with the National Business Center each year or biannually, however you do that. Some Tribes do it each year. Others do it every two or three years. And then there will be a provision that will allow you to fix that rate over a term to be determined between you and IHS in the neighborhood of 3-5 years, something like that. I don't think a Tribe would want to fix its rate more than five years, nor would the agency want you to fix the rate that long, either.

OMB should bring IHS and BIA support cost work groups together, so that we can align the policies. This is not really an IHS issue or BIA issue. This is an Indian self-determination contracting issue, and I think bringing the IHS and BIA work groups together so that we can align our administrative mechanisms and our manuals, would be a marked improvement to the process both for BIA and IHS as well as for Tribes.

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Now, a little bit on contract support cost funding. During the CR and under the event a year-long CR happens. So if we have a year-long continuing resolution, it will tie us to last year's amounts. And likewise, what we've already seen that across the Board recession, at least in the interim CR, but there's likely to be a recession because Congress can never agree on what the budget caps are. So the easiest way to do that is to figure out what percentage am I over, and then they just apply that percentage cut across all the appropriations process. It's a real easy way for them to deal with the budget marks. But the agency and Congress have established a policy of fully funding Contract Support costs. If you recall last year, Director Roubideaux came back to us and had a discussion on cutting \$48 million from program dollars so that the agency could fully fund contract support costs. As the fiscal year went along, and eventually in August or September, that amount ended up being \$25 million. So they didn't need as much money as they thought they would need back in February when we had the initial conversation. And the agency ended up taking money from scholarships. There was some money that was found at headquarters. There was a couple line items -- the Self-Governance line item was reduced by \$1 million. And direct ops was reduced by \$1 million. And that was sufficient to fund the \$25 million. This year, we may have the same thing happen. Because if you're not -- if you're funded at last year's levels, and there is some program growth in the system, so there are Tribes in other parts of the area. There might be Tribes in the Portland area that are serving more programs. You're having an expansion of the program which means -- Self Determination programs -- which means the amount that you allocated the previous fiscal year isn't going to be sufficient to pay contract support costs on those new and expanded programs. So we're likely going to be put into another conversation with the agency about cutting the program base in order to fund contract support costs. If we were under a year-long CR or if congress is not providing appropriation that's adequate to fund CR. So the amount that's currently in the CR, that is based -- it's about \$55 million short of fully funding contract support costs. Yes, Cassie?

Cassie Sellards-Recks: I just have a quick question about the money that the Board's received. Are we going to be included in the process for planning what we'll be doing with that? Because I haven't heard any information about buying a building or what might be the priority of the Board. We probably should look at our priorities so we can be part of the planning for the budget.

Jim Roberts: I think that has happened with the Executive Committee. There was a conversation had with the Board. Joe, do you have -- yeah, I think there was a conversation at the quarterly Board meeting about that. I forget which one.

Cassie Sellards-Reck: Buying the building?

Jim Roberts: Yeah.

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Cassie Sellards-Reck: And how much we were going to receive?

Jim Roberts: Yes.

Cassie Sellards-Reck: OK. That would be great to have that update. Because many people don't remember that.

Joe Finkbonner: It was during the executive session, Cassie. We discussed the amount that we receive. And it was -- a decision was made then to move forward with purchasing the building so that the Board would have a permanent spot and not be subject to increased indirect rates through lease rates going up annually, and that would stabilize our indirect rate that way.

Cassie Sellards-Reck: OK.

Cheryl Sanders: Jim?

Jim Roberts: Yes?

Cheryl Sanders: I have a comment for Andy and kind of a discussion with the 1McSwain yesterday about -- you know, we like take ten steps forward and we're five steps back. You know, we need to know where this money's coming from. All of a sudden there's money "found"? You know, we really need to chip away at that process when we're doing these kinds of things, because it's just like we work really hard to try to get this money, and then it's all taken away again, and then -- we just need to do more, you know. I want to just encourage you again, Andy, to just really dig in and find out where these pockets of money are. And I don't know how or what. We just need to hammer away and chip away. Because this is so frustrating. All the work that goes into the Tribes trying to do all this stuff to prove that we were supposed to show our contract support and now it falls back again. I mean, we don't have that capacity to continue to do this work. And get left behind again. We can't be left behind all the time. I just really want to encourage Andy and Steve to really dig in and find out where this money is. How can they find millions of dollars somewhere? You know? It just frustrates me.

Jim Roberts: Yeah. So Cheryl, on that note, the legislative committee did identify priorities for the White House meeting that we're giving to NCI and Andy and those that will be participating. And this was one of the issues, this budget transparency. You know, I do find it interesting that in February of last year, we had a discussion with the agency about cutting the program \$48 million and eventually \$25 million. But then when it came time to settle this kind of union issue, the agency was very easily able to find \$25 million to settle that. You know, part of it -- I understand that part of it involved taking Navajo staffing package, because that project wasn't available. And they'll get

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that money back because it's in the base budget now, so it will become a recurring appropriation. But you know, there were third party collections that were there, and there was \$10 million in past year's money as Bob reported yesterday. But you know, I think it calls the question about where are the different pockets of money. And the staff advisory committee has brought that issue up with Secretary Burwell. And so I think there's need to have -- you know, in some ways we've kind of fallen asleep at the wheel in the Portland area. As I understand, there was a lot of budget transparency in the Portland area, and I think with Dean bringing back the all Tribes meeting, we'll get back there. But I think the staff has brought this issue up. Ron Allen, Steve Kuntz, Steve really took the director to task during the staff meeting over this issue back in June when it was first reported about this settlement. But it will be a priority issue that we'll ask NCAI and our Tribal leadership to address at the White House meeting.

Leslie Wosnig: So Jim, I don't recall if I've heard anything about efforts to exempt us from the sequester. Is that still afoot?

Jim Roberts: I talked about it right there.

Leslie Wosnig: Did you? OK. I'm sorry. I can't remember!

Jim Roberts: Yes. So there is administrative remedy, and there are congressional remedies. So there's a two-pronged approach that's underway.

OK. So kind of moving through here quickly, because I've got a few more slides. IHS "Dear Tribal Leader" letters, we talked about this one yesterday. Not going to kind of belabor the point, but comments are due October 31st on this. You're all welcome to submit your own comments, but I think based on the discussion and what I've interacted with Tribal health directors, I'll prepare a comment letter here in the next couple weeks. Actually, I've got to do it sooner than that, don't I? They didn't give us a lot of time on this thing. Because this letter just came out about two weeks ago, maybe three. But we'll prepare some comments. I'll send them out to you. And if you all concur, we'll file them on behalf of the Board.

For the Health Directors and Medicaid Liaisons and others, I did send out this white paper yesterday, that CMS has issued a new white paper with comments due by December 17th. And just to kind of recap the issue, Alaska and South Dakota have submitted policy proposals to CMS that if CMS agrees to revisit its policy on services that are eligible for 100% FMAP, and that's basically where a service is provided to an Indian person, the state is reimbursed by CMS at 100%. It doesn't cost the state any money. That money is borne entirely by the federal government. And the philosophy there is that, in recognition of the trust responsibility, the federal government should be paying that bill, not the states. Alaska and South Dakota have submitted Medicaid expansion proposals, and this is more so the case in South Dakota than it is Alaska.

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Alaska last month started to expand Medicaid, so they're in the midst of it right now. But they still have a pending request that they want to be reimbursed for services that are delivered through the Indian Health System and "through" meaning in the facility, the four walls, or through some type of arrangement between a specialty care provider and that facility.

Some years ago, CMS had ruled that the policy is that the services had to be delivered within the four walls of the IHS facility. So South Dakota's proposal is for some services, but their proposal is that unless you give us 100% FMAP, we're not going to expand Medicaid. And of course, the administration really does want all the states to expand Medicaid under the ACA. Kind of gives them another feather to stick in their cap and kind of, you know, an implementation of the ACA. So they really want to see South Dakota and of course Alaska, expand. So there was consultation on this issue over the last six to eight weeks by CMS, to kind of All Tribe's calls, and then a consultation session at the National Indian Health Board's annual conference. And I think that process informed this white paper that's been developed. So CMS has that paper developed. We've already submitted comments. But we'll refine those comments and also add it back here. I think the policy proposal that's being presented by CMS is very opportunistic. I think it provides some good opportunity here for us to enter into contractual arrangements with specialty care providers and be reimbursed at 100% FMAP for them. So you know, there are some things we need to do to work out with the specialty providers and the managed care plans and the states. But I think -- and they've also asked comment from the states. So this is going to create a really kind of difficult administrative financial reimbursement nightmare for the states. They are already challenged with how they reimburse our programs and Medicaid. And this is just one additional nuance that they have to deal with.

TTAG Advisory Group issues. Summary of benefit documents for zero unlimited cautionary plan variations. This is a problem. QHP's aren't issuing -- I won't say accurate information, but they're not disclosing full information, and you know, some QHP's are real good, and others are not informing beneficiaries of their cost sharing exemption benefits.

Referrals for cautionary and proper payments. You guys know this issue. We've talked about it. The Board submitted comments to CMS about this. Really, this is just one problem that I'm aware of, and that's with Premera Blue Cross in Alaska and Washington. So they're really creating kind of a stir. So John and I -- John. Joe and I are having a call with CMS with Andy Slavitt [sp?] this afternoon, with the Region 10 CMS administrator. Andy is visiting Region 10, and John Hamill, the administrator, has asked us to participate in a conference call to discuss Tribal issues with them. So we've prepared a list of issues, and this is on there to talk about. And we're just going to tell them, you know, CMS should just talk to QHP. They need to comply with kind of the guidance that has been issued. Because since Iowa issued guidance on what the

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minimum standards are for a referral under the CHS program, market call center Tribal scripts, the feds have finally acknowledged that they probably aren't the best entity to be dealing with call center issues around Tribal issues. So they're going to actually issue a contract to someone to do this. So you know three or four years ago, we told them, you really should just hire, you know, a special Tribal call center. And they've agreed that this is one that they've really been challenged with, and they're looking at developing an alternative mechanism for the call center in the FFM. Now the state base exchanges, they also have their own call centers and that type of stuff. But this is for those states that participate in the FFM, like Idaho, Oregon, and others that haven't established a state base exchange.

Simplified family plan provisions, this is the tagalong policy where you have split households where some members are Tribal members and others, you know, usually the parents and the children are not Tribal members so you have different cost sharing issues, and then you have to split the family up to put them on different plans because the Indians gotta go on the zero or limited cost sharing plan variation, and the non-Indians have to go on a different plan. It gets complicated. But that's an issue.

Enrollment data, transition from marketplace coverage and Medicaid, this is going to affect Idaho. If they fully develop, if they expand Medicaid. So if you're from Idaho, you should kind of pay attention to this issue. Alaska started expanding Medicaid last month. And as they are trying to transition, those Indians that are between 100 and 138% of federal poverty level, to Medicaid and off of QHP plans because Alaska has a very big Tribal sponsorship program. The eligibility thing, because they're enrolled in a marketplace plan, is screwing them up, the Medicaid. And they can't get them off the marketplace plan and into Medicaid. So this transition issue is going to impact Idaho if Idaho decides to expand Medicaid, and we should learn from the experience of Alaska from this.

The VA letter. This was discussed in the VA subcommittee. It's included in your packets. It's on the back handout. But the Veterans' budget and choice improvement act was passed by Congress. The act requires a report to Congress from the VA on how they're going to streamline all non VA programs into a single program. So non VA, there are certain programs in the VA that aren't provided -- delivered by actually the VA. The other one is the Veterans' Choice Act, VACA I think it was called, where it provided the VA and all stemmed around this kind of VA controversy that happened about two years ago. But the VA receives kind of like a CHS line item now, where if they can't provide care in a timely manner to the vet, or if the Tribal distance is too great, or if the service is not available in that facility, the veteran can go to a private provider and receive care, and then the VA will reimburse that care to them. So that's part of -- you know, that's an example of the non VA programs. But they're seeking consultation regarding Tribes as part of the VA core provider network, including efforts to streamline and provision non VA care to veterans. Now, the comment deadline on this is already

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closed, October 26th. But the letter indicates that an additional Tribal consultation will be held on November 1st. So I still think if you contact Terry Bentley, the kind of coordinator for our region, VA, I'm sure she will entertain the comments on this. So if you're interested in submitting comments, the Board -- we're not submitting comments on this issue. And you know, one of the issues I think if you -- how many of you have a VA kind of reimbursement agreement? I think you should ask for these core services, if you've got a VA reimbursement agreement, that you should be included in the provider network of this process.

HRSA 340-B, out in post guidance, we talked about this in the health director meeting. We saw comments that were submitted by the Board. I provided, cc'd all the Tribal health directors on this. But it basically has to do with requiring a relationship between the patient and the provider in a facility, in order to access the 340-B program. This would adversely affect some programs that use 340-B. And we've submitted the comments that, to just clarify the portion of the regulation so that it will maintain the existing process that's currently in place. Cheryl? That concludes my report. Unless there's any questions. Marilyn? Eric, you got one too?

Marilyn Scott: A comment that I have is going back to some of the issues that you had on your TTAG list. It relates to -- and you talked about the -- CMS talks about the network advocacy for ITU's and the contract issues with QHP. But one of the things that has happened in Washington State, and it relates to the managed care plans that are for Medicaid, and so the Health Care Authority who oversees the managed care plans for Medicaid, and the access, one of the things that they have said, the agency has said, is they do receive guidance from CMS on the requirements for the network adequacy of those managed care plans that they have contrast with and the requirement to include Tribal programs if the Tribes so choose. And different from the qualified health plans within our state exchange, you know, and the access to the referrals and accepting referrals, but neither one of those agencies, the exchange and the Health Care Authority, that are overseeing the -- you know, putting the RPL or the contracts and the selection of those qualified health plans and managed care plans, is the guidance that they receive from CMS to the state. The state has interpreted that they do not have the authority to hold those plans to the requirements for network adequacy and payment of services provided by Tribal Health programs. And so we're continuing to have now issues with -- and then now we're facing the rollout of the Accountable Communities, the health and the behavioral health organizations, that are going to have the responsibility for managing behavioral health and chemical dependency. So that whole issue, the state agencies responsible for the Medicaid program, are stating that yes, they received the guidance from CMS that they need to hold those requirements for the American Indians / Alaska Natives, but they do not feel - - the state has determined they do not feel they have the authority to hold those carriers in enforcing those rules that are in the legislation. So it's -- although there is that requirement in the affordable care act as the states are receiving the funding and

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implementing those programs, the guidance that CMS is sending to the states, the state at least in Washington has stated that they do not feel they have that authority to enforce those.

Jim Roberts: Yeah. We should ask that. And I should have put that on the list. That's on the list. It's on -- we're working on that. That's the number one priority on the list that we sent to John Hamerill [sp?] this morning. So that's --

Marilyn Scott: Especially the --

Jim Roberts: With managed care, not --

Marilyn Scott: Well, the other part is the funding that the state is receiving from the innovation planning.

Jim Roberts: Yeah. I would disagree with the interpretation in the state that they don't have the authority. They may not have the authority to require a contract from the managed care plan to contract with an Indian provider. But they certainly have a requirement to enforce network adequacy requirements that are included in the regulations access to care standards governing managed care. So you know, it's kind of one of those things that we've always dealt with Washington State and said well, you know, we don't have the authority to make the RSN's do something, and you go look at the WACs regarding RSN's, the state had a lot of authority. They just never implemented the requirements. The RSN's addressed the issues that they had in their Tribes for so long. But I think in this case, there's -- you know, the whole body and the access to care regulations that are contented in the -- in title 19, the state has a requirement in there, and you know, I think we should just make them do it. But I think with the managed care regulations that are coming out here in the next 3-6 months will close that loophole, and I think they will -- there's going to be something around network adequacy, contracting and using the Tribal addendum for these managed care contracts. I'll go to Eric and then Lesley.

Eric Metcalf: Real quick. 340-B. If we can't get the changes that we're asking for, will that essentially end the mail order that some Tribes are getting today?

Jim Roberts: Yes.

Eric Metcalf: And when will that take effect?

Jim Roberts: I don't know what the date is for implementation, but -- now this is being, you know, there's some question about that, that the attorneys are kind of debating right now, Eric, in that HRSA has issued this as a guidance. It's not a regulation. And in the closing conclusion of our -- the Board's letter, you'll make the note that if you can get

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that from your health director, and I can forward it to you offline here too, that this is a guidance. It's not regulation and it's not binding. So in the guidance, we want them to issue that this is just the way -- you know, these are a recommended way that you should run the program, but you're not -- it's not a regulation. But yes, it would change that because it requires a direct relationship with the patient and the physician. And the prescription has to be written in the facility. Lesley? Or -- OK.

Ann Lindroth-Jim: Yeah, I'm Ann Lindroth-Jim. Good morning. Shoshone-Bannack Tribes on the Tribal health director. But you mentioned Alaska, and I kind of compared us to Alaska. Well, I don't know how many people, patients they have on Medicaid vs. the ACA marketplace insurance. But I'd like to see that number, because Idaho you understand, having worked -- Idaho's so behind in their medical Medicaid expansion type stuff. But if you take a look at our Medicaid of patients, that's the number of patients -- we have a high number of patients on Medicaid. That's where we get our reimbursements. We probably have 5-6 people that are ACA -- the new insurance is not affordable. That's what we're finding out in Idaho. Plus they can't get on Medicaid. So we are in a huge gap. I mean, it's -- there's been a huge gap. But I'd like to see those numbers of how many people in Alaska are on the ACA vs. the Medicaid, because the Medicaid is what you're getting the reimbursement monies from. So.

Jim Roberts: Yeah. You know, Alaska just expanded Medicaid last month. So their enrollment, their take up is still going on now. So we won't have good numbers coming out of Alaska for at least six months, I predict. I will say this much, though. Their percentage of Alaska Natives that are on Medicaid will be much higher than the percentage of Indians that are on Medicaid in any state in the lower 48. Just -- you know, they've got great, you know -- I'm looking at my colleague from Alaska that worked at South Central. Would you say that was true, Brent? Yeah. I think generally the proportion of people that are on Medicaid pre-ACA was about 35% across the system. The take up rates, or the -- you know, the amount that will be transitioned under Medicaid expansion, at least in Washington State, we're starting to see as high as 50%, and that's true in Oregon. And in parts like Aberdeen where they have greater poverty and stuff like that, I think the take up rates will be up at like 75/80% of the users in an IHS system. If everybody enrolls, would be unlikely.

Ann Lindroth-Jim: One more comment. On the comment carriers that have come out from the Dear Tribal letters, it seems to be we're missing the boat there. And I see it happening everywhere, because when the new OMB super circular came out, they said only 5 -- I think less than 5 Tribes commented on that super circular. And --

Jim Roberts: You're talking about the A85 -- OMB, so that was the change that moved away from requiring A133 audits and compliance with A85 created a standard set of regulations?

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Ann Lindroth-Jim: Yeah. And what I just think we're missing the boat on being able -- Tribes being able to make comments on some of these letters and stuff, because we meet with our Tribal Council, and we try to inform them and have them be involved, but we meet with them once a month. So I feel like if we could have some kind of extensions, I don't know if --

Jim Roberts: Sometimes they do extensions. Yeah, it really does -- at least for the Board, it's a bandwidth issue. You know, it's -- we can't track everything that's going on with regard to SAMSA, HRSA, CEC, CMS, IHS regulations. So we kind of prioritize where we channel our energy, and that's CMS and IHS. And then Joe does the CDC stuff. CDC hasn't issued too many regulations that I'm aware of, not to the extent that CMS and others have to implement the ACA. And then, you know, add to that, we've got the work that's going on in the states. So we've got three states. So it really does become a juggling act. And I think nationally, with the national health Board and the TTAG and the MMPC, they all do a pretty good job of kind of, you know, developing some synergy around all these issues. I can see one more question, and then Cheryl is going to moving on.

Marilyn Scott: One last thing. I wanted to go back and request that the Board and the Executive Committee considered supporting the legislation for the Stability, Family Stability and Family Kinship act. And one of the reasons I'm asking that is at NCI last week, the Tribal leaders across the country are asking all Tribes to do what we can to get the support for families to be recognized that are providing services for children that moved -- their families home or communities. But the other reason is in Washington State, we have had some of our children that were in foster care and placed by Tribal court order, not being able to get their medical covered with the federal funds that the state received because it was gap, and not all of the children that had, because of the Tribal code, did not allow termination of parental rights and adoption of those children. They were not being recognized as being in a guardianship placement. Long term guardianship placement by Tribal court vs. adoption, which the state receives the federal money to cover their medical services. And so we've been able to get that identified and the Health Care Authority is now accepting those placements. But it's a gap that some of our children are missing the health care coverage that they're eligible for because they are not being identified by the state.

Jim Roberts: OK. Let's not wait till January. How about if I just do a resolution and we'll bring it through the floor tomorrow. You know, normally we bring it through the legislative committee, but we'll bring this one through the floor.

Cheryl Kennedy: Thank you. That's great lively discussion. I know we always have a lot of concerns, and need a lot of clarification to understand these kind of complex issues that affect everyone a little differently. And a lot of it is the state we reside in. So now we are ready for our break. I do have an announcement. That instead of the clinic

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tour, they'll be offering Tamastslitk tour, providing shuttle. There's going to be a signup sheet that's over here, on the table here by Lisa. So if you need a ride, please sign up there.

We will go ahead and take the 15 minute break and reconvene back here. Shawna?

Shawna Gavin: Cheryl, we need to know how many people are going to --

Cheryl Kenney: OK, show of hands? Can we get some idea about those who might need a ride now, by raising your hand? I see 1, 2, 3, 4, 5 -- there's more up there. OK. Thank you. Make sure you sign up.

[BREAK.]

Cheryl Kenney: Well, we are at the late morning. We have ready to make a presentation here from the Portland area in health services influenza action plan, from Dr. Tom Weiser, the Board's epidemiologist. So welcome. And we'll get this moving. Thank you.

Influenza Vaccination Presentation

Dr. Tom Weiser: Thank you for the chance to speak with you all. It's been a while since I presented to the Board, anything related to immunizations or anything else, and the Indian Health Service tasked all of the areas back in about April or May to come up with an area-wide plan for this year's flu season. And so I began working on this around that time, in May. And did some initial analysis and presented it at the Tribal Health Emergency Preparedness meeting in June at Quinalt. I was hoping to be able to talk to you all in the summertime before we really implemented this plan, to get feedback and see what you all thought, but that was a combined meeting and there was just too many other things on the agenda for me to get this on there. So we're in the middle of our flu season right now. This plan is in action right now. So I'm just going to tell you about the way I looked through, about developing this plan. And then at the very end we'll talk a little bit about where we're at with regards to influenza vaccinations, as best as I can know today.

I want to start off with a brief story though, because I know that immunizations in general is something that not everybody has a clear idea of, or a clear vision of, or is in agreement about. And this -- I added this slide this morning because I had a conversation yesterday where someone was asking me -- well, why did you go into medicine. And you know, I thought about it quite often, and I think not necessarily my stated reason for going into medicine, but absolutely percolating in my history is my mom. And my mom developed polio because in 1958 they had a vaccine, but she was afraid of needles. And she lived in Buffalo, New York which is near lake Erie, and if you

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know much about that area, that was quite a bit of polio transmission in New York at that time. And the vaccine had been developed in 1954. It was the first time it had been rolled out. So it had already been out there for about 4 years. But my mom was scared to death to get a shot. You know? And she was an adult. So it turned out that a few days before she got married, she got sick. And she had a fever, and she just wasn't feeling well. And they took her to the doctor, and I only found out recently that this doctor actually knew that she had polio then. But he didn't tell her. She went on, she got married, she went down the aisle, but she had to be helped back down the aisle. She had a glass of orange juice at her reception. And spent the next nine months in the hospital.

So she was pretty sick. She lost a lot of function initially. And she tells me she was so sick that they had an iron lung right outside her door. She also told me that she was so sick, the nurses had to light her cigarettes for her! So this is 1958. OK? Things have changed quite a bit since then. As she recovered, she was left with the loss of her left leg. You know, she couldn't move it at all. Us kids teased her and tickled her where she couldn't move it. All my life, she was on crutches, and struggled with that. As she got older, she developed post-polio syndrome and had a lot of issues with fatigue and weakness. And by the end of her life, she was in a wheelchair permanently, full time. And so I bring that story out because I want to make sure that people understand that I support vaccination because of my direct experience with a vaccine preventable disease in my own family. And you know, I don't receive speaker fees from pharmacy or big pharma companies or anything like that. I don't get a bonus, a performance bonus if I get, you know, more people vaccinated or anything like that. It's really about protecting the people from these illnesses. And I want to make that clear at the outset.

So if you were to just stay for the next two minutes and then had to run off or something like that, these are the key points that I would want folks to keep in mind about this flu vaccination plan. One is that we have a number of data sources at the area level that we can use to help us understand where we've been at with regards to flu vaccinations. And that we can use that data to help us plan for what we're going to do in the future.

I'll talk about these different data sources, but IIAS is the Influenza-like Illness Awareness System. And that's the main data system that I use for our planning. But there's also the GPRA data, the CRS clinical reporting system that generates GRPA data. And then each of our sites uploads information about vaccinations to the national immunization reporting system, which is also another source of data that can be used.

I made a big point about advocating for early vaccination. As soon as the flu vaccine arrives, I ask the immunization coordinators to -- you know, don't delay getting the flu vaccine, but to be prepared and ready to give it as soon as it arrives. And then also to anticipate adverse media coverage. So last year when there was a mismatch between the flu vaccine and the circulating strain, there was a lot of negative media about that.

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And a lot of people chose not to get vaccinated because of that. And the result of that was that we had a later influenza B uptick in cases, because fewer people had received the vaccine in the fall. And then influenza B was one of the covered antigens in that vaccine. But we had a lot of cases nationally and in the Northwest because of that. So we need to get out front of any kind of negative media that might be out there.

I also need to show you all the IPC care model, because when we're talking about vaccinations, we're talking about how we're delivering our health care. And for those of you who haven't seen this, this is the Improving Patient Care model. It's an adaptation of a model that was developed a number of years ago by Nepal Institute. And this is what's been developed through IHS and improving patient care community. And I won't go into all of the details of it, it would take me the next half an hour to do that. But as we're looking at this model and thinking about flu vaccines, we're going to be focusing on several areas. One of them is delivering system design. How is our health care system designed to deliver that health care? What are the barriers to receiving health care as simple as getting a flu shot?

We're going to be talking about patient centered health care. You hear a lot of talk about patient centered medical home, this big movement that CMS is trying to get all of our clients across the country to be a part of. There's nothing about flu vaccination that isn't patient centered. Because at the center of every encounter, every shot, is that patient and their arm. And so we have to really be thinking about the patient, where they're at, and be prepared for that.

That's going to require that our patients are informed. That they receive accurate information about flu vaccination, and that that will then activate them and motivate them to come and get the flu shot, or to accept the flu shot wherever it's being offered to them. That also requires that our care teams, our provider teams, are also prepared. You know, if you do a good job about getting the word out about flu vaccine, and lots of folks come in, we don't have our supplies in order, we don't have our vaccines, we don't have people available to vaccinate, that's not good medicine. So we're not going to get there.

So the background for the Indian Health Service role is that it really comes from the healthy people 20/20 goal. And I've heard previous discussions in this meeting mentioning or referencing healthy people 20/20. So this is the nation's strategic plan for achieving health. And in that strategic plan is a goal of achieving 70% coverage for flu vaccination every year. Because right now it's an annual vaccine that has to be given newly each year. So, and the benefits of having this large area of coverage of flu vaccine are twofold. One is if you achieve 70% coverage, you'll be able to have an impact on the degree of severity of the flu epidemic that happens every year in your community. And then the second one is that individual case that a person can be prevented from getting the flu if they get the flu shot. Now, it's not 100%, and we're

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going to go through what the percentage is. It's not a great tool for necessarily preventing the flu. But it's really right now still the best tool we have.

So when the order came down to say "well, your area needs to come up with a flu plan, and how are we going to achieve 70% coverage?" I scratched my head and thought "well, is 70% high enough?" And where did they get that number? Is that the right number? And then I thought to myself, "well, how can we even get there?" Because our see what we did last year, 45 to 40% coverage. So how are we going to make up that big gap between 35% and 70%? And then I thought to myself too, what about timing? If we achieve 70% coverage by the end of the GPRA year, which is June 30th, you know, we know the flu stops transmitting well before that time period. So timing also has an important role, and how are we going to achieve our level of coverage?

It turns out, the right level of vaccine coverage for flu or for anything else to prevent a widespread transmission of a disease depends on two main factors. One is the effectiveness of the vaccine, and the other is the infectiousness of the virus, in this case the flu virus. And that some years, the flu virus is more virulent. It's more easy to catch, or it spreads easier among certain population groups, or among all population groups, than others.

And just this little quote from CDC, they still have -- you know, are supporting flu vaccination as really the best way to reduce the chances that you will get seasonal flu and spread it to others. And they bring up a good point. When more people get vaccinated against the flu, less flu can spread to the community. And that's really one of the driving points for the plan.

So how effective is the flu vaccine? These numbers come from a pool of data across multiple seasons, multiple years of influenza vaccines. And it turns out that about 50%, 52% effectiveness for ages 6 to 64. So that's not that high. It's not that good. And it drops even lower for those who are 65 and older. So we know that the flu vaccine isn't the magic bullet. It's not 100% effective. You hear a lot of people saying "I got the flu shot, and then I got the flu." And that does happen. That does happen, because it's not 100% effective. Things that make a difference in its effectiveness besides age are the stability or the strength of someone's immune system. So good nutrition, and good overall health has a big role in how well you'll respond to a flu vaccine. And the other issue, then, is how virulent that flu strain is. So there's a measure called R_0 . Did anybody see the movie Contagion? There was a nice lecture in the movie Contagion about R_0 which is a measure of how infectious the flu is. Someone's got a question.

Tim Gilbert: Tom, didn't mean to interrupt your flow there, but I just want to back up a half step to the comment made about "I got the vaccine and then I got sick." Because I found myself over the weekend replying to a friend on Facebook who was questioning the value of vaccination, and the question wasn't "I got the flu and later I got sick." The

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point she was trying to make was "I got vaccinated and the next day I got sick because I got the vaccine." Can you make that distinction between what you just said and what people perceive the risk of getting the actual flu shot?

Dr. Tom Weiser: As soon I said that, that rolled through my mind too. So you know, two distinctions. There are people who get the flu shot or any other shot, and then they feel some kind of symptoms, and they think that the shot gave them the flu. Gave them the disease that they're trying to prevent. And we know that some people do feel a little bit under the weather after they get a flu shot. They may have a -- depending on the version too, if you get the live vaccine, you might have a little stuffy nose, a little headache. Maybe a little ache and pain. And we know that people who have some symptoms like that actually, their body is developing a stronger immune response and that's why they're feeling that way. Whereas those people who don't feel anything may not be developing that strong of an immune response. And the other thing is for those folks who get a flu shot and then a month or two later are actually exposed to someone with the flu and they actually come down with the flu, and that's a different thing. That's where the flu shot didn't protect them fully. And what we know is that even though it may not protect people from getting the flu, particularly among our elders, it does help to reduce the severity of the flu that they get. Reduces the need for them to be hospitalized, and it does reduce mortality from the flu and from any other cause of mortality. So we know that elderly people when they get the flu shot, have a lower risk of dying from heart disease and other lung diseases as a result of having that flu shot. So there's some combined effects for how it protects you from getting the flu as bad as you would have gotten it otherwise.

All right, so back to R_0 . So R_0 basically is how many people will get the disease from you if you have the disease. And there's a wide range of values. For the seasonal flu, it's between 1.2 and 1.4. So that means that for every person who has the flu, they'll probably give it to one or one and a half people on average. So it can spread to that many people. To put it in context, measles has an R_0 of about 10. So for every case of measles, there will be 10 additional cases if they're susceptible, if they're not vaccinated. And I liken it to if you walk into a room, measles is such a virulent virus that it will be able to find anyone, pretty much, in that room who's susceptible. And we've seen that. We've seen that in our own clinics in this past year, where a person who was seen with measles in a clinic and then left, and then another patient comes into the clinic, didn't see that person, but that virus was still in the air, their granddaughter got measles. OK? It's that virulent. It hangs out in the air for a long time. And even if you don't have direct contact with that person with measles, you can get it.

Flu is not that virulent as measles, but it's still an important cause of morbidity and mortality every year. And you know, I talk about -- we're always afraid of pandemics and epidemics and things like that. Every year, there's an epidemic of flu. And we know it's going to happen. We can kind of predict when it's going to happen. If you look

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at pandemic strains of influenza, those things that cause widespread worldwide epidemics, it's more virulent. That's why it spreads so readily throughout the world. On average between 1.4 and 2.3. So thinking about the 1918 pandemic that we talked about, their R_0 was about 2.0 to 2.5. So there's certain levels of infectiousness, and that has an impact on how much coverage we need to achieve with our flu vaccine, given how effective the vaccine is. And that's the point of this slide. It's a little bit complicated. I'll try and walk through it. But on the left side, the y axis is how much vaccination coverage we need to prevent an epidemic, and on the bottom axis is the vaccine effectiveness. And these lines correspond to different levels of R_0 or the infectiousness of the virus.

Is there a pointer I wonder? Ah, here it is. I'll try not to -- there we go.

So what I've drawn here for those who are younger, the vaccine effectiveness I said is about 50%. And if you draw a line up here where it intersects with our seasonal flu R_0 , you see that we need to achieve about 40% coverage. OK? In order to have an impact on preventing widespread illness. And then for those who are 65 and older, we know that it's less effective, about 37.5% effectiveness. So we draw the line up there, and we see that we would need to achieve about 55% coverage in order to prevent widespread transmission of the flu. OK? That's for a given R_0 of, you know, similar to seasonal flu.

If you were to draw those lines further up to pandemic flu, you see that we only intersect with this. So if we were going to really have an impact on preventing a pandemic, we would need a better vaccine. And we'd need to get nearly 100% coverage. Fortunately, we don't always have a pandemic flu strain that we have to deal with.

So what I did was I took data from something called the influenza like awareness system, which many of your systems are feeding data into this system. It's a patch within RPMS that every night sends a little text file to Albuquerque that gets aggregated in Albuquerque. And every week they give us a report back about influenza like illness in our area. They used to give us site specific reports as well, but now we just get the aggregated reports for the area. It also, though, collects information on influenza vaccination rates and activity in that past week. And so I took data from the whole past flu season and tried to look and see how many people we vaccinated over the entire season, and then also what the influenza like illness was like in our area.

Influenza like illness is defined by 36 ICD9 codes. So this is the data they get. Anybody you see in your clinic, they have one of these 36 ICD9 codes, as a diagnosis for their visit, they get counted as an ILI case. So they have to have one of these ICD9 codes plus a document fever in the EHR and RPMS. And so then I also took that same data and I did some projections about what would happen if we make changes based on what we did previously. And so here's our data. And so on this axis here is time. This is August 30th. Going all the way out through pretty much the end of the flu

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season, March 28th. And I divided it up between the blue bar, the blue line which is children 6 months to 17 years, and the yellow is adults 18 and over. And you can see the -- this is the cumulative vaccination percent vaccinated.

So when we started at the end of August, nobody was vaccinated for flu. And that's what you'd expect. And we got our flu vaccine usually around the end of September, middle of September. You'll see we started to immunize. A few percent of people. And it went up slowly. And then this pink box here is the area where we were vaccinating the most people each week. And then if you look at the slope of this line, it slows down. And it tapers off and becomes almost zero. People were vaccinated the week of Christmas. And after the first of the year, there's a little uptick again, as people went back to school. Maybe there was more people who were getting sick, and people said "oh, I'm getting my flu vaccine because auntie was sick last week" or something. And so we had more people getting vaccinated. But then it went pretty much flat again. And so at the end of the year, we had about 42% vaccinated for those who are 18 and older. And almost 50% for children. And that's nowhere near the 70% that we need to achieve for the healthy people 20/20 goal.

This other line here, this purple one, is influenza like illness. So we started off with less than 1% of people having influenza like illness signs or symptoms. And then about the middle of November, you start to see this increase. And it's not just flu. There are things like RSV and other kinds of respiratory illnesses that are responsible for this. But this correlates very well with laboratory proven influenza activity as well. By the beginning of December, we had reached the true percent threshold of when we know that the epidemic is here and we're having lots of flu transmission. And then it continued to peak through the double peak here by the end of December / beginning of January. And then it came down, but not quite so fast. We still had a lot of flu transmission going out through the end of January and even into February. And what you notice then is we sort of wrapped up our flu vaccine in earnest well before the flu came to us. But we had time when we could have vaccinated more people. And protected more people. And that's what I started to key in on, in trying to come up with a plan.

This is another way of looking at it. This is the actual number of doses delivered. So when you think about from the health care system delivery viewpoint, what's the capacity of our system to vaccinate people, and so on this slide here is the number of vaccinations given each week. And this is aggregated across the whole area, not just one clinic. So at the peak of this time period, we were giving almost 2,000 -- over 2,000 vaccinations a week in our area. And we did that for about four weeks. And then look at that. At the end of October, it plummets really fast. And my question, and I would like to maybe explore this, is why our vaccination activity goes down so fast in November. You know, part of it may be that we saturated the market, if you use an economic model. That all the people who wanted the vaccine came and got one, and

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there aren't that many people clamoring to get the vaccine by the end of October. It could be that we've run out of vaccines. Some places may have run out of vaccine. But I talked with our immunization coordinators, our pharmacists, and they had plenty of vaccine. We had some sites that had 200-300 doses left over at the end of the flu season. So it's not necessarily a supply issue. Maybe it is a demand issue if people who still need to be vaccinated don't necessarily want to be vaccinated. Or we're just not reaching them with the appropriate message that "hey, flu season is about to come. It's still OK to get a flu vaccine. It will protect you if you get it now. It's not too late." Those kinds of messages. And you can see we really went down to zero in the week of Christmas and New Years. Came back up a little bit and then petered out again.

So as I thought about planning, I thought of at least three strategies. One is could we start sooner? OK, we started at the end of September. What if we start a little bit sooner? And started vaccinating people that much quicker.

The second one was, you know, do we have to accept that we taper off after October? Can we vaccinate at the same level in November as we did in October? We know our system has the capacity to deliver 2,000 vaccines a week. We could reach that many people with the number of staff we have, with the resources we have. So what's to stop us from continuing to do it at that rate in November?

The third was, and this is my least favorite, is what if we just make everyone work harder, with no rhyme or reason, no way to do that, just "hey everybody, vaccinate 25% more people each week." That's sometimes what we tell people to do. I don't like it because it's not logical. It's not taking into account the capacity of our system and that sort of thing. But that could be another option. Just work harder.

And then the fourth would be combine some of these strategies together. So the next slide shows you what it would look like if we do some of these strategies. OK? So the black dotted line is what we did last year. I already showed you. And this gold star is if we were to achieve 50% coverage by the end of November, remember I said if we can achieve 50% coverage, we have a good chance of preventing a widespread epidemic in our communities. Or decreasing community transmission. And if we could do that by Thanksgiving, when people are gathering together and you know, sharing and bringing, you know good wishes and flu bugs home, then we might have a better chance of preventing the flu. So that's what the gold star is. 50% by the end of November. And you can see that we were well below that last year.

So if we look at this red line, and we start sooner, it just shifts the curve over this way and we go faster earlier, but then we don't come anywhere close to getting the gold star. So what if we vaccinate throughout the month of November the way we did in October? And that gives us a little bit steeper line here. This green line. And it does get us higher, but it doesn't get us that high. Likewise, if we just work harder by 25%, each

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week, we get sort of the same thing. OK? We get closer, but we're not going to have an impact on flu transmission in our communities at that level of activity.

So then I said "well, what if we do more than one of these things?" So a combination of strategies. And that's what this is. Again, the dotted line here is what we did last year. And if we start sooner and sustain the maximum rate longer throughout the month of November, this purple line, we actually intersect that gold star. We get there. And not only that, we even reach the healthy people 20/20 goal of 70% coverage by February. Now, February at least will be our GPRA goal. OK? The schedule's measured in June. So we know we've met our GPRA goal if we were to do something like that. But you know, in terms of the timing, we'd really reach that 70% earlier if we want to have a big impact in our community.

So what if we sustain the maximum rate and then work harder? That's the red line here. That will do a pretty good job as well. And we'll reach the 70% goal by the end of December. That, if we have a little bit later flu season, that could have a big impact on transmission. If we did all three of those things and just work like gangbusters, we blow the doors off of this thing, and we reach our 50% coverage by the end of October instead of the end of November. And then we reach 70% by the end of December. So that would be -- that would probably have a big impact. We'd probably see a lot fewer flu cases in our communities if we could do that. And going forward, this is healthy people 2020. It's 2015 right now. We've got a few years to try and achieve something like this. These are sort of the things we need to think about going forward and might need to implement. There's a question?

Leslie Wosnig: Leslie from Suquamish. So a couple of years ago, we wanted to move our health care up earlier to the beginning of October so we could do flu vaccines sooner. But we couldn't find a reliable manufacturer who could guarantee that it would be available by that date. So you know, I think there's an issue of when the vaccine is available. Have there been any changes to make it a required available by a certain date or anything like that?

Dr. Tom Weiser: You're absolutely right. And I think -- so I also sort of put together what we call a driver diagram to try and think about both the things that make these strategies possible, and then the constraints to that strategy. And that's what's shown here. And so you hit right on the number one constraint, the starting earlier, is vaccine supply. So most of us are ordering the vaccine through the national supply service center in Oklahoma, the IHS pharmaceutical delivery body. And they get preference of pricing by tagging onto the VA, and they purchase the vaccine that the VA is contracting with these large manufacturers to deliver. Sometimes that's not necessarily the best vaccine for us, because the VA of course doesn't have any children in its system. And so we end up getting vaccines that we can give to, you know, those who are four years and older, but it doesn't cover those children. For is really the source vaccine for our

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children that's primarily not IHS, but VFC. The vaccine for children program through the state. And obviously, they are going to be delivering to us the vaccines that our children can get. But all of these are dependent on the manufacturers delivering the vaccines on time. And we're in competition. The VA's in competition with Walgreens and Wal Mart and all these other big pharmaceutical or pharmacy delivery systems to try and get the best pricing and the earliest delivery and all that stuff.

And right now, the technology for producing most of our flu vaccines is still the same old technology we've been using for many many years. It takes a long time to produce it. They identify the strains usually by the fall of the previous year that they're going to use. They begin manufacturing, so they manufacturing in the winter while we're still in the current flu season. They're producing next year's flu vaccine. And they finally get it out to us, this year they promised us between August 15th and September 15th, and most of those deliveries were made on that back end of that promise delivery date, right around September 15th. So if you don't get your flu vaccine till September 15th, it's hard to start on September 1st, vaccinating.

However, there are other things to do to prepare to vaccinate like gangbusters as soon as it arrives. And that's why I put in these primary and secondary drivers. Clinic readiness, which is setting up your schedule so that you can automatically, at the flip of a switch, open up these flu vaccine clinic slots so people can come in, you know, every 10 minutes -- you're giving a flu vaccine, people come in and pre-register for those, or you know, just have that capability built into your system so you reduce the barrier of "I can't get into clinic because there's no slot to get into." Well, you can, you know, make up those templates ahead of time and then deploy them as soon as your vaccine arrives.

Making sure that your pharmacists are trained to give vaccines if they're able to and willing to. If you want to go that way, you can vaccinate a lot more people when pharmacists are part of the vaccinating crew. And your medical assistants, your MA's. And your nurses are all comfortable and able to give vaccines.

Having all the necessary supplies. So it's not just the vaccine that you take out of the box and stick in someone's arm. You've gotta have the alcohol wipes. You have to have gloves. You have to have bandaids. All these different things that will lead to being able to deliver vaccines.

So you can preorder all those things and have those things ready, and then as soon as the vaccine arrives, you basically open the box, put in the lot number and RPMS, and go. And I was teasing the immunization coordinator. Basically, open the box, take it out and stick it in someone's arm, that fast almost, if all these other steps are in place.

And then the other part is community readiness. Because while you may have

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everything in place and be set up to do a flu clinic, if patients aren't coming because they don't know about it or they don't want it, then you have a different problem. So ahead of time, we can be talking about this in different public venues. So articles and ads that you can put in the local newspapers. Public service announcements on the radio. Discussion forums on public radio stations if you have those available to you. Things like that. If you've got Facebook pages and other kinds of things, you can get those messages out well ahead of time.

And applying these community based vaccine clinics, where you go out to the elder programs, you go out to other programs, Head Start and stuff like that, and give the vaccines there. So getting those kinds of things out really helps.

Around sustaining the period of maximum vaccination longer, so you know, getting 2,000 vaccinations a week throughout the month of November. How could we do that? It involves clinic capability, making sure that you have adequate staff, maybe having some extended hours or like I said, these extra flu clinic walk-in clinics and things like that. Making available in every part of your clinic, in dental, in diabetes education. In every part of your clinic that's touching patients, if they have the ability to give a flu vaccine or send someone over to the other part to get a vaccine.

And then again, ensuring you have all the adequate supplies in place. So again, it depends on sustained demand from patients. And it may require these additional efforts that you have to make to get that happening.

Thinking about what drives people to accept or not accept the vaccine, one of the big constraints is mistrust of vaccines. Mistrust of Indian Health Service. Mistrust of CDC. Anything that dot-gov in it can lead to people's mistrust. And you know, it wasn't until we did some focus groups a few years ago about vaccines that the lightbulb went on for me, that why wouldn't Indian people trust the government? It's not rocket science about why there would be this lack of trust around anything that comes from the government. And so we need to think about addressing people's concerns, where they're at, with accepting vaccines.

And again, negative media messages. So where there's a lot of things out there in the popular press. If we counteract that with other, you know, scientific evidence and things like that, that will give people other ideas about whether or not they should get a vaccine.

And then increasing what we do every week by 25%. You know, we'd have to really go through and take out a lot of other barriers to getting care in our clinic system. And that's a big issue, and there's a lot more bullet points on there. And that's why that's my least favorite strategy, but may be something that we need to think about.

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So there's a number of resources that are available. A couple years ago, I made this brochure, and all of our immunization coordinators have seen this. And it just talks about the different kinds of flu shots that are out there, because we had an increase in the different kinds of flu shots available a couple years ago. Made from different technologies, trivalent vs. quadrivalent, so covering four strands of flu instead of three. We had the intradermal shot, which is just a different way of delivering the vaccine. So I explained a little bit about each of those there. And it turns out that there's not necessarily one that's better than the others. And I make the point in the brochure that the best flu vaccine is the one you get! And then there's lots of things from CDC and from IHS as well that we can use. IHS has a Facebook page. You can go to the different pages on CDC and IHS websites. And more.

And so I wanted to close with just what we've been able to do with getting this plan out. So I mentioned I presented this to public health emergency preparedness conference at Quinault in June. I've been talking about it to our immunization coordinators. I was invited to present this strategy on the national immunization coordinators' call, so that other areas could maybe benefit from some of this work. I've talked with our immunization coordinators every month about this. And some of the things that they're doing, I just found out from some emails yesterday, and so Yellowhawk, they've scheduled flu clinics at various locations across the reservation. At the senior center, the governance center, here at the casino, to immunize employees. They've got posters and fliers and materials throughout the community advertising the availability of flu shots.

Up at Makah we did the drive-up flu clinic. They gave out about 100 vaccinations. They also gave about 50 vaccinations at the senior citizens' program and the health care. And next week, their nurses are going out to the school to vaccinate both children and staff. In Spokane, we've been working a lot with the Spokane clinic at Wellpinit. They did their first walk-in flu clinic ever. And they vaccinated 55 people. There was a comment from one of the nurses out at Yakima. She's a long standing nurse, 30 years of experience. She said "this is the earliest I've ever given flu vaccines in my career." So she's listened to some of these messages, and she did it, and it's happening.

One last thing and I'll shut up. Last week I had the pleasure to go out to Ft. Hall to work with them for a week on various issues. As I drove into the parking lot, there were these people waving signs and somebody gave me this beautiful bag which had like breakfast items in it. I was like "wow, thanks. This is a great way to be greeted at Ft. Hall." And around the corner in the parking lot was this activity going on. This was their drive up through clinic. The last time they did this for about 4 hours on a Saturday, they got about 35 people vaccinated. This year, just one hour more on a weekday, they did over 50 vaccinations in one hour. And they even had a bus full up. And it would be great propaganda to say -- yeah, we'll bus all the people there were really about two people on the bus. But it makes for a great picture. But they had RC staff, they had nursing

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staff out there. People were just rolling up their sleeves and getting flu vaccines.

Now because I can't not just look at one health initiative when there's vaccines, and smoking, or vaccines and safety or injury prevention, I did notice that there were a lot of opportunities to combine flu vaccinations in a drive up fashion like this with seatbelt safety and prevention. So I would argue or encourage folks to when they plan one of these flu vaccine things, think about all the other Public Health Initiatives that you've got going on, and try and do two or three or four of these things all in one shot. Because I think you'd have a lot more bang for the buck that way. And certainly it would be really helpful. So I'll stop. I think she wants me to shut up, so if you have questions I'm happy to take them if there's time.

Leslie Wosnig: I just had a question on the drive up. So are they not filling out any paperwork or anything?

Dr. Tom Weiser: No, absolutely they are. So they have a laptop out there, and people would fill out the form with their birthday. If they knew their medical record number, then they would put that in there. If they didn't, then on the laptop they could look up their medical recorder number and then they could go in and document the vaccine in the EHR. But no, they absolutely filled out all the information. They got a copy of the vaccine information sheet. So they knew what they were getting. And then they got their vaccinations. And there was even a 4-year-old who got vaccinated, and the nurse was a little bit hesitant. She was like, you know, I'm not sure about -- I want to do a 4-year-old in the back seat of a car! But this little kid scrambled over, his mom's lap, and in the driver's seat, stuck his arm out the window, didn't flinch, got his vaccine, was perfectly cooperative, and you know, was -- he got vaccinated. So again, --

Leslie Wosnig: So what if a non-eligible person pulled up?

Dr. Tom Weiser: I'm not sure whether they were doing at that vaccine clinic, but from the IHS standpoint, flu vaccination is a public health initiative, and so as far as Indian Health Service is concerned, it's OK to give a flu vaccine to ineligible people. We certainly make it available to all employees at our clinics because it's part of -- if someone lives on the reservation or is married to a Tribal member but they're not a Tribal member themselves, they are in our community and it benefits the community to protect them with flu vaccination. Now, as far as how you bill for that, get reimbursed for that, that could be a constraint and an issue. Other questions? Any other concerns or questions? I'll be around until after lunch today, too.

Tim Gilbert: Thanks again, Tom. Great information. I really appreciate that you shared your story about your mom. That was very moving. Our vaccine coordinator but just from my information as we try to keep track of how we're doing internally, what's the denominator as we're looking at the percent coverage, percent vaccinated?

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Dr. Tom Weiser: So the denominator that I used for the slides was active user population as reported in the influenza like awareness system. And so there probably are some glitches in the accuracy of, you know, who's being counted and that sort of thing. In my way of thinking, for clinical reasons, the active user population makes a lot more sense, because these are the people that we're actually seeing in our clinic as opposed to the user population that includes people who we haven't seen for a couple of years. But active user population is -- I think it's two visits in the last three years. So it's a little bit more meaningful to me, and that's why I chose to use that one. But the IAS system actually collects both, and reports the information based on both denominators.

Cheryle Kennedy: Thank you Dr. Weiser. That was a good report. I think that everybody gets the message. Start earlier. Do more. And we'll protect our communities. Just a reminder that there's the nominate the delegate of the year form in your packet. If you would go ahead and fill that out and turn it into Lisa, that would be great. And there also was the update Tribal contact list that was in your packet as well. And we'd appreciate it if you would fill those out and turn those over to -- turn them in to Lisa. I just wanted to mention the great meal that was provided by us last night, and express my appreciation to Umatilla Tribes for the dinner and for the entertainment. That was very good. I think we all enjoyed that, so thank you Umatilla.

[Applause.]

Cheryle Kennedy: For all the new delegates, there's a -- it's become a custom on Thursday for everyone to be able to dress comfortably. We know that we all get on the road after that and travel. It's in memory of one of our dear friends that left us quite a few years ago, Joe De La Cruz from the Quinault Nation. So tomorrow, you dress as you please when you come.

I just wanted to check in with the Tribes who are doing the reports next year. I know that we did not -- Coeur d'Alene wasn't here earlier, so has the representative from Coeur d'Alene showed up? No? OK.

Colville, are you ready to do your report this afternoon? OK, great. And the Coos, Lower Umpqua, and Siuslaw, are you ready with your report? All right. So with that, we'll go ahead and move on to our next agenda item, it's on Hepatitis treatment. Captain Rudd, MD, the chief medical officer, deputy director of the Portland area.

Hepatitis Treatment Presentation

Captain Rudd: Well, good morning everybody. So we're going to switch gears to another virus. So, Tom's just talked to you about influenza virus. And Joe had sent a

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request to me to do a presentation on Hepatitis C virus. What I term on this slide as the silent epidemic. Part of the reason I call it the silent epidemic is Hepatitis C isn't new, but it certainly is a new growing interest in Hepatitis C. But it's been around, impacting people for decades. But it's reaching truly what are epidemic proportions at this point within the US and for our Tribal communities.

Hepatitis, that word in itself means a disease that's characterized by inflammation of the liver. And there can be lots of causes of Hepatitis that a person can come across. So it can be different toxins, so chemicals that we can be exposed to. Heavy metals that can cause liver inflammation. Certain drugs, both prescription and non-prescription drugs that can cause this sort of thing. Some diseases that people can have that can cause liver inflammation. Something many of us are familiar with is the concept that heavy alcohol use can lead to an inflammation of the liver. And then there are different bacterial and viral infections, and the ones we're particularly concerned with from a virus standpoint are termed Hepatitis A, B, and C. So they're sort of lettered to give us a way to separate the different illnesses.

So in talking about that viral Hepatitis alphabet soup there, A, B, and C, there are definitely differences between the types of viruses that cause liver infection in that way. Hepatitis A is a virus that's spread through food-borne spread. So often this is the type of Hepatitis that can occur when you've got a restaurant worker that's sick with Hepatitis and they end up spreading it through contaminated food to other people that may have eaten at that restaurant. Or as often early in my career, we would see outbreaks associated with the nursery on the reservation, where you might have one child that had gotten sick with Hepatitis A and the workers in the nursery inadvertently spread it to other children and to other workers. It spreads through something called a fecal-oral route, something many of us don't like to talk about, but this whole concept of hand washing is a really important way of preventing spreading certain diseases, and this is one of them. With Hepatitis A, there's not a chronic carrier state for Hepatitis A. So people get sick right away with the infection when they get infected. You don't have people in the community that stay chronically infected. It usually improves without treatment, but that doesn't mean it's something that doesn't cause harm, because definitely there are some people who get Hepatitis A so severely that it can cause liver failure. And I've known a patient in my career that as a young girl ended up with liver failure and had to have a liver transplant from Hepatitis A. So it can still be a significant disease. And it's vaccine preventable. So back in the early 90's, there was a vaccine that was developed to help prevent against Hepatitis A. We started giving it within the Indian Health Service back in the early 90's. And it has dramatically decreased the impact of Hepatitis A in our communities, to the point that we often don't even see Hepatitis A any longer.

Hepatitis B is a little different. So instead of being spread through food-borne source, it's spread through exposure to blood or body fluids from somebody that's infected with

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the disease. Hepatitis B can be both an acute illness, where the person gets sick right away, but it also can become a chronic illness where the person stays chronically infected with the virus. And there are people that are carriers for it, who are infected with the virus, don't show any signs of the illness, but they can be there to spread it to other individuals. And again, this one is vaccine preventable. There was a vaccine that was developed I think it was in the 80's when the Hepatitis B vaccine came around. And there are certain people that are highly recommended to be vaccinated, such as myself as a health care worker, because we come into contact with people with their blood and their body fluid. So we get vaccinated to help protect ourselves from that.

And then the one we're focusing on today, Hepatitis C. It is spread most commonly through blood exposure. There may be some other more minor ways that it can be spread, but the vast majority is through blood exposure. Again, it can create an acute illness or a chronic illness. And this one is a little different than Hepatitis B, in that it's not so frequent that when people get suddenly infected, they actually show symptoms with it. So that acute illness, you may not even be able to tell that the person's become sick. But it's the issue of the chronic infection that really creates the problems with Hepatitis C. And unlike the other two, there is no vaccine available. So it falls into the same realm as certain other diseases like HIV that have very significant impacts in the population but we don't have the ability to produce a vaccine that helps protect against it.

So Hepatitis C is a contagious liver disease caused by the Hepatitis C virus. Spread mostly by blood, as I said. So that's through things like needles or syringes. Blood transfusions that someone may have gotten before 1992. And unregulated piercing and tattooing. So piercing and tattooing that's done in a home setting among friends or may have happened in a jail setting, because there's a lot of tattooing that can go on in prisons and jails.

When I talk about blood transfusions before 1992, the reason that's important is before 1992, we didn't have a way of really identifying Hepatitis C virus. We knew that it probably existed, but when I was in medical school in the late 80's, we talked about Hepatitis A, Hepatitis B, and something that was termed non-A, non-B Hepatitis. Because we hadn't identified the virus yet. We knew that it acted like there was one out there, but it was only in the late 80's / early 90's that we developed a test to be able to detect the virus. And that's when they could start screening the blood supply to make sure that people weren't being transfused with blood that could have been infected.

There also can be low risk situations through sexual contact, where occasionally it may be able to be spread through sex, but not near as commonly as with other viruses like Hepatitis B or HIV. The risk is increased for those who have multiple sexual partners, who may have other STD's, including particularly HIV.

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So there's sort of two states that we were talking about. Being sick right away, what we call acute Hepatitis C, and then there's people that get chronically infected with Hepatitis C. Chronic disease. So in the acute state, it's a short term illness usually, and it will occur within the first six months after exposure to the virus. In 70-80% of patients, they will not have any symptoms to tell you that they're acutely infected with Hepatitis C. So they don't look any different than any of the rest of us, often. So you can't look at them and tell they're sick. 15-25% of people who get infected with Hepatitis C will clear the infection. But what that means on the opposite side is that 75-85% of people who get infected with Hepatitis C, stay infected the rest of their lives. They don't clear.

So chronic Hepatitis C is a long term or a life long illness that people can suffer from. And the complications of that is that 60-70% of those people who have Hepatitis C virus infection develop chronic liver disease. Chronic liver inflammation related to that virus. And about 15-20% of people get it so severely that it leads to scarring of their liver, which is what we call cirrhosis. And there are a lot of different complications that occur for that person who has cirrhosis. The way it impacts their health in other ways. And it can lead to earlier death in life.

Of those patients who have cirrhosis from Hepatitis C, between 2-6% of those patients will develop liver cancer every year. So there's an annual risk for that person for their potential development of liver cancer, primarily one called hepatocellular carcinoma that they develop.

So what do we know about the statistics, about how many people in the United States have Hepatitis C? Our best statistics from 2013 say there were 29,718 cases of Hepatitis C reported that year in the United States. So it's estimated that somewhere between around 3-4 million people in the United States have chronic Hepatitis C virus infection. Truly epidemic proportions there. And at about 15,000 deaths each year from Hepatitis C occur nationally at the current rate. So that was in 2007 data.

Other populations that have been affected, the VA has really struggled with Hepatitis C among veterans. In 2014, they reported that they had 175,000 cases of Hepatitis C among the veteran population that they serve. And for data that we've been able to obtain for the Indian Health Service from looking at the data in the national data warehouse for IHS, from December of 2014, we had 25,815 patients who have positive screening tests for Hepatitis C virus among our patient population. So there's a significant number of the patients of the Indian health service that deal with this disease.

Regionally, to try to get a little snapshot, it's some data Dr. Weiser helped me pull together some data sources that I was able to draw from this map of the state of Oregon is looking at chronic Hepatitis C. So there's people that have been chronically infected, and looks at the rate of that infection by county within the state. So the darker the county in the picture there, the higher the rate of people in that county for having chronic

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Hepatitis C infection. As you can see, Jefferson county, Multnomah county, and I believe that's Malheur county off on the side there, are some of the areas with the highest prevalence of Hepatitis C in the state. All those years that I worked in Warm Springs, that's in Jefferson County. I certainly saw impacts of Hepatitis C among the population I was treating there.

This slightly different look at Washington, this is data about acute Hepatitis C, so new Hepatitis C infection rates within the state of Washington. And it's sort of done regionally. Tom helped put this slide together, and he put on here where the reservations are within the state, so can sort of see those regional rates related to their proximity to some of our patients that we serve. And you'll see that there again, the darker the area, the higher the rate. Gives you an idea of sort of regionally what's going on in the state of Washington. I didn't have any graphics like this for the state of Idaho, any data that I could really come up with that showed the impact in Idaho.

As to what to expect, and when we talk about epidemics, this is some projections that have been given nationally for the United States population about where things are going related to Hepatitis C and infection. This relates to the impacts in the infections, so these various lines on here look at either the incidence of hepatocellular carcinoma, that cancer associated with Hepatitis C virus, with decompensated cirrhosis, so those people with cirrhosis that has gotten so bad that it's truly impacting their health, or the combination of the two. And then of course that very bottom line is looking at projections about the need for liver transplants in some of these patients.

So what you're seeing is, you know, in this view here, if I can figure out the -- in this view here, here is 2015 right here. This is where we're at. Looking at the impact in decompensated cirrhosis and liver cancer over the next 15 years, there's going to be dramatic increases. It will be the early 2030's before it's predicted that we'll see the top of the peak of the impact that Hepatitis C is going to have in our populations. Where rates will be four times what we're currently seeing, is what the projection is.

Also, we've seen some disparities in the way Hepatitis C impacts various populations within the country, and as is true with certain other disease issues that really impact our communities, and American Indians and Alaska Natives, end up seeing infections with Hepatitis C virus at a higher rate than other populations. So in this graphic here, that white line at the top, that's American Indians and Alaska Natives.

Also, we've seen similar disparities in some of the data that we've been able to get from the state of Oregon, where we see that the rate of chronic Hepatitis C virus in the state of Oregon is higher among American Indian, Alaska Natives. And we see that deaths from Hepatitis C virus are more frequent among that population as well.

Who's at risk for Hepatitis C? There are definitely patients within the population we

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serve that would be considered at risk. The highest risk exists for those people who are current injection drug users. When you look at various populations that inject drugs, if you look at the population of people who are between 18 and 30 years of age, that inject drugs, about a third of that population is infected with Hepatitis C virus. And of course if they're sharing needles between each other, they don't have access to clean needles or they're in situations where needle sharing is going on, that certainly increases the risk for spread. But it's not just those current users. Also, there's an impact on past users of IV drugs, even those people that only ever used an IV drug one time in their life. They've shown among older and former IV drug users in the US that between 70-90% of them are infected with Hepatitis C virus. And this may begin as something that they did 30, 40, 50 years ago. That they've been carrying that infection chronically and not realize it.

Other people at risk are those who received blood or blood products or organs before 1992. We talked about sort of that we didn't have a way of screening the blood supply. Now the current blood supply is extremely safe, related to Hepatitis C. Currently, the risk of getting Hepatitis C from a blood transfusion nowadays is one case out of 2 million units of blood that are transfused. So the risk there is extremely small from our current blood supply, because we do have ways of screening that blood supply.

Long term dialysis patients are at risk. People who got tattoos or body piercing without using sterile instruments can be at risk. People with known exposures like health care workers who've come into contact with blood are at risk for needle sticks. HIV infected persons and children that are born to mothers who are infected with Hepatitis C. The risk there, among those infants when you know the mother has Hepatitis C is about 6% of the infants born to those mothers will be infected.

Less common risk is seen with sexual contact of persons infected with Hepatitis C, or those who share personal care items, such as razors or toothbrushes in the home.

Female speaker: In that category of personal care items, would you also include jewelry that enters piercings, such as nose rings, earrings, eyebrow piercing?

Captain Rudd: You know, I haven't ever seen any data on that. Most piercings are well healed over. There's a layer of skin there. So unless there was some trauma, you know I've known some girls who let -- or men, I guess could be to, but who have let a piercing partially grow over or it stays chronically enflamed. So in those situations, putting a ring into that piercing certainly could create some blood exposure through that. But in general, that would probably be fairly low risk for people who have a well-established, well healed over piercing.

So Hepatitis C symptoms. Acute Hepatitis. What does it look like when the person has symptoms? They can have fever, fatigue; feeling tired all the time, loss of appetite,

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nausea, vomiting, abdominal pain, darkly colored urine, clay colored bowel movements is a symptom. A very frequent symptom can be joint pain. So one of the things that rheumatology specialists, those doctors who specialize in arthritis, will do when they see patients who are complaining of chronic joint pains, is do a Hepatitis C test to see if that could be the source of it. And then of course that classic symptom of jaundice, that yellow appearance to the skin or to the eyes that people with liver disease can have.

Now I put a picture in here. Some of you may recognize Naomi Judd. Naomi Judd was part of a mother/daughter duo in the late 80's / early 90's, the Judd's, that were probably one of the biggest country music groups of the time. And her fans were really shocked in the early 90's when she retired and broke up that country music duo. The reason she retired is she had become infected with Hepatitis C virus and was dealing with chronic Hepatitis. She's not the only famous person out there, as you might imagine. There's a number of rock and roll superstars that are Hepatitis C infected and have been dealing with the disease. People like Steve Tyler, that have come out publicly about their infection. Other folks like Jim Neighbors. Gomer Pyle fans of the day. He's dealt with Hepatitis C. So it impacts a lot of people in the population. And part of the reason I put Naomi's picture in here is she was probably infected at the time this picture was taken, but you can't look at that picture and say "this is somebody that's sick with a chronic viral infection." And that's one of the difficulties here, is there are people in your community that have no idea that they're infected and don't look it. You can't look at them and know that.

So, screening becomes really an important part of helping people to understand that they may have this disease. There is a blood test that can be done to screen for antibodies against Hepatitis C virus, and that's the test that we primarily use for screening in the population. It's recommended that people who are at high risk, so we talk about those people being high risk for Hepatitis C, that those people be screened. It's also recommended that anybody in the United States that was born between 1945 and 1965 get screened. That's what we often call the Baby Boomer population. Why do we screen that group? Well, it turns out that that population of people in the US are five times more likely to be infected with Hepatitis C virus than the rest of the population. In fact, three out of four people with Hepatitis C virus infection are in this age group. So there's been a concerted effort over the past couple years to provide screening for that Baby Boomer population, and many of your clinics have started looking at doing that, or have been actively engaged in that.

A positive antibody test only tells you if the person has ever been infected with Hepatitis C virus. So any that are positive, you want to follow up with a test that tests for the viral genes in the person's body, and that tells you if the person is still infected. So that lets you know who's part of that 75-85% of your population that will be chronically infected.

Why do we screen for Hepatitis C? One, it allows us to counsel patients on how to

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prevent spreading the disease. Two, it allows us to vaccinate them against other viral Hepatitis, Hepatitis A and B, because if they were to get those infections on top of their Hepatitis C, it only makes things a lot worse for them. It lets us counsel them on avoiding alcohol and how important it is for them not to be using other substances, alcohol or certain drugs, prescription pills, supplements, over the counter medicines, that could cause further liver damage. It helps us monitor that patient for chronic Hepatitis and cirrhosis and the development of complications associated with those and liver cancer. And it helps us identify patients that would benefit from treatment for their viral infection.

So when we go into talking about treatment, there are two sort of important concepts to talk about a little bit that do impact treatment and what's provided. One is the idea of this term called sustained virologic response, SVR, which is a marker for people who have been cured of their Hepatitis C infection. What that term means, that SVR means that this is a person where we have not been able to detect the virus in their blood at 24 weeks after their therapy. They can go that long and we can't detect the virus, we consider that to be a cure. The other concept is genotype. So we talked about there's different types of viruses that cause Hepatitis. Hepatitis A, B, and C. Well among Hepatitis C, there's different strains of Hepatitis C that a person can be infected with. In fact, we know about six strains that circulate within the population. Three of which are most important in the United States related to Hepatitis C.

Genotype 1 is the most common. It infects somewhere around 70% of the population that have Hepatitis C have genotype 1. And there are actually subtypes of that. So there's even little variations among some types of 1. Genotype 2 and 3 are important because they respond better to treatment. Genotype 1 is harder to treat. They don't respond as well to the medications. But 2 and 3 respond quite well. So antiviral medications, medications that would kill the virus for Hepatitis C have been available since the 1990's. Recently, there's been a rapid increase in newer drugs that can treat the disease. So these drugs have been around since the 1990's, someone might ask, well why haven't we been treating more patients for their Hepatitis C infection? Well, let's talk about that a little bit, about what things looked like in the 1990's related to how we could treat it. The combination of drugs that we had at the time were two drugs named interferon and ribavirin. To treat a person with these drugs for Hepatitis C, you had to treat them for anywhere from 24 to 48 weeks. So anywhere from half a year to a year, almost, to get them through a course of therapy. It involved a weekly injection of interferon for that time period, where they'd come into the clinic and get a shot of the – of interferon, along with taking a pill a couple of times a day for this long period of time. And the side effects from these medications were really difficult for a lot of patients to deal with.

80% of patients on this combination would have flu-like symptoms. Can you imagine a flu that went on for 6 months to a year? And having to put up with daily fever,

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headache, body aches? Also, depression and irritability were seen in about 40% of patients. In fact, people who had underlying uncontrolled depression weren't considered to be candidates for this drug therapy at all because it was known that it could worsen their depression problems. There are other problems like low blood counts and inflammation of their thyroid and about 10-14% of patients just couldn't tolerate the therapy at all.

So here's a regimen that goes on for a long period of time, has a lot of side effects that are hard for patients to tolerate, and then when you talk about how effective it is, how much of a cure did you get – with genotype 1, only about 45-60% of the patients had that sustained virologic response. Genotype 2 and 3, 75-80%. And then there was the cost. A 24 week course of therapy cost around \$12,000. A 48 week cost around \$24,000. So can you imagine spending \$24,000 on a patient who felt really terrible for 6 months to a year, and only have a 50% chance that it was actually going to cure the disease you were trying to treat? So we had – definitely we had treatments available, but they weren't good treatment choices. And there were a lot of patients where it really wasn't going to work well for them. But now let's fast forward to 2015. In the last several years, we've had multiple new drug regimens that have come out on the market for treating Hepatitis C virus infections. I'm not going to begin to try to pronounce those, because those really twist your tongue up, trying to pronounce the name of the drugs. The important part is that these drug regimens usually last only 12 weeks to be able to get a cure. So much shorter period of time. They involve only taking one pill a day. And it's a pill that's not having to come in for shots. They're very well tolerated in general. The side effects of these drugs have been extremely few. So patients are able to take them better. They're also very effective. That's the same virologic response that's greater than 90% for these drug regimens, and some of the regimens it approaches almost 100%. That you can pretty well be guaranteed that the patients you're treating are going to actually get cured.

Now, the cost still remains an issue. The cost of therapy for that 12 week course of therapy is between 38 to \$91,000. And that's Indian Health Service pricing. That's not what the private sector is paying, where they're paying a much higher price to have access to those drugs.

So who should be treated? Well, curing Hepatitis C virus has been shown that it definitely improves the survival of the patient. It reduces those complications that the patient can experience. And it gives them a higher quality of life by going through treatment for the disease. The safety and the efficacy of the new regimens really create a benefit for all patients with Hepatitis C infection, who at least have a reasonable life expectancy. So the model doesn't prove out that those that are having other diseases that are going to cause them to die within the next year, that it probably doesn't benefit them to go through a course of therapy. But for those who are expected to live more than a year, there's benefit. But then there's that cost issue. So I told you that we've

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estimated there's about 29,000 known patients in IHS that have Hepatitis C virus infection. It would cost us, to provide them with the drug harvoni for 12 weeks of therapy would cost our agency \$1.1 billion. Just for the drug. So that doesn't include the lab testing they'd need or their visits to the doctor or ultrasounds or other tests that might come up as part of the therapy. Just the drug cost alone would be \$1.1 billion.

So with limited resources, the recommendations are that we should prioritize who we treat. And we want to try to treat those that are really at highest risk for going on to cirrhosis, cancer, or death. So among that include those patients who have advanced fibrosis, that are showing scarring of the liver developing for them in advanced stage. Those that may have received a liver transplant related to Hepatitis C infection. Those who have severe manifestations of the disease other than just the liver. So maybe suffering from chronic edema. Maybe suffering from fluid building up in the abdomen. Putting a strain on their heart. Causing heart failure and things. Those would be high priority patients. And then those who are really high risk for fibrosis progression are those who may be co-infected with HIV, patients who have diabetes and Hepatitis C, or those who have other types of liver disease on top of their Hepatitis C.

Denise Walker: I have a question.

Captain Rudd: Yes?

Denise Walker: So for the patients who are newly diagnosed with their healthy, young liver, your recommendation is to just do nothing till years down the road when they're symptomatic, and would they then possibly spread it to a partner?

Captain Rudd: So the recommendation is not necessarily to do nothing. Because we talked about counseling. We talked about vaccinating them. We talked about counseling them about avoiding alcohol and other drugs. There's many things you can do when you identify them. If resources are not a limit, then there's benefit to even treating those newly treated. But resources do become a limit as to what we can do. So with our available resources, the recommendation is to focus that on the people who are greatest risk for dying from their infection as opposed to those who are newly infected. If money weren't an issue, we'd treat everybody. But unfortunately it becomes an issue. And of course you want to advise them, don't use IV drugs. If you do, don't share needles. Don't -- you know, don't share your toothbrush and your razor blade with people in your household. And as I said, the sexual -- risk for sexual spread is pretty low. There have been long term couples, monogamous couples where one was infected with Hepatitis C, and the other remained virus free for long periods of time. So it appears to be these other situations of multiple sexual partners and other STD's that can increase that risk of sexual spread. So that still remains low. It's not a perfect answer. Because if we could treat everybody, I'd treat everybody.

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Cheryl Sanders: Dr. Rudd?

Captain Rudd: Yeah?

Cheryl Sanders: How do we communicate that to our communities? When you know, we're really just starting to really take a look at all this information and, you know, the expense is going to be huge to the Tribes. Kind of where Denise was going, our youngest -- I don't know what the data is right now in our community, but I would imagine it's our younger people, as she's saying. So you know, prevention is the key. But you know, how do we communicate that as Tribal leaders or community members?

Captain Rudd: Well, we'll talk a bit about how do you pay for it. We're going to get to that in just a bit. Because --

Cheryl Sanders: But that one slide that you showed, so the \$1.1 billion is for --

Captain Rudd: If we took the population that's been identified in IHS that we know is infected, well, December 2014 data, that's how much it would cost to treat that group of people if we treated all of them.

Cheryl Sanders: All the people?

Captain Rudd: Yeah. Right. So risk stratification. So if we're going to recommend sort of identifying people at risk, you know, how do we stratify? Will we stratify based on the level of fibrosis? The measure of scarring that the person has in their liver? The gold standard, what we've sort of done for quite a long time, particularly like in the 90's to determine those people that may benefit, was to do a liver biopsy. Well, liver biopsy isn't the most practical test as we get more and more people identified with the infection. Because there's only a certain number of doctors out there that can do it. So there's limited availability of the test. There's a cost to it, because it usually involves going into, you know -- have this, see a specialist, have the test done. And there's a risk to it. They're taking a needle from outside the body, pushing it through into the liver and withdrawing it to have taken out some of the liver cells and be able to look at that under a microscope. As you can imagine, this is a person who already may have some liver disease. Many of you know that people with liver disease don't clot their blood so well. So here we're sticking a needle into their liver from outside the body, you can have bleeding complications. Of course, that's pretty close to where the lungs are, so if you got a little too high with it, you could cause them to get air inside of the chest outside the lung, what we called a pneumothorax. So there's risk, definitely, to liver biopsy.

So in more recent years, we've been able to use something that becomes a good substitute for the liver biopsy, which is to use a calculation based on certain commonly available blood tests to help us approximate the amount of fibrosis that a patient may

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have. There's two of the more common calculations. One is called APRI, the other's called fib-4. And these use blood tests that -- almost all of us, that provide lab services in our clinic, would actually be doing the testing that would be needed to calculate these scores. To help with that, Jessica Leston and Briggs Riley who work for Indian Health Service, Jessica Leston works particularly with the health Board on issues of viral and STD infections. They have developed a process for being able to export data out of I-care on patients with Hepatitis C infection, and then put that into an Excel spreadsheet tool that then automatically will calculate these APRI and fib-4 scores. And by having that sort of process, it helps you identify who in your patient population is at greatest risk related to fibrosis and would be the ones most important to look at for potentially treating. So it helps you identify who those folks are.

Paying for treatment. That becomes a big issue. CMS and some third party insurance payers will pay for antiviral therapy for Hepatitis C infection. Why would they do this, when it costs so very much? Well, keep in mind that a liver transplant costs about \$300,000 for the transplant itself, and then about \$25,000 each year for the anti-rejection drugs for that patient for the rest of their life. So allowing these people to progress on to the level of needing a transplant certainly isn't economical for these payers.

And then cirrhosis. Even if they don't get bad enough to need a liver transplant, but they're dealing with the impact of cirrhosis, and admission in Oregon for cirrhosis costs about \$25,000 per admission to the hospital. And of course, these folks don't just go to the hospital once. They're frequently in and out of the hospital several times a year when they're getting into decompensating cirrhosis. So there's definitely costs to not treating as well.

So certainly some payers are looking at it. But these various payers do have different eligibility criteria for which patients they will pay for, and that does end up still limiting access to the number of patients that can be treated underneath these programs. And every state is different with their Medicaid program as to what their criteria may be in their state for being eligible for that sort of care. An avenue that's been really important to our patients has been use of something called patient assistance programs. So these are drug company sponsored programs that provide free medication to certain patients. Patients must meet low income eligibility. So there's some paperwork involved in applying to the company's program for that patient, that includes providing some of their financial data about their tax returns and things like that, to show that they would not otherwise be able to afford these drugs.

But as an agency, in talking to Briggs Riley and Jessica, what we know about different programs that are utilizing this approach, is we haven't heard any stories of any of our patients being turned down for patient assistance programs at this point. So it is a way to provide access without costing the clinic or their pharmacy budget, or their PRC

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budget, to provide medications to patients. But it does involve having somebody that can work with the patients to complete the paperwork and submit it, because a lot of times these forms are a bit more complicated than many of our patients really would be able to do on their own. So it's worth the time to have people identified in your clinic to help with that.

Another important part of this, and really critical there, is not having the drugs on our local formulary. So not naming them to the drugs that we carry in our clinics. In fact, as chair of the national PNT committee, I was asked to write a letter to Giliad, that's a drug company that makes some of these drugs, to tell them that we have not added these drugs to our national core formulary. And it was important for Giliad to have that letter, for them to continue to make these drugs available through patient assistance programs, to our patients in Indian Country. Had we put this on our formulary, Giliad would likely start across the Board denying patient assistance programs for our patients to utilize.

Mandated treatment. So, earlier this year, back in February, the VA announced that they were going to be providing treatment to all patients in the VA system that had that Hepatitis C virus infection. They set aside \$700 million for drug cost as they implemented the program, and by June they had completely depleted that fund. So in June, after June, they had to take a step back. And now they are actually prioritizing treatment. And they're using outside resources and other things to try to continue to address the problem within that VA service population. So mandates for treatment can occur as political pressures come up from different groups that would be addressed, and that these populations need treatment. And just as it happened for the VA, there are some calls going out about Indian Health Service and what we're doing to try to provide treatment to patients. So currently, in the last month, I've seen an early draft of an IHS policy that would address Hepatitis C infection and treatment within the agency, and how we're providing care for that within Indian Country.

So support for treatment. You know, previously, if you go back to the 90's, most of the patients who had Hepatitis C who were getting treatment were usually under the care of some sort of specialist to get that treatment. So they were either seeing a hepatologist, so a liver specialist or they were seeing an infectious disease doctor who specialized in these sort of infections. With the safety of the new treatments and the growing number of patients, that care is now shifting more into the primary care setting. Out of necessity. Because there's just not enough of these specialists to see all the patients that may potentially need treatment. And truly, with the safety, it's something that primary care physicians should be able to manage on their own. But a lot of these docs never got education on this when they were coming through training, because it was either before these drugs were available, before Hepatitis C -- like I said, when I was in medical school in the 80's, we didn't even have a name for Hepatitis C yet. So we didn't learn a lot about treatment back in those days. I've learned through my career. But a lot of your doctors may not have had experience with treating Hepatitis C, so may need

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support as they gain that experience, and be ready to provide that.

So one of the ways of providing that support is through a program that was developed initially through the University of New Mexico, that's called Extension for Community Health Care Outcomes, or project ECHO. So UNM developed this initially, but it's been replicated by other programs throughout the country. Here in the Northwest, are a couple of main options. One is through the University of Washington that conducts a project ECHO program, although the University of Washington's part of that 2:58:42.0 [INAUDIBLE] district, they have been gracious enough to allow some of our Indian health science down in Oregon to also participate in their project ECHO, so I know Warm Springs and Klamath have made use of participating in project ECHO that way. Also, IHS a couple of years ago started their own project ECHO together with UNM. It's now the first Wednesday of the month between 12 and 1 mountain time. So what does project ECHO involve? What it involves is people participating in video conferencing as a group, with a group of specialists that includes hepatologists, infectious disease experts, behavioral health people because often people with Hepatitis C may have other issues like alcohol abuse that need to be addressed. But they meet in video conferences on a regular basis, usually at least once a month. As part of that video conference, some education is done for the group about some aspect of treating patients for Hepatitis C. And then people on the call do case presentations about people in their clinic that they're trying to provide care for. And they have this group of specialists that they're able to give them advice about how approach their patient. And for the other people on the call, they get to learn by listening over time to how the specialists are recommending treatment be done, so that they can apply the same sort of ideas to their patients that they're treating as well.

So project ECHO can be a good way to develop that capacity within your clinic for your providers to be able to deliver this sort of care.

So what are the recommendations? Screen your patients for Hepatitis C infection, particularly those who are at high risk or that Baby Boomer population. If the person tests positive on the screening test, then do that confirmatory test to find out the people who are still infected. Then educate all of those Hepatitis C positive patients on how to protect their liver, how to prevent the spread of the disease, and offer them vaccination against Hepatitis A and Hepatitis B. Create a panel of your Hepatitis C patients, and then risk stratify that group of people so you can identify those people who are at highest risk of going on to cirrhosis and other complications. And then use a multi-pronged approach to how you might provide treatment. Be it whether the patient has resources like CMS or a third party that you can access, or be it patient assistance programs where you may need to provide support through your clinic to help patients get access to those programs. And then utilize ECHO support for your medical staff, to help them gain that experience to be able to provide this. It's been my goal over this fiscal year, FY2016, to work with our six federal programs to be sure that every one of

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those programs is able to at least get one patient through treatment, to a sustained virologic response. And I feel like if we can break the ice with that one patient, we'll start to develop some confidence about providing this to more and more patients with time.

So I have that goal to get there. We do have some programs that have already done that. But we haven't had all six of our programs do that. So I'm working with them currently to sort of push that agenda along so that they start to provide this really necessary treatment for this epidemic that's not quite so silent anymore.

Cheryle Kennedy: Thank you for your presentation. More of a comment than a question. I appreciate your information. But I think that we're going to see such a rise in this with the recent drug use, especially in our young people, and when all of the dust settles from that, they're going to have all these health problems, and Hep-C's going to be a big one. So I hope we can prepare and teach our providers how to look for that.

Captain Rudd: Yeah. You know, we're all hearing about like the rise of heroin within the US in general, and of course that goes back to IV drug use. That's the way heroin's usually used by patients. And so it does, it worries me related to that. And that young population is at risk. You know, I've seen within my own practice the impacts of Hepatitis C. When you -- I did a study looking at a group of patients who had died from cirrhosis. And those who were alcoholic and had died from cirrhosis in this population of patients I was looking at, their average age of death was around 60. But if they had both alcohol and Hepatitis C, their average age of death was around 40. A 20-year difference in how long these people were living. And in some of the last few years I was working in Warm Springs, I noted and I talked to other reservations who have seen similar issues, about the number of their population that were in their 20's, dying from cirrhosis. A disease that used to be something that impacted people in their 60's, that's now impacting them at such a young age. When they've only lived a quarter or half of a life.

MALE SPEAKER: Thank you for your presentation. This doesn't have to do with Hepatitis, but I just wanted to know -- does IHS provide any vaccinations for identified individuals for other preventative measures for like pneumonia, shingles, and that type of thing?

Captain Rudd: Yeah. So far, federal sites, the national core formulary for Indian Health includes that all of the CBC recommended vaccines should be available through our federal clinics. Of course, Tribal and urban sites, they have autonomy to decide what they're going to provide. We certainly encourage them towards that. But for our federal locations, and that does include things like pneumococcal vaccine for seniors and zoster vaccine for seniors as part of that. So we do maintain that we feel like that's an important standard of quality care that we keep in line with the CBC

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recommendations on that.

Cheryle Kennedy: Dr. Rudd, thank you for your informative presentation. I think you've sparked a lot of interest, and will you be here the rest of the day?

Captain Rudd: You know, I'm heading off to get back to central Oregon here in a little bit, but I am always available by phone and email and things like that, and happy to answer any questions that I can.

Cheryle Kennedy: Thank you. We're adjusting the schedule for you to return at 1:30 to start our next half of the session. Have a great lunch.

LUNCH

Andy Joseph, JR: We'll see what we do at our meetings. Hopefully, we'll have a great host when that time comes. I'd be Omak Stampede week

Colleen Clawston: So good afternoon everyone. I'm going to introduce us. So we have a very unique health system at Colville, because we have 12 Tribes make up our Tribe. We have three language families there. Historically, our Tribes came from Northeast Oregon all the way extending up into the north central British Columbia. So we have a large area. So for our health services, we have a very diverse system. Because we have one of the only long term care operating health facilities in the country. We have four clinic operations. Two are direct service and two are Community Health Centers. And then we have the public health passes. So the presenters that are going to be presenting today are Dr. Alison Ball. She'll be covering the public health side of the house. Ali Desautel is my counterpart for the two Tribal operating clinics, and then myself. So just again, our health services are comprised of the three entities, the cultural, the health and Family Services. The Colville Service Unit. And the Lake Roosevelt Health Committee Centers. We have 1.4 million acres. We cross two of the largest forest counties of the state of Washington. And you can see the lines here. Those are our four political districts. And both Nancy and Andy are elected from the Nesplem district. And we're in north central Washington State. And it's my pleasure to introduce Alison Ball.

Alison Ball: Thank you Colleen. Alison Ball. I've been at the Tribal -- with the Colville Tribe the last almost three years. I came from the University of Oregon, so I have to say "go Ducks!" Can you imagine being in Cougar and Huskey country? We could have some Ducks up there.

One of the things when I first came on, working with the Caldwell Tribal health system, is that we have a lot of buildings that were kind of located all over the campus, and some of them were just kind of all over. What's really been fortunate is this past year

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we've been able to build a Governance Center that also helps our Tribal health programs in a real nice way. So this is the first time we had this opportunity for our Tribal health system to come together and house together. So because we've been all scattered out, one of the things is we were organized through our budget process. And sometimes that's not the most efficient and effective way to operate, but that's how we've been operating because that was our system. So since then, what I've been doing is kind of creating leadership, using kind of transformational leadership where we can create a little bit more efficiency, you know, to let some of the programs grow and kind of bring them together. That's been a really challenge -- I think in Indian Country, programs can change a little bit before they come together. But actually it's doing very well.

The other thing we've been focusing on is building capacity within the Tribal Health Services. We've been collaborating, kind of everybody collecting genius because we have a lot of good people within the Tribal health system.

Oops, backwards.

Thank you. One of the things that we're trying to do is really establish a little bit more productivity with kind of our programs, bringing them together. And one of the things is we're starting to endorse the action strategies. And that's to be able to set goals within the programs, but a System of care, one system of care. And that's been kind of a real slow process to get everybody on Board. But by the time we really have our goals set, you know, we're going to be operating as one unit and one kind of health system of care. And I really look forward to that as we continue to do that kind of work. One of the things that we're doing as well, is what we want to do is build cultural integrity into the Tribal health service programs. To do that, we've been looking at this model that was from the Tonka Tribe. It was developing a competent Tonka. But we want to take that model and look at it and start looking at it as developing a competent Colville. And the way to do that is we want to help prepare our members to be Tribal citizens. And so what we're doing is we're going to take our behavioral health program and really, that's our end goal, is to be able to build competencies within the members, within the clients that come to our office. And what we have to think about is what competencies are needed to develop a competent Colville as it relates to behavioral health. As it relates within our community health system.

So that's something that we've been working on developing. And the first step that we've been doing is we've been working with Dr. Calvin White who's Dine' and he has a program where you can actually bring in the western psychologies and integrate the indigenous knowledge into that psychology, and to be able to work with -- whether people want to work the western model, or if they want to work the indigenous model, we'll be able to incorporate it. What he's doing with us, is he's trying to create a language for us, you know, to develop a language that integrates these philosophies

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together, and yet we can get paid for those. And that's really important. I think one of the things is we've never really validated our indigenous way of life. And so this is something that Dr. White will be working with us in the next year or two years.

And it would be like the language that we'd be looking at is, you know, when we talk about -- in mental health, we talk about DBT. We talk about emotional rational therapy. We talk about behavioral therapy. And what we'll want to do, is we'll want to start looking at like cultural psychosocial processes to therapy. So it's being able to talk like that and actually get paid, you know, to get reimbursement without getting into too much trouble with CMS.

And so a lot of both our alcohol and drug and chemical dependence specialists, they actually go through a lot of training in this area.

The other really big thing that we're doing is, to build capacity; we're working with Empire Health Foundation. They come in we they looked to work with the Tribe. They want to work with the Tribe in the Spokane region. And so they came in and they did a presentation. And they -- wasn't quite sure how they could actually -- you know, how could we utilize our resources? So one of the things we did was we invited them in and said "we really need to develop our system of care. So we need to help operational planning." So they're working with me to be able to develop this. And once we get this developed, we'll go ahead and introduce it to our Tribal Council Leaders and then get it endorsed by them.

The other really important thing that we're doing is we also have a Native American Research Center for health project that was funded by National Institute of Health. And one of our Tribal members, Nancy Johnson, is on the Tribal consultation. They're going back to DC and talking about research. You know, NIH has billions of dollars that really go untapped by Tribes. And this is a real good area. I think, you know, that really we could start really developing a niche for Tribal research. So with these large projects, NARCH project about them, I think about they've funded about eight or nine cycles of these large projects, and it's to help Tribes build their infrastructure. Infrastructure, they're building their research capacity, and then while doing small and medium projects. So we have a funded large project. And one of the exciting things for our large project, they call it Casa Rensum [??] which is House of Good Medicine. And what we're doing is we're collecting our own data. I know that, you know, if you don't control your own data sometimes, you don't control your own information. So this is the aid that we want to do with Caldwell, is to go and start collecting our data from our programs and putting them into the system and running them and then using that data for kind of a threefold purpose. One is for program improvement. Two is for grant writers, and three are for Tribal leaders to be able to go and help legislate for certain issues that we have.

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The other thing is we have a Health Data System. The GIS system. We're trying to map some of our chronic illnesses and so we're working with several different programs with the GIS system. They look at adverse into the system. And then be able to map certain chronic illnesses like diabetes, heart and lung disease, those kind of issues, and look to see that there's any kind of environmental factors or they kind of map and see what's happening on the reservation. That way they'd be able to maybe target those areas a little bit better and create a bit better health care system. So that's really something that we're really doing within the Tribal health care system that we're real excited about. And hopefully we'll be able to come back maybe in a year or two and really show you what our system looks like and how it's really helped us improve our health care system.

My next presenter is Ali Desautel, who's been -- she's a CEO at Lake Roosevelt Community Centers.

Ali Desautel: Thank you. So I wanted to talk to you a little bit about the clinics here and how we are funded, which may be interesting to some of you. Some of our partnerships, the services that we provide and what we're forecasting for our future.

Move it down one slide because we thought we were going to have to slip through these quickly.

So I'll talk a little bit first about our funding. Of course, we have a 638 contract like most of you, which you're very familiar with. So I'll move on to -- we are a 330 grantee through HRSA, which allows us to be a community health center. And that allows us to serve our communities as a whole, Native and non-Native. It has been very beneficial to our communities, and it provides us the ability to add on more providers, more services, so that our Tribal communities can have more services, more of I guess about more services, basically, than we would normally have. And our funding from HRSA right now is about equal to the funding that we get from our 638. And like I said, it allows us to serve our communities as a whole. When we first went to Community Health Centers, we used to be called Colville Nation Community Health Centers. But our health Board -- being a community health center, we have a Board of ten community members. And they didn't feel like the community as a whole still understood that we were a community health center and they could still come into our community. So they changed it to Lake Roosevelt. But I would recommend that many of you look into the HRSA funding. Because it is very beneficial. And right now, the way they're giving out their granting is they're doing it by -- well, of course you have to apply for your new access points, but after that point, basically they're doing on your user population. And they have a formula that they've developed, and they kind of give you an amount, and you tell them what you want to do with the funding, and it's basically your amount to do with what you want. And so they're kind of just giving you money, specifically for you. So if you're looking at serving your communities as a

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whole, I would recommend really looking into HRSA.

We also of course do third party, and with Affordable Care Act we've increased our third party billing 23%. Earlier they were talking -- Jim was talking about the VA Tribal agreements, and we have that also. So we are able to bill the VA for direct services onsite at Lake Roosevelt. We are also working with the Veterans Choice, trying to get Veterans Choice so we can serve non-Tribal members also with the VA.

Some partnerships that we have, of course with the Colville Service Unit, and then Tribal health department. We work closely. We also work with Providence in their electronic health records. We're a part of EPIC. We have RPMS ourselves, but we connected our providers to their EPIC system. So if we send somebody to the ER, we're able to track those patients through their EPIC system and see how they're doing when they get discharged and things like that. So that's very useful for our providers.

We also contract with them for the mammogram van. And the Susan G Komen grant, we get that. In the last two years, we have had no women with breast cancer diagnosed in our -- with our Community Health Centers. And Ferry County had the highest mortality rate in Washington State a few years ago. And so that's a big deal for us.

We also partner with New Alliance. They do our behavioral health. And our local medical centers. The VA of course. Our schools. We do telemedicine onsite. At our clinics also. We have telemedicine at both facilities. I'm a member of the Washington Association of Community and Migrant Health Centers. So we work a lot with them. And we do some work with the Colville Housing units authority, things like that too.

Some services, of course we have Medical, Dental. HRSA has allowed us to do things like optometry. We have pharmacy. Our third party pays for podiatry. We also do podiatry. With the collaboration we have with Colleen's group we're able to bring cardiology onsite. We have lab and X-ray and do well child. We have OBGYN. We have referrals onsite, telemedicine as I mentioned. We have a hygienist. We get outreach and enrollment through HRSA. We have certified billers and coders. We have Clinical Application Coordinators, which are CACs through IT program.

And for the future of Lake Roosevelt, currently we are in a medical expansion right now. And we're working with our local medical facilities. We're extending our labs. In our Keller facility, it is very remote and so we have to bring labs out and then to another place to go to panel. And so we're working to try to eliminate that. As I mentioned, we're working on non-Tribal members VA with Veterans Choice. We're also looking at naturopath. I don't know if any of you have looked at naturopath. It's about the closest I think we're going to get to natural traditional medicine at this time and be paid for. I hope one day it changes, but right now it's not. And naturopaths, with naturopaths, you

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can get your counter rate. I don't know if any of you know that or not. But you can. So we are looking at naturopaths.

Also, we're expanding, looking at expanding optometry into our health facility. As I mentioned, Keller is a little more remote and smaller, so we're expanding. We're also with our HRSA grant; we're able to add another pharmacist this year. And between our Keller pharmacy, we do telepharmacy also. It's a little more remote. So we'll have two pharmacists onsite. And we are looking at professional housing. And within the last week, we're looking at adding physical therapy. So we've got a lot of things going on at Lake Roosevelt.

So with that, I will introduce Colleen again. And Dean and I talked a little bit about the collaboration that we do on -- between Lake Roosevelt and Colville Service Unit with the fires that we had. And Nespelem was extremely affected, and Colleen had to close at some point. And she called me and said "is there any way we could relocate into the Kewa facility," which is kind of between Inchelium and Nespelem. And I said sure. Let's figure that out. And so we did, with a collaboration between the two. And so this is kind of -- we've been trying to brand. Something on our reservation. So if you see this logo, this look across our reservation, you know it has to do with health care. And so we're trying to brand that across. And so this is just one of, an example of something we put out at that time. And so with that, I will introduce Colleen back to you. So thank you very much.

Colleen Clawston: Thanks Ali. So I'm going to borrow something from my mom. She used to always really like the Simpson's. And how many remember Grandpa Simpson doing this? "Hello world! Are you out there?" OK. I just needed to make sure you're still awake its after lunch.

So for those that don't know me, I am Colleen Clawston and I am a member of the Colville Tribe. And I started my first career at Colville. Had a lot of positions. And then at Colville, having served on our Business Council. When I left Colville, I went and worked for the state of Washington for 12 years with the Office of Indian Policy and Support Services, and then we changed it to Office of Indian Policy. And then actually it was a year ago today that I got the offer to go home. And go home to become the CEO for the Colville Service Unit. And I still remember because Carol goes -- my colleague from Warm Springs was in the interview, and they said "well, why do you want to come home, you know and work here?" I was like "well hello, I'm from Colville" at this little person about this big. So we have a granddaughter, and I'm very blessed to have her, and actually she gets to live right next door to me. But going home, we really did look, Ali -- Alison and I, about how can we build this spectrum of health care at Colville because we do have a lot of unique nuances like I mentioned at the beginning.

So for the Colville Service Unit, and as you saw in Dean's presentations, there's four

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elements that continually we work on within Indian health on the furtherance and enhancement and development arm. And so with the renewing and strengthening of our partnership with the Tribes and with the urban Indian organizations, some of the things that we have been doing is really the biggest one is in health leadership. Ali -- Alison and I attempt -- and we all know what that's like, to attempt to always have a regular routine meeting, but when we have issues that come up, just like when we did have the fire and I was able to reach out to Ali and say "hey, how can we work through this situation?" That's one of the real big strengths that we have, is that the three of us do work in collaboration, identify what the situation is, and set aside any of our roles and say "how do we get to yes?" And for those of you that have worked with me in the last 12 years, you knew that that was my mantra. Get us to yes. Make sure that we can make it happen.

The other thing that we really do look at and listen to is, you know, a policy development or situation that happens, you know, looking at all facets. Is it going to impact the Service Unit differently than it impact Lake Roosevelt Health Center? Or the public health side of the house? And then presenting the information to the business council so that they can make an informed decision.

The other thing is really partnering with those same entities to make sure again that a decision that's going to be made doesn't have an adverse impact to one of the three of us. Or worse, any of you.

The Clinic collaboration, you know I don't think unless you were there you can really fathom what the fire that we went through this last year was. For one, it was the largest and worst fire in the state of Washington's history. So you might think -- well, that was the wrong record to break, when in actuality a part of our usual and accustomed areas was impacted last year, it became the worst fire in Washington State history. Nancy and I, my brother in law, her brother who is our and in actuality, this is what our summers are going to be like. So we don't want to be prepared for the future. If these things are going to happen, how can we maybe make them so that we can still provide health care?

I'm really proud of the clinical staff that I have. This is how bad it was. I would not have been able to see Cheryl. The density of the smoke was that bad. The day that I -- the first day I closed the clinic in Nespelem, I still needed to go into work. I had reports I had to get to Portland. So I opened the clinic door. I hit the little code to shut off the alarm. I take two steps away from the keypad, and the alarm goes off. I go over, the little green light's on, and the alarm's supposed to be going off, but it's still going off. So I called the facilities guy who says "no, you hit the right code. It's green." I called my home up and said "Dennis, that's an alarm because" he tells me, "Colleen, that's the fire alarm." The smoke was so bad when I opened the door, the vacuum sucked the smoke in and it triggered the alarm for the clinic. So it was really bad, and it was like that for us

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for about ten days, I mean where we just couldn't see. Patients couldn't breathe. We had to figure out, OK, patients still need pharmacy. Patients were needing ambulances. Patients were needing inhalers. Patients were needing eye drops. Not only patients, but fire fighters. I went to the morning briefing and we discovered that fire fighters were out in the fire with expired epi-pens. What do you do? So we worked through, you know, emergency policy developments. And we didn't want an impact to be different in Nespelem or Omak than it was in Keller and Inchelium. So whenever we did something like that, I got on the phone to Ali. We got her clinical director. I got my clinical director. We came in with a blanket policy that we could deal with, so that our patients heard the same message from all of us. And we thought that that was really a good sign of partnership and collaboration.

For us, communication was really paramount. Like Ali said, we're really trying to work on branding so that if you can imagine that there's an emergent situation like that, there's all kinds of paper everywhere. So how do you filter that? So one of the ways we found to filter that is to have that branding take place.

This is another example of the branding that we did with the collaboration that happened. I had the schedule sign working at certain hours and being closed at certain hours. The Bureau of Indian Affairs was looking at being open and closed. The Tribal government center was looking at being open and closed. So I pulled together all three of us as leads and said we need to have all the same hours of operation. Because if you have spouses and one has to be at work at this hour and the other has to be at work at that hour, what's going to happen? Again, the visibility was so poor, I almost got hit head-on twice. Because you just could not see.

So we tried to stay with the hours of operation so it didn't impact when the firefighters were needing to get out into the woods.

So we really worked hard at doing that collaborative message and having these PSA's be very, very bold. Simple in the words but bold in the message.

This was another PSA that we did with regards to "OK, how can we make it be the best as far as air quality that was happening?" And as Ali indicated, we're trying to make sure that branding happens. And when it's a collaborative message between Ali, and between the Lake Roosevelt health center clinics and the Service Unit, then as you saw in your opening slide where we had all of our logos, we have all of our logos there. So they know it's reservation wide and clinic wide.

The other element that we're really working on is improving access to care and quality of care. As you can imagine, Indian administrators and certainly each one of you faces from day to day is patient education. Patient education for everything from what the clinic operations are telling them, to when they get referred out will they be able to get

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paid. You know, I spend a lot of time with patients, walking them through the process of getting their bills paid. Walking them through the process of why is it taking so long to get an appointment. And I don't know about where you're at, but where we are, sometimes you know, you refer to a provider and the provider's like "I'm not going to take that patient because of whatever the primary insurance is." Or they don't take any more new patients. And so those create delays in getting patients referred. And the most frustrating thing for a patient is they see the doctor, the doctor says "I'm going to send you to the next doctor." And it takes a while to get them to the next doctor. So doing a lot of patient education in that sense is something that I work a lot with our clients on.

Ali and I have another little unique nuance in that we have every morning, we have a phone call, because I have a staff member that books the appointments for two of the clinics, and she has a staff member that books the appointments for the other two clinics. So to make sure we're all on the same page and that we know who's being referred from each of the clinics, we have a morning meeting. And it's a brief meeting, but it's a really important meeting.

We're looking at developing specialty clinics at the Service Unit for pediatrics, diabetes, obstetrics, and so we're looking pretty excited about that.

For us, it's really important to have transparency. So I made myself available to the membership, either they can come into my office, or we have four district meetings a month. And if the council wants me to present at any of those, I'm available to do that. I'm also doing a lot of meetings with vendors. Because having relationships with our vendors is really important. As you all know, if you have a great relationship, they're more apt to bend a little bit to help you out. If you have kind of an abrupt relationship with them, they're more rigid as well. So I'm trying to build those relationships and those partnerships as well.

So in closing, we just want to say thank you. Again, three different languages at home. Four districts. 1.4 million acres. And we did have a much longer PowerPoint. We trimmed it all down because we thought we were sharing 30 minutes with two other Tribes! So if anybody's interested in all the background, just let us know and we're happy to send the PowerPoint out. Questions? Mr. Jim?

Jim Roberts: Yes Colleen. Thanks.

Ali Desautel: Don't throw me an orange!

Jim Roberts: Thanks for the presentation. I'm kind of interested to know on the 330 site, how you guys have integrated that with your overall population to kind of manage any potential conflict that might occur on the 330 side serving non-vets but on the IHS

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side. You've got your own policies that you've got to adhere to. Sometimes when Tribes integrate a 330 program in with their Indian health program, there's kind of a delicate balancing that you have to do. I'm kind of curious to hear how you guys have managed that.

Ali Desautel: So are you meaning funding wise? Or patient wise? Or --

Jim Roberts: Sliding fee scale piece and all that other kind of stuff that you have to do with the 330.

Ali Desautel: We -- yes. With your 330 HRSA funding, there is a sliding fee scale that goes with that. And so we encourage everyone to fill out the sliding fee scale. Because we would like to use our 638 funding as a payer of last resort. And so we encourage everyone to fill it out. And so what would happen, say, if a Tribal member came in, low income, didn't have insurance for instance, I don't know why, right now they wouldn't. But let's say they don't. We would try to put them on a sliding fee scale, ask them to fill out the form. If they don't, then they don't, because we have 638 money. Ask them to fill out the sliding fee form. It is a delicate balance all the time. But we show them throughout our clinic all the services that they get as a benefit of the HRSA funding. All of our expansion stuff. And so they would fill out the HRSA sliding fee scale. And we would bill HRSA first. Whatever's left over would then go to the 638. That's how we do it. So it is very delicate, for sure. And it's very confusing, and I'm glad I have lots of very intelligent staff that do that for me!

Female Speaker: How do you bill HRSA?

Ali Desautel: Well, it's really -- I guess you wouldn't bill. It's not a draw down. It's an adjustment. It's more of adjustment, I would say, than --

Jim Roberts: Just contact HRSA.

Ali Desautel: Yeah. They give you a lump sum. And then you adjust, like I said -- higher intelligent accounting people do that! So it would be more of an adjustment than billing.

FEMALE SPEAKER: And another question. What was done to your patients at that clinic 3:39:17.3 [INAUDIBLE.]

Ali Desautel: So at Inchelium, the population is about 75% Native and 25% non. At the Keller facility, it's about 80% Native and 20% non.

FEMALE SPEAKER: And do you get people that come from off the rez?

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Ali Desautel: We get people come from everywhere. We get people that come from the post. We get people in all the counties around. Yeah, they come from everywhere. Especially for the dental. Because the Dental's also on a sliding fee scale HRSA. And so before the Affordable Care Act, they added adult dental back into Washington State. They came from everywhere for our sliding fee scale for dental.

FEMALE SPEAKER: What is the non-Indians that come from post and all over the place? 3:40:17.1 [INAUDIBLE.]

Ali Desautel: Yes. They come from everywhere. Right now, we're getting a lot from our own reservation people. It's not just non-Natives. Like I said, about 75% are Natives. So we get a lot from our own reservation too, coming from Omak or Nespelem, Coulee area. Some come from 3:40:43.6 Wellpint. So yeah, they come from a long ways. And Inchelium, when I first moved up there, it's a pretty remote area. And I think there's like 1200 people in the area. And when I came from Spokane, I used to work at the NATIVE project. And I was touring the facility, walking around, and I went into dental -- I totally remember this. I went in there and I said "about how many people do you serve a day here?" And she said "40." And I said "where do you get 40 people a day in Inchelium Washington?" I couldn't believe it! And that's it. They come from everywhere. So yeah. I would definitely look into it for your facilities. Any other questions?

Colleen Cawston: I have a request. You know, everybody's really committed. And this young lady gave up her birthday to be here for our meeting. So can we sing Ali Happy Birthday?

Colleen Cawston: Ready?

[Many voices singing "Happy Birthday."]

Ali Desautel: Aw, thank you.

[Applause.]

Colleen Cawston: So the last thing, you can look at us, we didn't color coordinate. Yeah, wear purple! Thank you very much, and we look forward to hosting you in August.

[Applause.]

Cheryle Kennedy: We are now at the report from the confederated Tribes of Coos, Lower Umpqua, Siuslaw Indians

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FEMALE SPEAKER: Good afternoon. I'll make this short and sweet because I know we're on a time schedule. So I'm Iliana Montiel I'm an Assistant Health Director at the Confederated Tribes of Coos, Lower Umpqua & Siuslaw Indians We currently have about 1131 Tribal members. This is a picture of our admin building, and we have a dental clinic. We don't have a medical clinic. But we have two outreach offices. We have one in Springfield and one in Florence.

So some of the programs and services that we do -- we have Elder activities. We provide monthly. Our Community Health Department, we have three CHR's. We have one in each location -- one in Coos Bay, one in Springfield, and one in Florence. We do the OTC's. We do them in all three locations. We provide transportation for medical. Our dental clinic is in Coos Bay, so we transport from the outreach offices.

We have one inner Family Service Department. I have one behavioral health coordinator. We have two case workers, one in Coos Bay and one at our Springfield outreach office. And those are just some of the services that they all provide. In A and D, I have one Prevention Coordinator.

They are ten hours a day. We are open 5 days a week in Coos Bay. Our hours are from 8 to 5. We have one full time dentist, two part time dentists, and hygienist, a dental assistant. We have a dental assistant trainee because we're rural, and we need another assistant and we couldn't find anybody, so we decided to do a training position. So we're going to train them. And a dental receptionist. We, like Colville, Dental Services are very much needed, and we are busy. We have Native Americans that come from all over. They will travel 2, 3, 4 hours to come to the clinic.

Our Contract Health Service is in our Coos Bay office. And we also operate on IHS only. Through third party and reimbursement or general funds. We did two flu clinics in early October. I think we talked about it yesterday as people, we had some 3 did it too late last year. And so we were able to do it in the first part of October, and it was very very successful.

Some of the activities that we've done throughout out this year is we host Elder Honoring, Coquille Tribe. This last year we were 350 attendees. This next year in 2016 will be our 20th anniversary. Some of the activities, we do activities for the Elders every month. And this year, we hosted the 10th Annual Native Caring Conference. About 200 persons attended that conference.

We are Prevention and trying to do Prevention activities every month. And this year we acquired the Healing of the Canoe Community Grant. And so we're going to implement this into our after school program and into our A&D programs. In 2014, we just acquired property Camp Easter Seals, 20 minutes away from our admin office. And we are going

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to start doing our camps and prevention activities. We actually did our first youth camp So we did our first camp in August, and we did our culture camp. We had about 50 kids come out, and it was very successful. So there's a little bit more work, but we're hoping to hold elder events as well out there.

There's just one picture of a couple of the buildings. And the last thing is, so we are the first Oregon Tribe to send students to Alaska to participate in DHAT program. So we're very excited. So what that means expanding, so we need to expand, and we're looking at getting some grant funding and doing a dental local bus to go out to our higher counties. Thank you.

[Applause.]

Iliana Monteil? I'm sorry.

Cheryle Kennedy: Thank you. That was a very thorough report. Thanks again. Now we are at our DHAT projects update. Pam Johnson, project specialist for the Northwest Portland Area Indian Health Board Oral Health Project.

DHAT Projects Update

Pam Johnson: Thank you. Hi, thanks for having me here today. My name's Pam Johnson. I'm the Oral Health Project Specialist. And today I'm going to be giving you an update on our oral health project. Three months ago, we gave this update. I just want to say we've done a lot of work since then, and it's exciting to be here today to share that with you.

I've just got a few introductory slides. We all know oral health is important to overall health. For some reason, we've separated them out from the rest of the body. It makes no sense, and we also know that there's millions of people living in Tribal communities that can't get the dental care that they need. And while there are a lot of good solutions out there, there is one solution that's been working for a very long time that we are working on at the Board now. And that is dental health aided therapists. The model began actually in the 1920's in New Zealand. The therapists are practicing now in 54 countries. They work under the supervision of the dentist, although they can work outside, remotely from the dentist in that supervision. The evidence shows that the care provided by Dental Therapists is high quality, cost effective, and safe. And the history of providing routine and preventive care in community settings is well established.

And this is a picture of the Dental Therapists in Alaska at a reunion meeting, I believe. Again, Dental Therapists just for review are primary oral health care professionals. They do basic clinical dental treatment and preventative dental services, so they can do fillings. They can do simple extractions. They do a lot of education, a lot of preventive

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work. They are multi-disciplinary team members. And they advocate for the needs of clients. And then where they can't treat a patient, they refer the services that are beyond their scope. And in their training, they learn what exactly they can and can't do, and what they refer on to a dentist. And this chart right here is just saying that 84% of the care that Dental Therapists provide is preventive and routine, which is a lot of what is needed in dental care.

The Alaska program has been around for about 11 years. And right now in Alaska, they have 35 Dental Therapists. And those 35 Dental Therapists have increased access to about 45,000 Alaska natives. They provide culturally competent care. The dental health aid therapists are recruited from the community, and they go back and serve their community after a two-year training program. They, in all of the research and the reports that have been done, they produce a high patient satisfaction rate. They're reducing the amount of emergency care that is needed. They increase preventive care, as I said before, and they create jobs and generate economic impact. In Alaska, they've created 76 full time jobs per year, with a total personal income of \$4.4 million. And the economic effect of the program is about \$9.7 million in rural Alaska.

So we know that Dental Therapists make a lot of sense for a lot of different reasons. So why don't we have Dental Therapists in the lower 48? If they make so much sense and they're working so well. Well, after losing the battle in Alaska to prevent the DHAT from expanding services to Tribal communities, the American Dental Association said "fine. Keep it in Alaska, but what we're going to do is insert the following language into the Indian Health Care Improvement Act." And what they were successful in doing is getting language that said "expansion of the community health aid program shall exclude dental health aid therapist services from services covered under the program. This shall not apply in the case of an election made by an Indian Tribe or Tribal organization located in a state other than Alaska in which the use of dental health aid therapist services or mid-levels is authorized under state law." So they said keep it in Alaska, if you want it in the lower 48 you're going to have a battle in every single state at the state level. And so then they've spent the last five years battling every single state that's trying to authorize DHAT to mid-level providers. And in most cases, they have been successful. Minnesota has been able to pass legislation, and Maine.

So after five years of battling the Washington State legislature, in June, as many of you know, the Swinomish Indian Tribal community said "we have had enough. And we are going to have a DHAT initiative at our Tribe." And here's a picture of Chairman Cladoosby announcing the beginning of the DHAT initiative at NCAI in June.

So going back a little bit, Swinomish Tribal community worked for two legislative sessions with the northwest Portland area Indian health Board and Washington State housing senate to craft a Tribally specific DHAT authorization bill. It was of course lobbied heavily by the Dental Association. And no Tribal or otherwise bill, Tribal bill, or

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the statewide bill which a big coalition of groups were working on, were able to not only get passed, but not even get out of the House or the Senate in their committees. So at that point, the Swinomish determined that it has the power and obligation to address oral health systems change under Tribal sovereignty.

Why does this make sense for the Swinomish clinic? They looked at their procedures for a number of years, 2012 or 20 -- actually 15 and found that about 50% of the procedures that they do at the clinic could have been done by a two-year trained dental health aid therapist. And that analyst also shows that the same procedures could have been covered with 50% personal cost savings, replacing the dentist time with the DHAT's time. And then what this does, it allows the dentist to do other services that the DHAT is not able to do and practice at the top of their license.

DHAT licensure authorization at the state, if the state were to pass a bill, it would help ITU clinics fill a huge gap in service demand across the IHS system for native patients. The other thing to point out is that the workforce development strategy of a DHAT based in the community assures longer term community and public health benefits. We all know if you recruit somebody from your community, train them, have them come back to the community, that is the absolute best care that you're going to get.

So the Swinomish right now, moving forward weather their initiative, has adopted two Tribal laws under its own regulatory framework. It has created a division of licensing which is roughly equivalent to the state of Washington's. And it has adopted a dental health provider licensing code which is not only going to license the DHATs at the Tribal clinic, but also the dentists and the dental hygienists.

And here's a picture of the very first meeting of a Tribal dental provider licensing Board in the lower 48. Still smiling after 3.5 hours of their first meeting! And this is some of the staff at the Tribe as well as the Board members. And this was two weeks ago.

The other exciting thing is that this summer, the Swinomish also sent one of its members, Aiyana Guzman, up to the Alaska training program to train as a DHAT. And she will come back in two years and provide services at the clinic.

The other exciting news is because two years is really too long to wait, is that the Swinomish are actually going to be bringing in an experienced DHAT who's been working in Alaska since 2009 as a DHAT, and he's going to be starting services at their clinic at the beginning of January.

Just an overview of the Swinomish solution. They feel that this is a huge step forward in advancing DHATs, not only at their clinic, but also in the lower 48 for all Tribes. The Swinomish solution develops a replicable Tribal model under Tribal sovereignty. Unfortunately, the model can't be duplicated by all Tribes, especially resource poor

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Tribes, and that's why there's still an effort to make sure that the state legislature is moving towards authorizing DHATs, especially in Tribal settings, under the current IHCA language.

So that's what's going on in Washington at the Swinomish. And at the same time, there are Oregon Tribes that are also moving forward with DHAT pilot projects.

The Oregon Dental Pilot projects were authorized by state Legislation in 2011 to increase access and improve quality of oral health care. And this legislation was passed. And gives authority not only for our pilot but anybody who's moving forward with a pilot to teach new skills to existing providers, development categories, dental providers, and accelerate and expand the training to current providers. They passed this in 2011. They didn't really set up the program or have adequate funding until last year. And then this year, 2015, legislation was passed in Oregon that extended the sunset date of the pilot from 2018, which would have been a problem for any of us starting in the year 2016, to prove anything that was working, to 2025. So they did acknowledge that it had a slow start and lack of funding. They also, there's a provision to make sure new providers and services would be covered by Medicaid. And then outside of the legislation, the Oregon health authority was also funded for the upcoming year to administer the program, which was all good news for us, since we were writing a pilot project application. And we have submitted a pilot project to train and employ DHATs at Tribal health and dental clinics. And here's the list of the outcomes of the pilot. Expand access to consistent, routine, high quality oral health care and Tribal communities, grow the number of AI and oral health care providers, bring culturally competent care into Tribal communities, create a more efficient and effective oral health team, establish cost effective solutions, and bring care where it is needed most.

We are working with two initial pilot sites, the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians, and the Coquille Indian Tribe. The pilot project application was the first pilot project submitted to the state, and that was submitted about three weeks ago. We are project 100, and we are excited to be the first ones in. The application includes a full summary of the project, what the training program in Alaska looks like, the employment options for those going through the pilot, patient notification, evaluation, and monitoring plan, and cost. So it's a very thorough application that will give the pilot sites all the authority they need to move forward with the DHAT programs.

Last week it was deemed complete by the state. So they said "we've got it all, all the pieces and parts are in." And it's now sent to a technical review Board who will look at it for 30 days and give any comments, concerns, questions to the state, and we will also be presenting information at the end of their 30 day review. They do not get to make the final decision. The technical review Board only gives advice, and the final decision will rest with the Oregon Health Authority's Dental Director. And we expect this whole

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process hopefully to be done by the end of the year.

So the next steps in Oregon is to work with the pilot Tribes, to start informing and educating the Tribal communities about adding a DHAT to the dental team, so it's not a surprise to anybody. To start recruiting a second DHAT student from Coos Bay and a first DHAT student from Coquille for July 2017 start of training. To initiate training for the supervising dentist at Coos Bay. To start recruiting an experienced DHAT just like we're doing at Swinomish to begin providing services before the DHAT students return. And then explore with the Tribes that are moving forward with a regulatory structure and a licensing code similar to Swinomish is needed.

And here is a picture of the student in training, Naomi Petrie from Coos Bay, who will also be coming back in 2017 to serve her community.

That is the update, and I'm happy to take any questions if you have any.

Cheryl Sander: So where are they licensed at? Are they licensed -- is the Tribe licensing them? Or out of the area?

Pam Johnson: In Oregon or in Washington?

Cheryl Sanders: Either.

Pam Johnson: So in Washington, the Swinomish Tribe is going to license their own dentists, dental hygienists, and DHATs. So their dentists and dental hygienists will be dually licensed from the state and from the Tribe, and their DHAT will be licensed with the Tribe, because there is no licensure process in Washington State right now. In Oregon, there is no authorization to license. All of this is going through the pilot project which is saying "let's try out these new providers until 2025. We'll collect the data, look at if they're improving anything, and then we will potentially put this into State law." Which they could do before 2025 as well.

Marilyn Scott: One of the things that I wanted to just bring up was there was an article that was published by the Washington State Dental Association. And you know, we knew that the Dental Association was going to be very oppositional to the -- because they were behind the failure of the legislation getting passed that was introduced of the Tribal DHAT in Washington. And they continue to be. But it continues to be a very negative article about the Washington and the Swinomish DHAT program. But we do have as part of the Tribes working with the department of health and the foundational public health services, we have been able to meet with secretary Weisman and in advance, share the work that the Swinomish Tribe has done, and the development of the licensing and the certification process and the codes that they have established at Swinomish. And, given advanced notice met with -- you know, Swinomish leadership

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has met with the Governor. Have met with the Secretary with the licensing responsibility, knowing that the Dental Association is going to be pressuring them to really go after the dentist that is the provider and supervisor of the program that is going to begin at Swinomish.

But I just want to make sure that the Tribes are aware of -- that there still is a lot of negative coming from the Dental Association. And the information that they're not denying, that there is need more access to oral health care. But they're putting information out to say that they are doing their best to address access to oral health care to Indian Country within Washington State, which is absolutely -- there are no dentists in Washington State that will accept Medicaid patients. And this is statewide. And so it continues to be a health disparity for our people in getting access, and the statistics are horrible with regards to the decay, with our children being able to get access even though we have increased the coverage that they have available to them to get into services, because the dental services is included in the benefit package, but if you don't have providers that will accept them, it does not do us any good. And so this option gives us another way. But we need to make sure our Tribes are supporting the effort that is being -- and we are going to be pressuring again, and there will be introduction of legislation with the legislature again for the authorization for the mid-level program in Washington. So we need Tribes to support that legislation. And we do have Senator McCoy that is a real champion in asking the Dental Association to address what they're doing to improve access. But what they say and what is actually being done is just not the same.

Pam Johnson: Thank you for bringing all of that up. I think that absolutely, Washington State Dental Association and the American Dental Association, is going to be coming at this in Washington State from every angle, and we are preparing as best we can for the challenge to sovereignty, for them looking at Medicaid reimbursements, to pulling the license of the supervising dentist, that there are many ways that they could come after this program. And we've been working really hard with Swinomish to make sure that we are as prepared as we possibly can be. And I think it says something that they are coming out swinging right now. That they're -- not only do they have the blog piece that you're referring to that was incredibly offensive and basically saying "we know better than the Tribes about how to take care of your own members, even though we are doing nothing about it," was the gist of the piece. They also had an Op Ed in the Seattle Times just last week. Really painting themselves as the ones looking for solutions to access in Washington State. And really preparing their image for what is going to come up. Where they know they're going to lose in the battle of public opinion on this one like they did on Alaska.

So all of that is happening, and we will need the support of every Tribe to stand behind this program as we move forward. And you will be -- continue to get updates from our project on what's happening with legislation and what's happening with efforts to

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support the Swinomish as we move forward against the Dental Association.

FEMALE SPEAKER: Excuse me. I just want to make a quick comment. In Washington State, the Community Health Centers are very interested in this also. And so I don't know if you're working with them -- OK. OK. I just wanted to let you know.

Pam Johnson: Yeah. So there's been two bills every year. There's been one that was specifically for Tribal communities, and then there was also a bill that would have allowed Dental Therapists statewide to work in Community Health Centers on Tribal lands in FQHC's, in -- you know, in a bunch of different areas.

Cheryle Kennedy: Thank you for your report.

[Applause.]

This is a program that we need to stay involved in and keeping letting all those that want to know, that this is a program that works, and Tribes are trying to get their own programs started. So our next agenda item is the WEAVE-NW Project Update from Nanette Yandell. And so I welcome you to the podium.

WEAVE-NWt Project Update

NanetteYandell: Thank you. Good afternoon everyone. I hope everyone's feeling well. So I'm just going to kind of give a broad overview of the WEAVE-NW Project. Some year 1 highlights, and talk about a funding opportunity which I did put a flyer on a lot of people's computers and at your seating area for an information session coming up.

So first of all, WEAVE-NW stands for Wellness for Every American Indian to Achieve and View Health Equity. And it's actually a cooperative agreement through the center for disease control. And here you can see a map of the United States, and there's different areas that have been funded, but they're all underneath this grant. At the CDC they actually call it Good Health and Wellness in Indian Country.

So the long term objective is really to decrease cardiovascular disease, obesity, and type 2 diabetes in Indian Country. But as you know, this is a five year grant. So it started last year, and it ends in 2019. So being able to reach these long term objectives and actually show a difference is very unlikely to happen. But what we can do is show some small steps. So the primary focus of this project is really looking at the policy systems and environment focus. And my favorite public health story that kind of for me sums up this project is thinking about upstream. And it's thinking about there are two fishermen who went to go fishing. And one of them while he is fishing sees somebody drowning coming down the river. And so he goes in and gets him out. You know,

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relaxes, makes sure that the gentleman's OK. And then they see somebody else coming down the river. And this happens again and again. And the two fishermen start getting very exhausted pulling these people out of the river. Well, the other fisherman is like "let's go up. You catch the people coming down. I'm going to go upriver and I'm going to see why all these people are coming down drowning out of the river." And when they get up further upriver, what they end up seeing is that there's no barrier. There's no ledge. So there's an environmental built environment item that could be addressed in order to stop the people from falling in. But the focus of this grant is really for us to look upstream. So this isn't really looking at programmatic topics. This is looking at what kind of change policy system and environment wise, and I'll go over some examples, can we implement within this five years to start getting toward that long term goal of decreasing chronic disease.

The other focus is to make sure that anything that we're adapting in our communities is all culturally adapted preventive activity. So it's not just the CDC wants us to use this best practice. But what is this best practice for our people and our specific community? So we're working with a lot of creativity with this project, which I think makes it really exciting.

So just a little quick background for policy systems and environment change. What I'm talking about, policy is really passing of the change to a law, ordinance, resolution. Its focus is to influence behavior. It doesn't have to be written. And before coming here to the Board, I worked at Crib. And some of the Tribes that I worked with, the community policy, so it was unwritten, had the most weight within the community. When an elder established that at one of the rec centers you do not bring sugary, sweetened beverages into the facility, kids didn't bring the drinks in. And then there were other Tribes I worked with where they had something actually written down, you're not supposed to bring this type of food into the facility. But everyone ignored it. There was no implementation. So thinking in your community what that influence of behavior could be in terms of policy, we're very -- we can be very creative in how we want to define that, but making sure that it's appropriate for your community.

Systems can involve lots of different things. And I will give some examples of the way systems can be health systems. It can be food systems. So also thinking broadly about that. The environment can be something as simple as signage. There are some walking paths that sometimes don't have signage, and so people don't use them. Sometimes they don't know they're there. Or if they're there during their lunch break, they don't know how long it will take them to do the entire loop. Sometimes having just basic signs can increase people being willing and able to take that walk.

So some year 1 highlights. So over year 1, we've had five sub awards. And the emphasis has been on creating logic models for the work that's being done. And a big emphasis on evaluation. We have a full time evaluator. So being able to identify and

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adapt to what the needs are in the community has really been the primary focus for this first year. Data sharing agreements also. And I'll talk about some of the reasons why as I talk about some of the technical support available. Site visits. So we go out to all the different sites and learn about specific communities. Because every single community is different. Some of the funding can be specifically through Tribal admin or planning. And some of it might be through the Tribal health center. So all of those are going to bring up different activities that can take place.

And then dissemination of resources. Whether you just want assistance doing a literature review, looking at some best practices, looking at millions hearts program, or finding some other policies in other Tribal communities that have been done before, that's something that we're happy to assist with. There's been multiple trainings and workshops this year. Risky Business, Native Fitness. The Health Data Literacy Workshop. All will continue next year, and then we'll also add some more.

So here's 2-4 as we're stepping forward. 2015 to 2019. So every year we would like to add five new sub awards. And that will make by 2019 a 68% reach. The primary focus for this, direct funding, is to implement specific projects. So down toward the bottom where you see technical support, I'll go over that. You don't have to be a sub award to get any of these services. The sub awards are just for specific policy, systems, environment, project. So we also want to extend our year long contracts. So our current sub awards that are in our year 1, extending them to have a year 2. Monthly training modules which are available to all the 43 Tribes. We also have a new tobacco project specialist, Ryan, who just joined our team and we just got an additional funding to focus on tobacco cessation, prevention, and second hand smoke exposure.

Creating Tribal community fact sheets for anyone who would like some. So it will just be basic data. We usually use GRPA data. But at least it does have like a snapshot of what's going on in your community.

We're working on developing a website for our WEAVE-NW team. And on it we hope to have an online policy system environment library. And that will be ongoing. And that's one of the things that's also really exciting about this project, is as we're thinking about these activities, as we're thinking about this PSE library, when the grant's over in 2019, if there isn't additional funding we'd want it to be sustainable. So what could be sustainable? Well, a PSE library, whether it's examples of policy that you pass in your own community that you're willing to share those with us and we can post it on there so other communities can also use that as a resource bank, that will exist regardless because it belongs to the Board.

And then the technical support. So technical support is available to everyone. And what we do and we have training modules, and they can be by phone, but we also have a video zoom. It's some kind of video conferencing mechanism. And it's going to be

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once a month and about 45 minutes, and they're going to be on different topics. So I really encourage all of you to feel free to participate. Some of you already do. And I really appreciate that. But also we have resources and Technical Assistance for all of you, too, which can include -- this is limited, but public health surveillance. Tribal specific data collection and analysis even. If you just want to talk to one of our epidemiologists and just find out -- I want to do a Health Assessment. What type should I do? How should I connect with my community? We're happy to assist with that.

Program evaluation for ongoing programs you have or programs you're thinking about creating. Strategic action plan. Commercial Tobacco Prevention and intervention as this grant is just starting. Ryan actually starts next week in the same position. So we're really excited to work with all of you on whatever policies or programs are the best fit for commercial tobacco prevention and intervention.

Capacity development sustainability and then best practices and prevention and management of chronic disease. And I do want to emphasize the best practices according to what's right for your community, not according to the best practices.

So the year 2 sub award announcement, the application is due September -- not September. November 9th. There's a maximum of \$25,000 a year for up to two years. So that will equal \$50,000. The funding needs to be focused toward health policies, health systems. It can also be focused on food systems or built environments. And I'm happy to have individual conversations with any of you that are interested to find something that would work with the programs that you already have, or in order to include youth sometimes. Youth and elders is a really great way to make programs you already have more sustainable.

Quarterly updates and interim reports. And the quarterly updates are really just a one sheet, invoicing sheet. And we talk -- we ask questions about what policies, systems, and environment activities you've done over the quarter. There are some funding restrictions, and these funding restrictions are specific from the CDC. And that includes using the funds specifically for research, clinical care, furniture, equipment, clinic and patient supplies, and building such as breaking ground. Now if you already have a community garden, we can use -- you can use some of these funds to emphasize your community garden according to whatever plan ends up being agreed upon. But not to actually break the initial ground. So it's just, it's going to be very specific for whatever activities you would like to do.

Some examples of projects for increasing access to healthy traditional foods, which can also be a traditional herbal garden. Is a community garden. It said food policy in schools, elder centers, and head starts. Farm to school. Farmers markets. Sometimes EBT with your farmers markets, or being able to use your community garden and sell some of those, or provide some of those, the extra food from your community garden to

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the elders in your community.

Increasing physical activity through increased walking paths. Prescription referral to fitness opportunities. It can also be prescriptions to work in the garden. Prescriptions to eat healthier, more fruits and veggies. We already know that if patients get a prescription, they're more likely to do it than if someone just tells them to go do it and it's a good idea.

Breast feeding initiatives is also included. Reducing commercial tobacco use and then second hand smoke. And then teen based care strategies for chronic disease. And I've heard some of the wonderful presentations about some of the -- what some of the work that the Tribes are doing now that are sometimes based on the wraparound program. Some of this funding can be used to assist with that, can be used to assist with the training. Because we want, again, this to be very sustainable and primarily when it comes to the trainings, we want it to be a "train the trainer" type. So that it's not "this one staff went to this one training," and then if that staff leaves, that knowledge is gone. So we want to find a way to make sure that any projects that are utilized have some kind of sustainable component within them.

And then this is our routine. It's a -- I'm very grateful to be here and be a part of such a great, very diverse and experienced group of people. So that's it for me. Is there any questions?

Cheryle Kennedy: I've heard from all the different groups. Those are beautiful pictures.

[Applause.]

We are now at our agenda item called OHSU School of Nursing and Native STAND Program. Our good friend Michele Singer is here to make that presentation along with Joann Noon. Welcome.

[Applause.]

OHSU School of Nursing Presentation - Native Stand

Michele Singer: Hey everybody. How are you? That means "what's up?" Well, I'm amped from lunch and a 4 hour car ride to get here, so I'm going to be a little fast, a little crazy, but I want to thank the Board, Joe, Lisa, everybody, certainly our executive Board members for allowing me once again to come back. I'm humbled to be here before you. I want to talk about this exciting opportunity called Native STAND. This is a quick overview of the presentation I'm going to give. I also want to send greetings on behalf of our OHSU community, as well as our Center for Healthy Communities Director, Dr.

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Tom Becker, who most of you guys know. He's always going like this. So going to send that to you as well. Dr. Bill Lambert, my colleagues.

I'm the project manager for a dissemination project called Native STAND. And it stands for Native Students Together Against Native Decisions. And we are in our second year of this particular grant. This particular grant has a background, and I'm going to quickly go through it. The rationale and purpose, as many of know and you see here all throughout your meetings and as you travel throughout Indian Country depending on what issues that you talk about, we're hearing a lot about our youth. We're hearing about our communities, the challenges we're facing in our teens, our community. And how are we going to get our communities ready for a response around these particular areas of health disparities, of identity, bullying, suicide, healthy relationships, communication, etc.? Well, there was a template that was done, a program called Stand that originated out of the South in Georgia by Mike Mercer out of Mercer University School of Medicine. Well, a lot of smart Indians got together and they decided "hey, this is something that we can adapt to work in our communities. Something that's culturally relevant, culturally appropriate. A curriculum that maybe perhaps we can use among our youth and our communities and help each other." Well, they adapted the original Stand. Native youth and professionals were involved in the curriculum, transformation. It was used in four BIE schools and one Tribal community back in 2007, and it was evaluated with findings.

Here is the example overview of what's in the curriculum and the core elements of it. As you see, and just so you know, this is all on our website and I'll show that. But they are a series of lessons, very textbook. 29 sessions. They're roughly about 60-90 minutes each. They touch upon our aspects of our traditional ways, at least as far as the medicine wheel comes, mind, spirit, body, physical, emotional. Talks about all of these various areas that we know are so important in our communities and who we are as a people.

Well, you couple that with active learning, the primary prevention, looking at positive role modeling, healthy positive social expression in relationships. Well, when we took -- when this was originally brought out in 2007 and validated in Tribal schools and Tribal communities, these were some of the samples of findings that were put forth by not only the students, the facilitators, but also the community members. It was well-received. It was recognized in addressing gaps in sexual health education from Native perspective, most importantly in Tribal schools and communities. The adult facilitators learned how to better communicate and work on teaching these topics in their communities as well as the kids. Tribal youth, and we're talking ages 14-17 here. High school age, grades 9-12. Provided one on one peer education to each other, referrals. They started learning from each other and communicating based on what they learned in their curriculum. And then also hey, they learned something. They took a pre-questionnaire from the very beginning of what they knew at this particular point, the implementation

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happened, and then they were questioned once again on the same topics, and this is what was found. That between those two pre and post questionnaires on knowledge, attitudes, and behaviors, look at that. They improved in their knowledge in these areas. So to me, that's pretty impressive.

Well now, what does this have to do with OHSU and the Northwest Portland area Indian Health Board? Well, we are working together through the grant through CDC and the Indian Health Service northwest, NARCH. Through the center of healthy communities, which I'm the project coordinator, we offer a certified educator training program and also we have -- we're recruiting for sites right now for year 2. We offer a one week hands on training here in Portland in the summer. This year it's in -- the last week in June. We offer implementation footwork planning to communities to administer and implement, and we also work with them, the evaluation data collection of those projects and also offer Technical Assistance as they move through in this project.

And as you see here, we work through this process to obtain MOA, local IRB approval. They attend the training, confidentiality and action plan, etc. This is a terrific opportunity, folks. I'm telling you, especially for the 43 Tribes in the Pacific Northwest. We just went through our first year this past summer. And it was incredible. Again, one week in Portland. We pay for it. We provide the curriculum. We provide the material. They get hands on practice at our own THRIVE conference. But Stephanie and Colby and Tommy and Selina and others work so hard to do. There's human subjects protection, so learning how to work with students and sensitive information, to make sure that they're protected, and mandatory reporting happens. Technical Assistance. And they leave with action plans and ideas as to how they're going to then bring this home, work with students, a co-facilitator, and administer that in their community over the course of the year to two years.

We see that it works with the reach. The effectiveness. The adoption of this in their communities. The implementation. The maintenance. Keeping this going and sustaining it. As you saw, there's a terrific grant opportunity that this could be leveraged with. With the WEAVE-NW program. Working with youth, with elders. So, it's community driven. What we're hoping to do over the course of 5 years is to continue to have this as a snowball effect between training educators as well as with Tribes and organizations, not only here in the lower 48 but also Alaska. But we always like to keep it close to home. So we encourage the Pacific Northwest Tribes to apply. Over time, we're looking to have over 50 educators. Ideally, it would be great to have 80 to 100 over the course of 5 years. This year right now, we have 12. So we hope to grow that in year 2, year 3, year 4. And these are the results that we've seen.

So we made the commitment to build capacity in our own communities. To engage in research that's driven by the community. Indian people handling their own information. Working with us as we continue to work with the northwest Portland area Indian health

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Board and allow communities to have more local control and understanding and data and benefit that help in their community. And certainly we need that with our youth. What's going on in their world, from their perspective. And how can we work with them to mobilize and try to make a difference together as a community.

Applications are online and will be available -- I should say that. Will be available the first week of November. And this is going to be online. They're due in February, so you've got some time. We'll have a one-hour live webinar to walk through what Native Stand is and this process. You can certainly view our website. You can certainly contact me. And this is who's involved in this project. I think you recognize Dr. Bill Lambert. He's our OHSU TI and Stephanie Craig-Rushing for the Board. And this is my information. And just wanted to let you know in the back, this lovely PowerPoint was made available to you by the wonderful Lisa Greg, so look for it in the back. We also have informational flyers about what I just talked about, a one-pager in the back as well as our center for healthy communities projects and programs that we continue to work on as well. So I'll stop there and turn it over to my colleague Jonah. Thank you.

[Applause.]

Joann Noone: So thank you for having me. My name is Joann Noon and I'm with OHSU school of nursing. And I was the driver for 4 hours, so I'm with Michele. And so this is my first time to this part of Oregon. And as we were driving, Michele and I told each other our stories about ourselves. And so I'm coming to talk to you a little bit about a project we're doing at the school of nursing and to ask your advice. And I did have a handout of questions, that are on the last slide, and I don't know if they're in your packet or not. But I know time is limited. So I have my contact -- I'll have my contact information at the back, and if you have that handout, if you want to jot down answers to those questions that I ask, but it's really to -- our project is also about advancing health equity. And it's really to try to increase the number of nurses in our community who represent the community that they live and work in. And so we have a project at the school of nursing right now called Advancing Health Equity through Student Empowerment and Professional Success.

And so just a little bit about the nursing profession in Oregon, a comparison to -- is this a laser or no? Oh, sorry? Yeah. That's OK.

So on the top row going across, a comparison to the Oregon population. Nurses who are Native American are under represented. So some of the acronyms, the first column is Oregon RNs. And they are 7% of the nursing workforce. Oregon nurse anesthetists, there are no Oregon nurse anesthetists that are Native American. Or clinical nurse specialists or CNS's who are advanced nurses or in the hospital. And nurse practitioners are underrepresented in nursing as well. And so as I was talking to Michele on the way here, I -- you know, went into nursing right from out of high school.

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And it was my father who -- in line to promote a very self-supportive daughter, advised me to go into nursing. And I had an older sister who was a nurse. And for many of us who are Caucasian, we had aunts or mother or sisters who are nurses, who were role models for us to go into nursing. But if there's no one in your community that -- in nursing, to encourage you to move into nursing, you may not consider that as a career option. So that's what our program is really about.

So if you did not know, and Michele didn't -- wasn't even aware that we actually have four schools -- five schools of nursing throughout the state of Oregon on our Oregon -- formerly Oregon university system campuses. So I live in Ashland, and I'm the program director of the nursing program there in Ashland on the campus of Southern Oregon University. But it's part of the Health and Sciences University School of Nursing. And so we have sites all throughout Oregon. And we actually have a virtual one, too, which is what we call a complex program for nurses who get educated at the community college to continue on and get their baccalaureate degree. So we provide nursing education throughout the state of Oregon.

So a little bit about our program is we have a support system to support diverse students. And we're really hoping that they're going to go back to -- we know that diverse nurses go back to the communities they serve and are typically, more commonly will work in medically underserved communities. And so that's how we're hoping people -- that nurses will help improve health equity. And so we really looked at what are the barriers for students. And try to create strategies for them about helping them have mentoring. Have financial resources so this does provide scholarships and stipend awards. To connect with nursing leaders in the community. To feel included on the campus that they're on, etc. So it's a model of academic support for students.

And so this is the project team. I'm the Project Manager of this grant. An Peggy Wroos was on the Portland campus School of Nursing as is our project leader. Rana Najjar is a faculty member on the modern campus. On the campus of Western Oregon University. And we have two student affairs diversity coordinators who provide case management for our trainees.

So we provide scholarship and stipend support and classes. The licensure exam that students have to take after graduation, and we help them prepare for that. We pair them with a nursing mentor in the community or upper class, you know, junior or senior nursing student. We provide individualized case management. And we help them with -- particularly the nursing coordinators help them search for scholarship money. Help them write essays for those scholarships. Mock interviews to get offer job, in preparation for job employment. Considering graduate school opportunities. So they'll go out to become the nurse anesthetists and nurse practitioners that are not there right now.

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And one of the things we know about many of our students, is that there's a need to really understand financial literacy around debt management of student loan debt.

So just a little bit about our scholarship recipient. We've just started year 3 of our program, and in the blue is the first year. In the red is the second year. So the top bar is students who are underrepresented in nursing, underrepresented minorities. And so that was about -- we had 44 students the first year and 46 the second year. And half to two-thirds of them are scholarship recipients or underrepresented minorities. We also look at educationally disadvantaged students, and that's the middle set of bars. And the majority are scholarship recipients or either meaning that they were first in family or came from a high school that a lot of students did not go to college from. And then the last set of bars are students who are financially or economically disadvantaged.

So of those each year, you know, one Native American student of 46, year 2 we had three Native American students out of 46. And then this year we'll be funding 2-3 Native American students.

We have good retention in our program, and so that's one of the things that, you know, we're concerned about. That students will stay in the program. We graduated 15 students from year 1. And then people are -- so our goal is that people get licensed right away, so we look at how they perform on their licensing exam. And if they go into work in a medically underserved area. And from our first set of graduates, three-quarters of them did that.

So a little bit about what our students are saying. So the young man in the middle with the orange tie is one of our graduates who just graduated last June. And he is a Native Hawaiian student, and he wants to become a nurse anesthetist. And he was paired with a mentor who was a nurse anesthetist in our community, and his mentor took him up to lobby up in Salem for the Oregon Association of Nurse Anesthesia lobby. And so he was really excited to network. And right now he's working in the ICU in Medford in preparation to go to graduate school to become a nurse anesthetist.

One of our diversity coordinators, so they work with nursing students, people who are interested in applying for nursing school. So this was just a recent story that I thought was pertinent to share with you. She said "I wanted to share this great success story. I wrote last year about Native American pre nursing student, and I showed her a path to scholarships essays" That's the workshop I was telling you about. And she applied for a lot of scholarships. Anyway, I saw her the week before last, and she told me she won \$28,000 in scholarships this year. And she has a 4.0 GPA, and we're really optimistic she's going to apply this year, to our nursing program.

So we've done outreach, and this is some of our project team. Doing outreach recently, and in 2013. We also do some pipeline activities, and some of you may know that

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Southern Oregon University has a pre-college youth camp for Native American and Native Alaskan students, and we've been doing nursing class with them to explore it, and they love taking out fake staples and fake sutures. And so this is some of the comments from them, and this is one just from this past summer. "I want to be a doctor, so being in this class helps me learn skills and how to talk to patients."

So my questions for you, and I know I don't have the time to really get your answers, and I know some of the answers to this is "yes" or "it's important," but what is the role of nurses in improving the health of Native Americans in our regions, and how can it be improved or expanded? Is it of interest or priority for you to increase the number of Native American nurses in the workforce? And if so, how can OHSU school of nursing partner with Native American groups throughout the state to increase Native American student interest in nursing? And what advice do you have for us?

So we could probably talk for an hour about that, but I will -- like I said, I will have my cards available. And so thank you very much for the time and if you have any questions?

Cassie Sellards-Reck: Oh, I have some questions. I have some -- if you could go back really quick? My name's 4:46:13.1 Cassie Sellards-Reck I'm a Tribal leader from the Cowlitz Indian Tribe. No, not that far. Your questions. I wanted to give you some immediate feedback in not too too much time. So I'm also a trauma nurse and work in the ER at Legacy Emanuel Hospital. And so I work in the neuro trauma ICU. And so you know, when you start talking about American Indians, I'm -- used to be urban Indian who grew up. My mom is from Dupont Nisqually area. I come from a 4:46:53.3 [INAUDIBLE] family. I grew up on Easter Day road in that land there. But she moved to Portland, and so I was raised in the Portland area and went to Walla Walla College School of Nursing because that's where she went when she escaped the horribleness that was her life growing up. And we have those stories of, you know, our great grandmother being taken, you know, and forced into Indian schools, and you hear those same stories. So I'll never forget Ed Fox was here one time, and he's a Tribal leader -- not a Tribal leader. He's a leader in our community when it comes to health. He used to be the director of this Board and now works for the Tribe. But you know, and I've been a nurse 20 years. And I really see nursing change. And it's changing somewhat for the good, but somewhat not for the good. There are -- we should always strive for excellence. But I think we're pushing out and pushing down on people who aren't straight A's. Your slide up there is the example. You had a 4.0 student who got \$28,000. That's wonderful. What happens that encourage our kids who are suffering in poverty and don't have that opportunities, but still could make a good nurse. Still might want to be a nurse. You're not giving them that opportunity. You're not giving regular kids who don't have the best GPA's from whatever reason, socioeconomic or underprivileged or whatever, the opportunity to be that nurse. You know when it comes to your graduate schools, your expectations are so high that you can't -- those Natives

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can't get in or can't compete and be in your programs. So I think nurses going on to school would be a huge improvement for our communities, because I myself have thought -- well, you know, what if I, you know, I could get my Masters and become a family nurse practitioner and practice in my community. But I think that, you know, what if it's too hard to get into your graduate school? You know, and how do I -- what do I do with my three children, and my travel obligations and things like that? There's a lot of inflexibility within that. And so I know it's a hard balance between balancing your scholastic expectations and the delivery there, but also you're dealing with a community, with a people who are very intelligent but don't have the same opportunities. So how can -- it's not dumbing it down, but how can there be people within our communities, our students, be excited. You know, my advice for you is to go to some of these communities. Go to Quinalt to their schools and do some of these programs, not at just like -- or other ones. Even though you're only an Oregon program. But go -- or Burns. Burns is in Oregon. Or go to -- go to the reservations where our people are at, and where our kids are at, so you can see our people. And see and talk to their teachers and see. Because maybe it's the kid that has a 2.5 that would make a good nurse. Maybe that's the person. It's not just about the technicalities. So even though you're asking me to coddle along these technicalities that don't offer our people -- you know, maybe it's the kid that has the 2.8 but powwow danced and took care of his grandma and some of these other things that they've achieved in their life equivalents, you know, the same thing. So I was fortunate to have a mother who sacrificed everything and anything she had so I could go to private school, because she had nothing. But that's not -- that's not everyone. And that doesn't mean -- and that's not fair. You know? That's not fair that she got out and did that, you know. So for me in my community, we do everything with our youth Board. And some of these Tribes do beautiful and amazing things for our kids, so maybe one of the things that helped some of our kids change their lives is Lummi offers a camp that they send them to for, you know, engineering and science and those kind of things. And gave them like a week that they can do that. That really changed and improved some of our kids' lives. So I really appreciate you coming here and asking, you know, us. Because there are a lot of us who would love to partner with you. And we'd love to have you be successful. But I think at home scholastically, you need to maybe broaden the definitions a little bit so some of these kids can have that opportunity. Because it's hard. It's hard in the communities, and it's reflected, the statistics that we represent and you know, the death and the alcoholism and the suicide and how we're just fighting and scraping, and you hear us fight and scrape, so you know, nothing has come easy. So that's what I would say.

Joann Noone: Thank you for your comments and your advice. One of the things that has -- is changing in schools of nursing and has changed in our program is looking broader beyond GPA, your totally right about that. And we have what's called a holistic admissions process, where we're looking at students' experiences and what they can add to our profession other than their scholastic aptitude. So thank you for those

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comments.

Pearl Copeman-Baller: Well, you could probably hear me. Quinault Nation, and we're very blessed that we have a young lady that's in nursing school right now, and I would -- she actually has a 4.0. She's got two children, so I don't know how she does it. I never could have. But my question to you is whether or not your services extend beyond Oregon. I mean, I think she's going to be an awesome nurse when she graduates, and so it would be great if there were other services or scholarships or something available to her. She's got two small children and an unemployed husband. So it would be great if you could, you know, find some other opportunities for her. But in saying that, I also understand Cassie's concerns about some of the students on the reservations. I think they need more encouragement and more people to support them. I know that. The on school reservations, the schools on reservations, we rate very poorly academically, and I think they need more encouragement and enticement. But my original question was are there other scholarships or opportunities for this young lady?

Joanne Noone: Unfortunately, this one doesn't extend beyond Oregon, although I would say that -- you know, to encourage that student to connect in with her nursing program and -- as far as financial aid and also to explore some federal opportunities through HRSA and some federal opportunities for loan repayments. So, thank you for your comments. I wish I could!

Michele Singer: I just would like to say on behalf of Joanne and myself and all of us, thank you so much for allowing us to have this opportunity here. For me it's like homecoming. I love seeing everybody. I'm so glad to see Sharon. The whole community's been in our hearts and prayers down there. And Tim, thank you so much. It's great to see you. And the host here at Umatilla. And we look forward to visiting with folks. Our information's in the back. But again, great to see the leadership of the Northwest Portland Area Indian Health Board. As I always say, this is the best area Indian health Board in Indian Country in the country, hands down. So keep up what you're doing, and I look forward to always working with you as a friend and partner. Thank you.

[Applause.]

Cheryle Kennedy: We are now at our break time. I'll ask for it. Do you want to take our break, or do you want to work through and be done early? Oh, two minutes? Five minutes? Let's do five minutes and come right back. Thank you.

Break

Cheryle Kennedy: We want to go ahead and get the meeting back on track, and so what we're going to do, we're going to make an adjustment to the agenda. We're going

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to have Ryan present on the final five year report on Domestic Violence Prevention Initiative. But before we do that, Joe Finkbonner just a couple minutes.

Joe Finkbonner: Thank you Cheryle. We had the opportunity in the Health Directors meeting to address this topic, but we haven't yet here. I know that some of the Delegates came in and weren't able to attend the Health Directors meeting. So I'd like to publicly acknowledge and thank Judy Muschamp for all of her years on the Board. Judy is retiring. And this is her official last meeting as the delegate for Siletz so Judy, thank you so very much for all the years that you've been a member of the Board and all your contributions to Indian health. And we have a little token gift here to give to you, I'll walk to you from the Board and Executive Committee and delegates, we would like to present you with a gift.

[Applause.]

Judy Muschamp: Well I want to thank the Board. I don't know if -- I talked to a few people, but when I first got a managers' job for the Siletz Tribe, about 30 years ago, the first meeting that Doni White, then, was later Doni Wilder, brought me to was a Health Board meeting. And listening to Jim talk about his frightening flight over here in a little prop plane reminded me of that travel to that meeting that was in Boise, and me and Dottie flew in a little plane, and the pilot was sitting up front reading a book, and it was the first time I'd ever been on a plane! It scared me! But the Board's been very special to me. I have learned so much. I feel like I've grown up in the Board and have appreciated all the knowledge and friendship that I've grown here, and I really do look forward to my retirement. So thank you all.

[Applause.]

Five Year Report of Sexual Assault Resource and Response

Ryan Swafford: Good afternoon everybody. My name is Ryan as some of you know, and this is just the five year project summary of the Sexual Assault Resource and Response Studies.

So this grant was originally for 4 years, funded by the Indian Health Service, domestic violence prevention initiative. And it was 4 years, but we were lucky enough to get it extended for an additional fifth year. And over the 5 years, we were awarded a total amount of \$722,000.

OK, so with 6 areas of focus, some of the things we did were a lot of Technical Assistance and just offering resources. We did train 72 nurses to do sexual assault exams. And these are our nurses from IHS clinics. Tribal health clinics. And also four nurses who served right off of the reservation, who served Tribal members but had

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more capacity than some small clinics, like for example here in this area it would be like St. Anthony's. So we offer trainings like that.

And then there was talking about, and working around, what it means to be sexually assaulted in the Tribal community. There's a lot of very complex difficulties involved in reporting sexual assault in Tribal communities because as we all know, they're very small. Everybody knows each other. It's embarrassing. There's fear of retaliation and rejection. And so we just try to find ways to problem solve around that.

Then there's Tribal Sexual Assault Advocacy Skills. Where what we did was we partnered with the Sexual Assault Task force of Oregon, and they have their basic curriculum of how to train Sexual Assault advocates for communities, but what we did was took their curriculum and we made sure that it was relevant for Tribes and culturally specific for Tribes in the Pacific Northwest.

We also did public awareness events, and this was probably my favorite part because what we did was we gave very small, mini grants to communities to address sexual assault in the way that they saw fit to bring awareness to the issues, and it was fun. A lot of people did like walk in her shoes. They did community dinners. The clothes line project, I know Siletz did. And so -- and some of them also did training. They wanted to fill in the gaps in services for people who were sexually assaulted, so they wanted to do a specific training and invite all social services from the areas, which was great because they were able to kind of sit down together and problem solve and see how they could work together to fill in those gaps.

So this is just a breakdown of events, how many trainings we did, how many -- I put subcontracts here, but really those are the mini grants. There's just language changing that we need to start doing around that, because they're saying now that we're not allowed to give mini grants. So you might see that language change in the future.

And one thing I like to focus on here is that sexual assault advocacy trainings, where we did 21 of those, and this was important because this was where we raised the capacity for sustainability through trainings and collaboration of several Tribes sitting down together, where they were able to discuss what was working in their communities. So they talked about challenges and achievements and that was really good, because then other Tribal members could go back, take that to their communities and see if it would work with things they might think of, maybe what they should not do. In addition to that, it was also nice because a lot of these Tribal communities, especially up in Washington, there are a lot of them that are very close together. And so if one community has -- offers a service that the other one doesn't, a lot of times they knew that when they sat down to talk to each other. So they knew that they could send people who had been sexually assaulted to that community maybe for a specific service or to get examined by a nurse, by a SANE nurse, or maybe they needed shelter. So that was great.

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And they also had a chance to kind of sit down and like tell stories and do talking circles, which is -- special assault work is really really hard work, so give your advocates a pat on the back, because it's challenging. Very personal work.

OK. And we also did one media campaign and a collaboration with Pride. We can see here. So this was in addition to sexual assault, we also focused on domestic violence, and that included elder abuse, child abuse, and then intimate partner domestic violence. And this went over pretty well and we sent all of these out to our 43 Tribes, and some of you might have seen it. Some of you may have not. But we still do have additional materials. We could mail it to you guys if you would like them. We even actually got a lot of requests for this nationally. People really liked it even though it's tailored for our specific area of Oregon, Washington, and Idaho. But not a lot of people are doing this kind of work and campaign and tip card stuff. So it's pretty well received in the community. So let me know if you guys need any more materials, and we'll definitely get those sent out.

Ryan Swafford: So we would like to say congratulations to the three Tribes in the organization who's received the next four years of the new funding through IHS. Yay! I think Quileute they got a big part of that, and that's great. So yeah. Congratulations and we will still be here if you guys need help with connecting some resources and materials of what we do have left. It is kind of limited but that's the end. Is there any questions?

[Applause.]

Ryan Swafford: I know you guys are really trying to go down to the Culture Center, so I'm going to make this quick. OK, thank you.

Cheryle Kennedy: OK. We want to go ahead and deal with the Board's Tribal organization 638 Tribal resolutions. And we need to have executive session to do that. Someone call the motion.

Motion called and seconded by Cheryle Kennedy. Seconded by Cheryl Sanders. Motion voted and passed

Any questions or comments? Andy?

Andy Joseph: I just wondered if it would be better to 5:15:41.2 [INAUDIBLE] so we don't have to have people 5:15:49.7 [INAUDIBLE.]

Cheryle Kennedy: We did do that. Any other comments or questions? All those in favor signify by saying "aye."

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[Motion passed.]

Joe Finkbonner: Thank you. So what that means, going into an Executive Session, is we can have Board Delegates and Requested staff only, please in the room. So thank you all for being with us, but we're going to ask if you could make your way early to the cultural center or get ready for it, if you get a chance to freshen up before you get going, I promise our delegates that we'll try to make this fast so you have the same opportunity to freshen up so that you can be ready for the tour at the museum.

EXECUTIVE SESSION

4:40 p.m. Recess

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Thursday, October 29, 2015

Call to Order: Andy Joseph, Chairman, called meeting to order at 9:05am.

Andy Joseph: Moving forward, today we're going to start our invocation with Michael Ray Johnson and Frank Lopez.

Invocation:

Michael Ray Johnson: As we gather here today, I ask the Creator to watch over each and every one of us as we conduct the business that's before us. And as the day progresses, I ask the Creator to watch over each and every one of us. I ask the Creator to keep a clear path for each and every one of you as you travel home. That your home is safe. That your home is the way you left it before you came here. Going to sing a song with the bell, and as we sing, I'd like to have you pray in your own way. Pray for your families. Pray for your loved ones, the ones that come to mind.

[Song.]

Chairman's Report

Andy Joseph: Thank you for the invocation and the prayer this morning. Michael Ray is one of my close relatives from my grandma. And just, we brought her home when her time was -- and she was resting right down here in the cemetery. And I really miss my grandma. When I was a little boy I got to stay with them when I was 5 years old at my grandpa's house. And they had this clothes line up, but it didn't have the string on it. And you know, they had the, it was like a bunch of weeds and some cheap grass out there, and so I see this old push mower and so me being the kid that I was, I mowed that Area for my grandma, and I found some string, and I put it up, and I was only 5 years old, and she started using that clothes line because, you know, before it was hanging all over the house and different places to dry. And you know, she had one of those old time washing machines that had the rollers and you had to wring everything out. If they wanted water for it, they had to pump out of the well with a hand pump and put it in there and it was a real task.

My grandma was only about this tall. My grandpa was 6 foot tall and just a giant that stood over her all the time. You know, my grandpa really loved my grandma. I'd go and see him, and he would tell me, you know after her passing, he would tell me well, he went over to Black Feet Country and seen this lady and she told him that should had like 400 horses or something like that. But he said, you know, no. I'm OK. And then he would say something about some other Tribe and a different woman. I was thinking about this. Every time I see my grandpa what he was trying to get to me was nobody's

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going to replace your grandma. That was true love. And that's what I remember about my grandma and grandpa.

Anyway, we'll move on to our agenda. I'm going to try to move us as fast as we can. I've got a 1:00, 1:30 meeting in Portland. So the sooner I can adjourn us, the sooner I can head that way. But I told them, go ahead and start the meeting without me in case I'm late, because I don't want business to stop.

Anyway, that's the fact meeting that's going to be happening. I will have to drive safe as I can and put the pedal down to the metal! Hopefully not get stopped.

You know, since the last meeting, it's been real busy. You know, I took a little bit of time during our what would have been our joint meeting with CRIHB. I have a new granddaughter that we never got to see, and I had an opportunity to help move my son and their grandbaby home. So we drove all the way down to Tucson and came back, and I thought I'd never get out of Nevada. That road is long and just keeps going and going and going! But it was really something to drive through all of that Area and see my wife hold the new grandbaby and get pictures. That was really a good time and something that as a tribal leader, we don't get to spend very much time with our families. So I want to thank our Board for helping with the joint meeting. I know everyone was well-behaved, and hopefully you came home with some good resources from our joint meeting.

I was at several meetings. Let me see if I got more in my report here. This will kind of help me look at some of the stuff that I did. I was able to attend the DST meeting that was in Flagstaff, Arizona. That was a pretty good meeting. It's kind of, if you like driving up to get up in the mountain range, you're going up over 6,000 feet above sea level, kind of at a steep pace. And then when you get up there, there's this bigger mountain that's really something to see. You know, when I was heading down there, our Tribe was going through all of its fires and it got to the point where I figured my communities was going to be safe. But then they were still dealing with all the smoke, and yesterday called in and said that, you know, I couldn't see from here to that door from my house. That's how thick the smoke was. We actually had the council meeting in our -- and you could see smoke in the room. You could smell it. It was all over the place. And it was so bad. And when I was in Flagstaff, was emailing because I wanted to make sure that, because they were already talking about trying to make our people go to work. And we had all this smoke. And I was saying I want to send some kind of air testers in there to test the quality of the air in the buildings, to make sure our people are in a clean environment. So they actually did, and those tests even in the Inchelium Area that's kind of over the mountains, over towards Spokane, they were above the level of being not in a safe situation. And ours were like three times worse than that in our community. So you know, a lot of our employees was thanking me for I guess keeping them home.

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We also wanted to be able to provide services. We did have some people that worked at their, at these hazardous levels because we needed to, you know, make sure that like Colleen said, people were getting prescriptions or getting things that they needed. And I was also able to be down there and talk to Dean Seyler and he was letting us know that, you know, they're getting -- what help they were sending us as well. So it was OK to be away from home during this hazardous time. Being able to breathe clean air for me was good, too.

After that, I went to meet with the -- we had our ATNI meeting. And at ATNI we were moving our resolutions that we had to present there. The main one that we were pushing was the one on the 100% FMAP and because we have three urban health clinics in our Area, we wanted to see if we could get them in on this, in the language so they could bill to get that 100% FMAP as well. And anyway, that resolution was passed. And there at ATNI they did have elections, and I actually was named for the first place, and I didn't even, was kind of a surprise to me to be nominated, and usually I'd want my council's approval and also the boss at home. I needed to ask my wife if it was OK. And so when I went up to give my speech, I told that because of them reasons, I declined the opportunity to be nominated. And actually we had two candidates that were really good candidates. And Greg was one of them, and it was a really close vote. I know if he would have got it, it would have been a real bonus for our health and our education because of all of the good work that Greg is doing.

Mel Sheldon won that position, and about halfway through the darn voting, some of the votes came for me anyway, even though I declined! So it might have made a difference I guess. But the third place position came up, and by then I had nine of my council saying go ahead and go for it. Actually it was when they was counting the first place's votes. I had nine of my council that said go ahead, and my wife also telling me it would be OK. So the third vice position came up, and I got nominated, and was seated by acclamation. So with that position at ATNI, we did have our executive committee meetings. And like it was, they're happy to break even. Before it was kind of in the red. And now they're at a break even budget and hopefully they'll be moving forward. We're working on the constitution and bylaws and their policies. I guess it hasn't been done for almost 20 years. They said "well, we've been waiting for you!" So it's a lot of extra work. It isn't the funniest thing to do. You know. But I would recommend that every Board look at their bylaws and their constitution and policy, kind of maybe every five or six years or so, to redo that.

And then budget-wise, we're looking at what was all necessary for ATNI. Is the office in Portland really -- it's an expensive place to have a program like ATNI. You know, the government is there. BIA is there and IHS is there. I told the Board they can come to us, wherever we meet. We need to be accountable for what we do. They're going to look at all the options there.

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Following that, I went to, I think before that we had our CDC meeting, and I was -- our Area hosted it in Spokane. One of the issues on the CDC was the medical marijuana and they're kind of wanting to understand like the pros and cons of like how the effects of Washington state and how that's impacting Tribes. And you know, one of the things I let them know is since it legalized, our children are being given by the drug dealers heroin. And the main drug that our kids, 6th graders level, are going to the healing lodge, some of them are using heroin. And so that's one of the negative impacts of it being legalized in the state of Washington. Hopefully they'll do more, I guess, drug enforcement with the tax money that they generate, because we can't -- and I told them we needed more hard core educational training to our kids in grade school levels, because that's where it's starting at. Teach them what harms it can do to their body and the impacts to their community.

So we did have a site -- it came up to Colville and it was really something for them to see. And it was kind of just before the fires. There was a little fire that kind of clouded the Area before, but it cleared up just in time for them to come in. If they would have come in a week later, it would have been a different story.

But after ATNI, I went to NCAI. And went to the health committee meetings, and we moved our resolution and it passed at NCAI on that 100% FMAP and it was something that we need to use in I guess our letters that they're requesting to CMS for their consultation and you know, my Tribe has like 160 families that utilize the Native Project in Spokane, and you know, it would give them that extra care that they really need, at that health care facility. So we all have our people in all the big cities. A lot of us are relocated. If we had the infrastructure at home to bring everybody back home, it would be probably a different story. We probably would be pushing more for our people at home at well. But it will help our people at home also.

From NCAI, they did have their elections. What was really good about the elections is we have two seats in the executive committee level. I'm really glad that Brain Cladoosby, from the Swinomish Tribe was reelected as president. And Ron Allen, from Jamestown is going to be their treasurer. One of his big hopes is that they'll have their own embassy fully paid off, and that we own that. And then nobody can I guess say anything about it! So that's one of NCAI's goals. And now they're really planning and prepping for the meeting at the White House.

During that meeting also, they had a conference call on the timing and preparation for the White House meeting. You know, they asked for questions, so I was actually the first one up to the mic, but since it was a call-in, there were about three other tribal leaders that were on the call before me, and then when we tried to talk, it was in the building trying to talk on the phone, it just made all kinds of noise, so we had to go outside for them to hear what I had to say. And what I talked about was what I talked

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about with Bob McSwain about the, you know, I let them know that the IHS budget and that not even a year and a half ago, we were scrambling trying to find -- I think Jim said it was like \$48 million. And then it got narrowed down to 25. They cut some programs, and they let us know what they was cutting, and how they'd come up with that money. And then I tell them our Areas, they was absorbed and so none of the Tribes in our Area, their budgets would be cut. And then anyway, I brought up the \$80 million that they had to figure out where to get for the union claim. You know, the Portland Area don't have any union workers that work for IHS. They, in the letter you received in July 27, said they found it internally. It's like what the heck? You know? It gives you this untrust feeling about our trustees.

Anyway, I said there's people that were needing emergency care, that needed surgery. This whole meeting at NCAI was really pushing on suicide in Indian Country. And we've got people killing themselves, and IHS come up with this \$80 million. I want to see an audit. I want to be able to know when I go to work on their IHS budget if there's any pots of money laying around, you know, let us have access to them for our health care needs. And you know, a lot of that money probably could have went into staffing and then all of our Tribes, if they got a few more doctors or something, they probably could have generated that much more third party. But you know, it just irritated me.

Anyway, they did ask. They says "well, maybe you should come to this meeting and bring it up there." And I says "well, but then the way they do it is they get one person from each Tribe, so usually it's your chairperson, and I'm not the chairperson." But I am hearing that through the different meetings, that this issue is going to be brought up, and you know, I just think that every time we have a chance, get up to that mic and make something known that it's your opportunity to speak for your people. And I took my opportunity, and that's I guess what people put us in these positions for.

Other than that, I know we've got more meetings coming up. Like I said, I'm going to be in Portland today, and in two weeks I'll be down in Phoenix. Then I'll, I believe actually two weeks I'll be in Portland again for all Tribes meeting, and that's where I work on their Area budget recommendations. I always tell the Tribes who are wondering where all the money is and how it's divided up, they should go to that meeting and give their input on what your priorities are. If you have statistical information like what Shawna showed the other day on her report, what's the main killer that's killing your people? Is it cancer that's going up? Is it diabetes? Is it we want to spend more money on prevention, or more money on actual health care? Our Area always pushes for the Purchase and Referred Care Contract Health Services. We always push that because we don't have a hospital. We don't have a regional care facility. So we need the money to distribute out and give for purchase orders for our Tribes. So that's really an important line item. For us it's hospital and clinic because our clinic is so poorly funded, and we need that extra support and actually health care services that our clinics provide. So they can use that to help get the doctors that we need.

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So we've got that meeting coming up, and then there's a facilities meeting in Phoenix, and then in December there's a meeting on purchase of referred care that the work group is going to be coming back together. So hopefully you'll have busy but timely meetings, and maybe have some time to do some hunting, visiting, and being with family on holidays and things like that.

I guess that's my report. Are there any questions? Marilyn?

Marilyn Scott: I just wanted to emphasize the importance of keeping the priorities of the Board. And when I asked the executive committee to consider a resolution that would support that family stability act that was brought to our attention, but in Washington state, the importance of the health care coverage for our children, because the American Indian, Alaska Native children in foster care in Washington State is higher than all other races. And we need to make sure that we are providing that protection for our children that are in that system, whether they're a dependent of the Tribal court or the state court. And coordination. One of the other benefits that we have in Washington state is the legislation that Senator McCoy has been able to get approved in the Early Start Act. He was able to get the funding within that act that was passed by the last legislative session that funded a Tribal liaison within the Department of Early Learning of Washington State. And the importance of our children from the time they start school in birth to three programs until they complete school, the coordination and protection for those children who our are future, it is connected to our health priority program. So I just wanted to emphasize the effort that was announced last week at NCAI. Also the memorandum of agreement that NCAI and the National Indian Health Board and the Indian Education Programs entered into that agreement that they are working together for the betterment of the youth of our future. And so I just wanted to reinforce that in whatever way possible as you're representing our Area, that you also emphasize the importance that we have with the protection of our children because we did hear at the centennial court meeting, all of the tribal leaders identified the crisis that we all have in our communities with drug addiction, with the suicides, with the losses of young adults in our communities. It really is impacting our future. So I just can't emphasize enough, and thank you Andy for doing the job that you do and the sacrifice that you have at home, at times when you're having to be away, but also representing the Area with the Budget Formulation as the co-chair on the national committee. I just can't emphasize enough and thank you for that time.

Andy Joseph: Thank you. There was you just jogged my memory that at NCAI there was a big meeting on Wednesday night, and it was with NCAI and everybody that wanted. NHB was there. SAMHSA was there. We all met on it's going to be like the first of a bunch of meetings that will take place. And it was kind of like -- what do they call those? It's like a strategic planning where they put these messages on the wall and different things that we feel that we need to be working on, on suicide and you know,

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what we could do. What SAMHSA needs to look at, as for funding different types of ways to deal with suicide. So it was a really good meeting, and there was a lot of really good things written on all these poster Boards or whatever they call them. But they're going to take all that information and put it together and we'll be able to share that like when they go to the SAMHSA meeting. I also chair that committee, and I was kind of pushed into it actually when Julia Davis was the chair, and I said I'd co-chair with her because I was really booked up, but once she lost her election, they said "you're it." It's really good though, because that work group does work on what we could do to deal with our Mental Health and Substance Abuse, and also kind of working with the CDC in combination of what we want and the traditional healing practice and the traditional medicines. I know the CDC actually formed a work group that's working on that. I think Cheryl, are you on that CDC Traditional Medicine Work Group?

Cheryle Kennedy: Yes.

Andy Joseph: So anyway, it's one of the things that I kind of really pushed on because they actually said they was getting away from it, and I said no, you've gotta get back into it. Shawna was there, and we kind of pushed them back into dealing with traditional practices. I use like the canoe journey, canoe families as an example of good traditional healing. The healing lodge at Seven Nations, and the best practices that are happening there. So I guess it's OK to be on these different work groups, because hopefully they'll be looking at more grant funding. And what the president's meeting with the youth and that, I think it will show them a little more I guess of an Area of where they should be focusing a little more attention to. I always say there are people traveled around the seasons and the foods, and it even mixes with diabetes. I always bring up that presentation of that lady, I think it was a winter meeting that we had this last winter on diabetes and a development of a baby that's in a mother's womb, what that mother's eating, the kinds of foods that help grow the brain and the different parts of the internal organs. It's all the big science that brings us back to our traditional foods and medicines and what's really actually more healthier for our bodies and can help us to, I guess, not want to kill ourselves. So it's having, I guess putting that into their mind. And I always wanted to find some highly educated doctor that could, I guess, document this down on paper so CMS will understand that this best practice is going to save the government money, so let's let Tribes go ahead and bill for this or maybe they'll open their eyes and do a pilot project like they did for special diabetes for Indians for mental health and suicide. So, give us one of those big grants to prove that our ways will work.

That's really important to keep pushing on those Areas. I guess any other questions?
Cassie?

Cassie Sellards-Reck: Just really quickly, you brought up -- I'm a Delegate and you brought up the children in August. Do you know the dates yet for the Board meeting that will be in your Area?

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Andy Joseph: In August, yeah. Our Omak Stampede is always the second weekend in August. So we'll be there --

Cassie Sellards-Reck: Before or after?

Andy Joseph: We'll be there before. And I kind of line it up with that weekend so that if people want to take in some of our Omak Stampede and the Suicide Race, that Thursday night is the first night of the race and the powwow. So we're looking at August, the tribal health directors would be on the 8th and the quarterly Board meeting would be on the 9th through the 11th of August. And it's usually around the hottest time of the year, so I would say dress for the heat! Like maybe if you was going to go to Phoenix or something. It can get really warm that time of year.

Cassie Sellards-Reck: So with that, in the past we've had a lot of discussions about incorporating our youth and allowing our youth to come participate. And I'd like to re-ask and re-ask us to think how we could bring our Tribal youth from our Areas and be able to incorporate them. Possibly have some youth track or be able to invest. Maybe it's a good time, OHSU could bring those fun pipe-like things and our kids could practice taking out staples or, you know, have something for our kids. Because these meetings, they really would help them feel special. It would help the change. A lot of times our kids just need that time to be touched, to feel like they have hope and opportunity, and what could we do as a Board to provide some of that? Maybe some of us could teach some of the tracks. Maybe there's ways to incorporate them. Maybe they sit with us and, you know, before we talk about any big issue, we explain just a tiny bit of the history so they know what we're talking about. But you know, I would just ask that we put our money where our mouth is, and put our work there, because I'm willing and committed to bring some of my youth. But, and you can try to find resources to fund part of it. You know, for myself at home. But just a thought for you as the director and the executive.

The other thing I would just like to ask, is I think it would be beneficial for Board members, I know myself, and I've asked in the past, but I'd really like to see meeting minutes from the Health Directors meeting. There is no agenda, so I don't really know what's talked about. But some of those conversations are really helpful. Because some of us who sit at these meetings don't go to that one, and you do discuss a lot of important information. For example, the IPC discussion that happened at the Health Directors meeting, I was able to network because Sharon shared with me so that I would know, because I think IPC really could change a lot of our clinics that might be struggling. So it also might be very beneficial to have meeting minutes from the executive meeting that you all do, so that we on the Board maybe don't have to dive into details, but we know a synopsis about the conversation. So those are things that I really appreciate all the work that you do, but and continue to do, and do even more.

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So our prayers at home are for you and the strength that you have. Thank you.

Andy Joseph: Usually at our executive meetings, we will get kind of like brief reports on some of the programs. And we'll get a more in depth report on them when the programs actually represent us here in our meeting. So it kind of gives us a heads up. We also get a financial update, and that's always really important to know that we're doing good financially. And we might look at things like the employee of the year kind of string things like that. And we also will look at let's say if there's anything legislatively that really needs our attention, or if we have these certain meetings that we probably should be going to, then that kind of gives our Board the direction to work out our travel arrangements and things like that. So it's kind of the important stuff, but it's just to keep our, I guess, things rolling. We could get the personnel report there also. That's about all that I guess I have to say. Is there any other questions? If not, we could move on to our next agenda. We have a financial report with Eugene Mostofi. Did I say it right? All right.

FINANCIAL REPORT

Eugene Mostofi: Good morning. My name is Eugene Mostofi. I'm the Fund Account Manager of the Board. Thank you for inviting me here to go over the financial statements of the Board. Jacqueline couldn't be here today. She couldn't travel. So she asked me to do this in her place. I'll be just going over some highlights of the financials as of August 31. Our fiscal year ends on September 30th. So we just finished up fiscal year 2015 a few weeks ago. And we'll start with the balance sheet.

Here's the balance sheet as of August 31st. I'll just go over a couple of highlights. The first one I'd like to point out, and I did make some paper copies, and I put them by your, on your desks here. The analog version. And so I highlighted the Areas on paper where I'm just going to speak briefly about. First item is cash and cash equivalents. \$2,562,485. And that number has two components and two separate checking accounts. \$1,491,00 approximately, of that is our IHS contract service cost settlement. And that's in a sweep account that is swept into a bond fund overnight and then swept back into the checking account and is fully accessible for our needs on demand. So it's fully liquid, fully insured, and available to us for whatever needs we have, and it earns some interest overnight. The rest of that money, about \$1,100,000 is the operating account from the monies to operate our different grants.

Going down to fixed assets, that number zero, those are capitalized assets like any item that we might purchase that's over \$5,000 that we might depreciate over a few years. As you can see, there's nothing there. Everything has been fully depreciated as of this

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fiscal year.

Then toward the bottom, our fund balance, which in nonprofit is \$1,334,417. And in nonprofit accounting is the equivalent of what we call the retained earnings. Monies that are, the difference is between the income and the expenses over time, as of this period.

So we can, and then the cash available, the draw downs from the payment management system. These are funds that are available to us but have not yet been drawn down because we haven't spent the money yet. But we've been awarded these funds from the different granting agencies. And that number is \$6.7 million as of August 31.

The next report is the statement of revenues and expenditures that I'd like to go over. And this one is, shows this is for the fiscal year 2015 from October through August 31. And the four columns we're looking at here, one is the grant revenues and expenditures by line item. The unrestricted funds, and that number as you can see is where our contract service monies from the settlement has been recorded in the "other revenue" line item of \$1,419,233. The next column is our indirect revenues. And the grand total of the three other columns. So the grants are the operating funds of our operations. The different grants that we have. So this is a compilation of everything by line item. So our expenditures for salaries, payroll, grant equipment, telephone, insurance, etc. etc. That grand total of our operating expenditures is \$6,302,000. \$635,000. And then unrestricted, the expenditures there. These are small miscellaneous items like the celebration at Pioneer Square and some other small events that we have. Things that might - honorarians, etc. Where we have about \$4,000. And then some travel supplies, etc. about \$17,000 for expenditures there.

Indirect covering the overhead of rents and salaries of our administrators. Equipment like our photocopiers. Insurance and travel supplies, etc. That total is \$1,630,461. And then the net total revenue over expenditures for all the operations as of August 31, \$1,265,945.

The next one I'd like to go over is the what I call the schedule of expenditures and federal awards.

Cheryle Kennedy: I have a couple questions.

Eugene Mostofi: Oh, sure.

Cheryle Kennedy: On the first, on the balance sheet, on the depreciation, is there a reserve account that's billed fully depreciated?

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Eugene Mostofi: Is there a reserve account?

Cheryle Kennedy: Right. Because I mean we need to replenish whatever equipment or whatever was purchased.

Eugene Mostofi: Right. We, to my reserve account is in the budget for replacing our equipment. I think Mike can speak to that, or Joe can speak to that.

Joe Finkbonner: Cheryle, typically how we do that is when our grants get renewed, we put in there "purchase of new equipment." So that's part of the operating costs for new grants when we get them in there. And that's the mechanism we've used to replace equipment like computers and desks and so forth. The only difference from that would be our work stations, like our cubicles, and that comes right out of our indirect budget, so we take that out of indirect.

Cheryle Kennedy: OK. So the reason for establishing a depreciation entry is because it just showed you that you need to --

Joe Finkbonner: And subtract the assets. When we purchase them, we track them and then we devalue them like technology, and then that way it can be written off when it's replaced.

Cheryle Kennedy: OK. And so for the investments, that's directly from the settlement?

Joe Finkbonner: Yes. I'll let you go ahead.

Eugene Mostofi: There's another line item of \$208,712.

Cheryle Kennedy: That's the one I'm talking about.

Eugene Mostofi: Yeah. That is separate. I think that, again, I think that money is operating. It's not from the settlement. The settlement account is in a separate --

Cheryle Kennedy: We'll come to that yet?

Eugene Mostofi: Yeah. So this \$208,000 is not from the settlement.

Cheryle Kennedy: OK. Then I have another question. On the next sheet, statement of revenues, for the professional fees and contract services, of \$1 million, what all does that entail? That's not the lease for the building, is it?

Eugene Mostofi: No. That's under the grants column, and that is the operations of our different grants -- pass through funds, the various contracts that the grants have with

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professionals or pass-throughs to the Tribes or -- so your question is, no. It's not.

Cheryle Kennedy: So it's for professional services, for consultants or --

Eugene Mostofi: Professional services. And pass through grants and signed contracts for operational grants and their budgets.

Cheryle Kennedy: OK. Thank you.

Eugene Mostofi: I guess I want to also say in terms of depreciation when we buy the building and we own the building in the future, then that will show up as an asset on our balance sheet and we will have depreciation on that. So that would be a major asset in the future.

It doesn't look on the color scheme here like you can see much difference. But I think on the piece of paper, I highlighted the grants that have ended in fiscal year twenty-five in yellow. And in green, I highlighted the grants that are new in fiscal year 2015. So this shows in detail by grant, the expenditures. And the previous report we just saw was basically a summary of all this activity by line item. And this one shows you by grant. And so just in summary then, just going over these, you can see some of the grants that are ending, like the Meaningful Use grant. The two NARCH grants, 5 and 6. The NARCH 6 has been renewed as NARCH 7. So summer institute and the training for the NARCH scholars is in another new grant, NARCH 7 which is this grant 119.

New grant 143 is very equivalent and similar to a grant that's now ending as our 638 funding. Our dental Support Grant. But this is through a new funding stream, and it's a separate grant, it's different and separate from our 638 funding. And so 143 which Tacey Casey and Joe are project director managers for.

Grant 149 is ending, or has ended. IPCM, the national Native network which 1:04:11.7 Kerri Lopez was their project director for. Funding for grant 220, which is a regional training center at University of Washington.

Ryan spoke a little bit out this grant 917, Sexual Assault Task Force Grant, which ended in 2015.

Grant 921, Texas, it's your game. Stephanie Craig-Rushing was the project director for that one, and it ended in 2015.

929. 934. 935 ended. And then the two DHAP grants, one from PEW Charitable Trust, and the one from the Kellogg Foundation were due in 2015.

So you can see that there are columns here where it shows the awards, which includes

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the previous year, and the new awards. So it's a cumulative number expended. As of, for this fiscal year. And the grand total of that expended column, of \$6,302,000, agrees if you look at the previous report. You can see it agrees to that first column of grants of \$6,302,000. So it's a different way of looking at expenditures, one summarizing by line item, and this one by grants.

Conferences. Cash received by grant. Receivables. And the balance of the award.

Any questions on this report?

Cheryle Kennedy: Those kind of negatives, are they not received yet but expected?

Eugene Mostofi: On which common? On the receivable column?

Cheryle Kennedy: The receivable?

Eugene Mostofi: That means that there is more, has been more money received than has been expended, so we are, we basically have, we need to spend the money in order to earn it. But in terms of, for example, that first line, IHS 638 funds are usually given to us beforehand. So that's why there's a very large credit balance there.

The next report is our indirect rates as a relationship to the total indirect cost and direct cost base. As you can see, our indirect rate, we use the provisional final indirect rate scheme. Every year, we renegotiate our indirect rates with our, the body that's HHS. So I graph here, how the indirect rate and -- has fluctuated since 2010. So you can see in 2010 our indirect rate was 41.4%. 2011, 35%. 35.6. 2012, 35.88%. And then in 2013 it made quite a significant drop to 31.5%. And this kind of shows why it happens. And the red line shows the relationship between the total direct cost base and the blue line of the indirect cost pool. And so it's a ratio. The numerator being the indirect cost pool, and the denominator being the total direct cost base. And when in 2013 when that, as you can see the indirect cost pool kind of remains pretty steady. That blue line more or less is steady. And then when the indirect cost base goes up, the rate goes down. So that's why the spending and our grants, the project directors did a really good job in spending that year, and our costs pretty much stayed that same, and that rate dropped quite significantly that year.

And so it's evened out a little bit in 2014 and 15. In 2015, we'll see the rate go up a little bit to 37.5% from our current approved rate of 35.9%. So that will create a little bit of, as you can see on the financials, we have a little bit of under recovery because our actual indirect cost rate is 37.5%, and our approved rate is 35.9%. And we have that difference of about \$130,000 of under recovery.

Any questions on that chart?

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I'll try to speed it up here for you.

Andy Joseph: Actually, I do. I'd like to, I guess I'd like to know how we can leverage what we spend, if we need to make increases in different line items to, I guess, make the money make money, sort of idea. What would we have to do, or would you consider we're already doing?

Eugene Mostofi: That's a good question. Joe, do you want to address that, or Jim?

Joe Finkbonner: Andy, with regard to the indirect, that's really the one where we have probably the -- you can see stabilized indirect costs. That's all of our accounting, me, you know, all our indirect costs. I try to keep those the same and try to expand our direct base so that it lowers the rate. So you can see that the fluctuation of rate has to do more with the grant expenditures and our direct service programs, or direct programs, to the Tribes. You know, all of the grants that Eugene went through. As we increase, those our rate goes down but our indirect spending has stayed pretty level. I hesitate to try to increase indirect spending, because what happens is the grants then have to pay for it. And that hurts our programs more. So what I'd rather do is try to increase our grant base and at that time, slowly increase our indirect spending so that our rate stays about the same. And that's the way we can leverage more services from our indirect pool, is by increasing our grant base. That gets us more revenue, and then from there we can add additional positions that could help.

Cheryle Kennedy: I just had an additional comment on that. On this graph here, if you look across at the total indirect costs, they stay pretty much within the same level. And that's because the staffing package to administer all these grants stays the same. And so I think that's a good thing. I think that it shows that the Board is being efficient as we get more funds. We're still able to manage what we have, and thank you for that.

Eugene Mostofi: Yeah, I think that the number of employees we have, a lot -- is that on? The number of employees we have allows us to keep our indirect spending pretty stable. And I don't know if you remember, but when we had 60+ employees, about 10 or so years ago, our indirect rate went up because of our indirect cost, the personnel costs that go with it. And so that's the trade up. I think we're at that sweet spot right now, where we can keep our indirect spending pretty stable, but if we increase our employees too much, then I think you'll see our indirect costs start to go up as well.

Cheryle Kennedy: I do have another question. On the, you keep turning this thing off and on. On the investments, have you sought out an investment company that would provide guidance to see whether we can increase the investment earnings? And what that might be? Or, I know that, I don't know if there's any restrictions on the settlement. I don't think there is. But --

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Eugene Mostofi: Not on the settlement. There isn't. But our grants, there is. So I haven't yet, because I've -- trying to keep the investment from our contract support cost settlement pretty fluid. And not investing anything long term, given that we likely will try to put it to use in the next 12-18 months.

Cheryle Kennedy: The only reason that I ask is that I know my Tribe has worked with a lot of investment companies, and we stage sometimes for the ability to draw it out or to have access to it, and that's been --

Eugene Mostofi: We did early on, but rates have gone down so low that it almost doesn't make sense to do timetable certificate of deposits or anything like that, that are staggered. Because it's almost getting zero now for any type of guaranteed investment income. Yeah.

OK, the final chart is our operating, total grant operating revenue. So it shows the trend of spending for our grants and grant operations. And where it's been since 2006. And so you can see starting in 2006, the total grant spending, which includes -- oh, I'm sorry, did I -- I'm looking at something different than you're looking at. I have a longer term chart here. So it's since 2010. That was the right one. It's OK.

So since 2010 you can see -- I'm looking at \$4 million 700 -- I'm sorry, \$4,671,000. And I think maybe when I made the photocopies; I printed that number out for you since 2010, or since 2006. So it's almost doubled our grant revenue and spending. I'm sorry, our total grant revenue and expenditures have doubled since 2006. So that's an interesting trend. And in 2014 and 2015, it's stayed about the same, \$8,469,000 in 2014 and \$8,500,000 in 2015. And you can see sort of the relationship between indirect. That's also pretty much leveled off between 36% and 37%.

So I think that's a way for us to sort of manage our indirect cost rates too, is in terms of making sure, seeing where our grants expenditures are going to be vs. our indirect cost pool, and it looks like it's kind of hit that spot the last couple years at least, about \$8.5 million.

Any questions on this chart? OK. Thank you. Next presenter?

Marilyn Scott: I don't think I have a question for Eugene, but I just have a couple questions for Joe. On the schedule of expenditures and federal awards, I was just looking at the listing and I was wondering about the, is the 211, house security Preparedness and Response, is that the Washington state Emergency Management Training? Or planning?

Joe Finkbonner: Yeah. We get a few different pots of money. We get some from

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Oregon, which is very minimal, and that's usually to cover the costs for the Oregon Tribes to attend the Public Health Preparedness conference. And then Washington contracts with us also to operate their conference. And what likely this year, it might be a joint conference with the emergency preparedness Northwest Emergency Management Council. And what we'll try to do is divide the agenda. So to answer your question, yes that's the money for the public health preparedness.

Marilyn Scott: But that amount is, so that's a combination of the funding you get from Oregon and Washington? This \$11,000?

Eugene Mostofi: No. It's --

Joe Finkbonner: I think they're separate. I think we keep track of it separately, the Oregon fund and the Washington.

Eugene Mostofi: Actually the Washington funding is at --

Marilyn Scott: OK. The reason I'm asking is that the Health Commission has requested, because the funding that has been designated from the state, Washington State Department of Health for the Emergency Management, and the planning and the part that the Board participates in, that conference. But there have been some Tribes that have not contracted their Emergency Management funding that was designated for certain Tribes. And instead of losing those funds so that they would have to go back into the state general fund, the commission has requested secretary 1:20:03.8 Weisman [sp?] to allow those funds to be retained within the commission on behalf of those Tribes. You know, so that they're not going back to the federal government that the state has set aside for the Tribes. So that we can do a better job of providing the training and/or the assistance for those Tribes that have chosen not to contract their portion of those funds. So I just wanted you to know that we have not received a response from the department, but we have a new contract officer for that funding that was objecting to that. But we went directly, rather than going to the program manager, we went directly to Secretary Weisman with the letter, and I think they sent you a copy of the letter. So I just wanted you to know that that has been a request that we wanted to maintain those funds whether the Tribes are contracting their piece or not. And the state has received a decrease in the federal funds coming to the state. You know, with all of the sequestration and all of that. So there is less funding available, but Secretary Weisman has maintained the funding set aside for the tribal piece so far. So I just wanted to let you know that.

One other thing that I was just wondering and I've asked this before. If the question that Cheryl raised, the investments, is part of that \$208,000 identified on the assets and has their been tribal contributions to the Board, is that something that is still happening?

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Eugene Mostofi: It is, but not on the scale that it used to. And part of that is we used to do an annual capital raising campaign. We'd send you a letter, ask to pay for lobbying. There are a couple of Tribes that just routinely will send us a check, and that's how it is now. It's been a number of years since we sent that letter to ask for funding. And agreements, because we collect -- Tribes -- everybody's asking for money. And so far with the contributions that we're getting, we even have a couple employees that are donating to the flexible fund, if you want to call it that, that we can use for lobbying. And we've been able to cover our costs. So I haven't come to you and say we need more money for our lobbying trips. And that's primarily what that fund has been used for.

Marilyn Scott: I wanted to just, because when Jay gave us the report about the settlement funds that the Board received, and the reminder that the Board had approved for the, you know, looking at purchasing a facility for the Board, and when Joe talked about the space that we're looking at and potentially more space than what we might need right now, but the investment is, because I'm concerned about part of what Andy reported with the ATNI. And it's been a struggle for ATNI for a long time. And when Joe mentioned potentially there may be an opportunity for space available for ATNI, it makes sense for us, the Tribes, to support the activity of ATNI. And if we're going to be investing -- so, I have advocated with my Tribe to continue to support the Board, and especially if we're looking at the investment of a facility that will be beneficial for long term, I really am in support of that. And if we are also able to provide the opportunity for some of the other organizations that the Tribes really utilize, it is an investment that we can't go wrong. So I just wanted to ask about the contributions and if in fact that is an opportunity that we may be providing, I really would be supportive of that. And I'm still willing to go back to my Tribe in support of that.

Eugene Mostofi: Thank you Marilyn.

Cheryle Kennedy: Does that conclude your report?

Eugene Mostofi: Yes. Thank you.

Cheryle Kennedy: All right. Just for everyone's information, Andy had to get on the road. He's supposed to be in Portland at 1:30, and I was sitting here and I said "you're not going to make it if you don't get going!" He looked at his GPS, he said "oh, that's right, I'm going to be 20 minutes late!" So anyhow, he left to get on the road. So now we are at break how many want to continue on, rather than stop for the break? OK, yeah. Let's go ahead and we'll roll along, and Lisa has a drawing that she wants to take care of.

OK. We are at committee reports. I'll call up first the elders. Who is doing the elders report? Oh, come on up. I think there's a mic up there by the podiums.

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COMMITTEE REPORTS

Elders Committee

Cheryle Kennedy: This is Gladys Hobbs, a member of the Grand Ronde health committee.

Gladys Hobbs: Hi. First of all, I would like to thank Umatilla for inviting us here. It's been a fantastic week. The elder committee meeting was, the members that were present were Bernadine Shriver, from Grand Ronde, Denise Walker from Chehalis, Gladys Hobbs myself from Grand Ronde, Wanda Johnson from Burns Paiute, Janice Clements from Warm Springs, and Kathleen Peterson, Confederated Tribes of the Umatilla, and also Andy Joseph from Colville.

Clarice Charging was in charge of the email for the staff. Janice opened the meeting with a prayer. Dan was not able to attend the quarterly Board meeting due to illness and requested Denise Walker of the Chehalis tribal health director, to attend the committee meeting in his place. That's why I'm up here. Bernadine Shriever otherwise I wouldn't be. Bernadine motioned to approve the April minutes, and I seconded, and the motion was approved. Umatilla -- 475 elders attended their banquet, of which Grand Ronde was one of them. The yearly energy assistance checks were recently distributed to 575 elders. Senior lunches are served Monday through Thursday, and Friday they have breakfast only with meals on wheels service to 30 home-bound elders. Grand Ronde, the elders are currently meeting the third Wednesday of the month, and will hold their Halloween party tomorrow, Friday October 30th. Elder housing is at capacity. Tribal restoration powwow is November -- I think it's November 21st. It's a Saturday.

Warm Springs -- their Tribe is providing transportation for elders to shop in Madras. Noon lunch is served Monday through Thursday to approximately 100 elders. Warm Springs benefit summit will be held November 6th and 7th at Warm Springs Community Center. Booths and staff will be able to assist Veterans and families with paperwork, answer questions, and provide information.

Burns Paiute -- the Tribe has purchased land in the Beach Creek Ranch and Wanda also gave a historical brief on the Tribe. Breakfast is served once a month with various program staff, taking turns preparing and serving the meal.

Chehalis -- elder program will move and be included with the clinic. They are building a new elder center next to the clinic. Chehalis Tribal Health Director coordinates the meal program. They have a new physician arriving next month, and they are hoping the state will pass legislation allowing nurse practitioners to do home bound visits to elders. The elders visited Memphis, Tennessee for their annual trip instead of going to Hawaii.

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Colville -- seniors received wood cords depending on the size of their home, and the program also provides jobs for tribal members. Elder lunches are provided Monday through Friday. Quarterly elder dividends payments of \$350 will be distributed in November, 2015.

Any questions? Thank you

Cheryle Kennedy: Thank you. It's a good report. The next is the veterans. Who is reporting out for the veterans committee?

Veterans Committee

Ryan Swafford: Ours is a little bit different. I only had one person, and neither of us had ever done this before. So we actually did not have a personal update, and we didn't know what we were supposed to be talking about, so we just kind of went over things. The only person I had was Toni Cordal from here in Umatilla, and she just expressed some concerns, or we looked at the handout from Warm Springs because she had already seen that. Twila Teeman had brought us some little quick reference books for veterans, just to I guess show them how to maybe like have access services and whatnot. So Toni took those and was going to pass them out. There was actually a request if maybe IHS could hold a webinar on how to process payment for services through IHS at the VA health, how that works, because there seems to be a lot of confusion. So if anybody could maybe work on that or put something together, and then we also discussed how to approve screening questions for the veterans. When they do come in and they haven't been seen for a while, because that way they don't fall through the cracks and get left behind for other things.

And then we talked about the VA Tribal Consultation that was put out recently, and she just was wondering if there could be like further explanation about how to start putting it into place, as far as how that building would go, because it seemed that unless they could get immediate care without having to go through within thirty days provider, but the question was, you know, can they bill IHS for that instead of paying for it out of their pocket, even though they're supposed to be reimbursed. So that completed our session. Any questions?

Cheryle Kennedy: Thank you. All right. Public Health? Victoria?

Public Health Committee

Victoria Warren-Mears: OK. A little juggling here. I brought my computer up because I just got the MMWR from the Centers for Disease Control and Prevention. I don't know how many of you get that in your inbox. But there's a report in there from a E-coli infection associated with dairy education event attended in Watkin county, Washington.

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So if you're a Washington person, you might want to take a peek at that if you don't already know about it.

In terms of the public health committee, we had a really robust discussion I think for our Delegates and tribal members that were present. We had Marilyn Scott from Upper Skagit, Kelly Little, Coquille, Shawn Jackson from Klamath, Susan Shoeships from Umatilla, and Karen Hansen from Kootenai Tribe of Idaho. And Marilyn had requested to be on our agenda to talk about the Washington health standards that are being developed under the direction of the governor and the department of health. And we had I think a robust discussion about the concern of the multiple reporting standards that will be potentially required between the states, Indian Health Service, and other entities. Marilyn and myself and several others from other organizations, include Barbara Juarez, Jan Olmstead. Sorry about that. And several other tribal other members sat on the foundational public health Board for the state of Washington. And one of the things that continually had to be brought up was the contribution of the Tribes to public health in the state of Washington. And a hazard that this is the same in each of the states that are developing health standards.

There was a survey released in Washington State that was a youth survey, and it talked about suicide attempts and suicides, and it was released stating that American Indians / Alaska Natives had the highest group for suicides in the state of Washington. None of the tribal schools were surveyed in that report though, and so again that was something that was left out of that report.

Another example is the child health profile, the immunization reporting back and forth. Not everyone's involved in that exchange. So again, it's a different picture than might be accurate.

So one of the concerns that I think we'll continue to monitor for each of the states as public health services are being revised is the performance measures that are being put out there. Probably all of you know that there are something like 1200 standards in healthy people 2020. And there is absolutely no one organization that can deal with that, regardless of how large they are. For the state of Washington, there's 52 performance measures. And then with the new reporting system that Mr. McSwain spoke about, and with this new system, I'm sure that GPRA measures will be revised, too. So it would be lovely if we could have a harmonic system where people were reporting on the same measures instead of having to do a lot of extra work.

Tom Wiser, mentioned that both he and Lou Schmitz were at the health informatics road map meeting, which I believe was about two weeks ago. And again, there was a need to emphasize the importance of engaging with the Tribes. The road map people had not really done that, and so that was brought up at that meeting. Tom said he felt that there was a willingness to do that, but it just hadn't been discussed.

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And so then there was also question raised about how many Tribes are reporting GPRA. And I had said that I was going to contact Mary Brickell at the Area office. And so to report back on that, and I did give this to committee members already, but 26 of 44 sites, which includes the Oregon Service Unit and the Tribes are reporting at this time. So clearly, there's if we go to this new system and there's a requirement or a strong suggestion to participate, those numbers will change as well.

And so we also had a robust discussion about data sharing and Tribes and sort of the philosophical underpinnings of that.

So that took up the greatest part of our meeting, and hopefully there was -- I think there's sweeping issues represented in the state of Washington that are also present in other states as well.

We also mentioned our injury prevention project. And we are in process of rebuilding that program again. We've had a grant for the last five years, and when Indian Health Service released the current cycle going out, those who had been previously funded, which included the Tribes and tribal organizations were not eligible to apply for the larger pot of money. So we applied for a modest pot of money which we received. And we will be using that for updating our injury prevention toolkit. And we're also looking at revitalizing the injury prevention advisory coalition. So if you are interested in that, you can contact Bridget or Luella at our office, or obviously me, and I'll pass that along to the correct individuals.

We also had a short discussion that I imagine we'll be continuing about vaccine injury and reporting of that. That hasn't been part of our injury prevention project, nor is it part of the systems that we currently monitor for our data. So I will be following up on that, taking a look at that.

There was also a mention that NIHB will be conducting a survey with the Tribes regarding public health community capacity. And the tribal Epicenters will be participating in a listening session next Tuesday for that. So hopefully we'll have some input on the way the questions are administered.

And a final request from the committee is that if there are Public Health questions that any of you would like to discuss, if you would please send those to me and we'll be happy to address those at future meetings. So thank you.

Cheryle Kennedy: Thank you, Victoria. Good report. Personnel? Who is reporting out for the personnel committee? Jim Roberts?

Jim Roberts: Just a question or a point for Victoria.

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Cheryle Kennedy: Sure.

Jim Roberts: So you got 26 and you subtract that from service units 21. But it would be helpful if Mary could clarify by what state.

Victoria Warren-Mears: I can actually do that. She said the list that she sent has each Tribe listed, and the western Oregon service unit lumped together, and it says specifically which Tribes are reporting and which Tribes are not. So our public health committee received that, but I'd be happy to clarify that and disseminate it to whoever would like to see that.

Jim Roberts: I don't need to know about Tribes, but if we knew the number by state, because what we don't want to do is get in somebody's Medicaid feeds that we're doing, where they're using clinical measures and talking about payments incentives and stuff like that. And say "use our GPRA measures to qualify for GPRA."

Victoria Warren-Mears: Right. So clearly that's not, obviously not the case. And so I'll summarize that by state so that we know. I think non-reporting is fairly dispersive across the region. So I don't know if that's good or bad, but it is at least it's not just one state where there's a failure to report more or a desire not to report that information. It's not a failure, just a policy.

Personnel Committee

Cassie Sellards-Reck: my name's Cassie Sellards-Recks from the Cowlitz Indian Tribe. I'll provide the personnel committee meeting, although I wasn't present due to driving to get here. I will say I guess I want to say really quickly, Shawna, how grateful I am to come. I wasn't going to come. I started to get burnt out and not feeling good and working a lot, and you know, politics. And I just wasn't feeling it. But my elder said "are you going to go?" And I said "no." And then my parents were like "are you going to go?" And "oh . . ." So I decided to get off the pot and we came, and I worked really hard before I came, and you know, just within being here the first day, like all of a sudden I'm just excited and renewed, and I feel good, and sitting next to Sharon and we're popping off ideas, and I'm finding ways to combat stuff at home, and then Denise next door to me, you know, she's like "oh yeah," and we talked for a long time, and I'm just really grateful to come to your land and have it be so beautiful and with that my spirit -- because I feel renewed again. I've already fired off an email, a couple to the chairman and "you think that is? . . ." So it's good. It's very good, and watching the sun rise this morning, I woke up to the beautiful hues of your land and just really it's been a very spiritual, good news for my heart. So.

With that being said, the Board is doing really well. We have several new hires and

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promotions and transfers. A couple separations, but all are OK. The annual and probationary period and evaluations are all done. So that's really, that's a good thing to know that people are getting their evaluations on time. Everyone is on task. And that means that things are rolling down the road very good. They got their CPR training and first aid, which is important. If anybody drops, you know that they can save us.

And then they got the Oregon's top workplace award, which I think we all need to give them a round of applause. Because that's a really wonderful thing. Joe and -- Joe's working hard, and he's got a lot of our faith. And I think it's really exciting to see them want to expand and take over and be responsible for the things that we actually might get help with. You know? I call IHS and they don't return my phone calls, and I call them again and I call them again, and I'm tenacious, and they still don't return my phone calls, I thought to myself, well they don't know who they're dealing with! I'll just show up. But then I figure no, let them be who they are.

But anyway, thank you very much. And Shawna, thank you for allowing us to come to your Area. We're going to go to your museum and then we're going to take a little trip to Walla Walla. My parents are with me and so they want to go see the campus of Walla Walla College and they want to go to Andy's for some brewer's yeast, and I'm like "oh my god, I'm on a road trip." She wants to go to Pendleton store. I'm like, oh, there's half our day! So we got a little slot machine revenue, so I'm applying for some funds. I'm like oh, I'm not going to spend Bill's money. So anyway, thank you.

Cheryle Kennedy: Thank you Cassie. The Behavioral Health Committee?

Behavioral Health Committee

Charlotte Williams: I'm Charlotte Williams from Muckleshoot. And Marie Starr also here from Muckleshoot, and she attended the state meeting. The other attendees were Kevin Collins, Health Directors, Elizabeth Buckingham, Health Director, Julie Taylor, Umatilla, Karen Cruz from Warm Springs, Rebecca Proctor Burns Paiute, Stephanie Craig-Rushing from the Board, Colby Caughlin from the Board.

Our agenda was, I'm just going to read the outline that she wrote. On the agenda, we had integration of mental health and chemical dependency treatment. Attendees voiced concern about the Washington and Oregon mental health and chemical dependency integration processes. In Oregon, they've been working through a transformation of two years now with repeated state level organizational changes. They are still shifting roles and responsibilities between the different departments and agencies, and they're concerned that they'll lose the progress they've made over the next five years with professional work and treatment in the prevention field. And the good news is in Oregon, tribal medicine practices can be reimbursed if it's part of a

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patient's treatment plan.

In Washington, the integration requirements aren't trickling down to the clinical level. But Electronic Health records allows for integration. But Chemical Dependency is still requiring that they keep dual records. Mandates are coming from the state without asking Tribes how they will be impacted. The agencies haven't figured out what they want and aren't providing sufficient guidance of how to integrate. And we're concerned that the 1115 global waiver is harmful to the Tribes.

At the Committee ask Jim and Joe to make a statement. They said we need legal advice on how to share information between Chemical Dependency and Mental Health records, to make sure we're treating the whole person.

And the next was the SAMHSA Behavioral Health agenda. We need to define health care so that all medical services fall under HIPPA, to allow for a truly integrated system with mental health, physical health, and Chemical Dependency. We need a consistent definition of Behavioral Health. We need a consistent definition of mental health. And recognize tribal best practices in patient treatment plans. Focus on prevention, and not separate prevention from mental health. We need cross-cutting funding for prevention and mental health, Behavioral Health. And the ----that's due on November 6th, Stephanie and Colby will send that input.

The Mental and Suicide Prevention Initiative. There were more applicants in the Northwest than funding was available, so all grants were not funded. We need additional mental and suicide prevention initiative carve out dollars so that we don't have to compete with each other for these funds. And then we made a member statement to Jim: please bring this issue up at the Budget Formation meeting in December.

Next was the National Action Alliance for Suicide Prevention. It includes the American Indian / Alaska Native work group that will be working to increase the visibility of this issue and develop tools and resources for the Tribe. And then there's another statement to Joe: we really need something at the Board. We really need someone at the Board to be dedicated to mental health, who will keep track of these issues and who can help keep the Tribes abreast of these issues. That's our report.

Pearl Capoeman-Baller: I've just got one question. Is this committee going to be making recommendations or coming up with language to differentiate between the mental health and Behavioral Health? I mean, you said that you guys discussed that, so is there somebody that will be doing that?

Charlotte Williams: I think that's why they want someone at the Board to be dedicated to this.

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Pearl Capoeman-Baller: Oh, OK.

Charlotte Williams: I think the main issue was mental health people -- you know, the different ones in the health field, like the claiming for mental health, Behavioral Health -- because of HIPPA, they can't talk to each other.

Pearl Capoeman-Baller: Yeah.

Cassie Sellards-Reck: I have a question. How is that true? If. A patient signs a consent and they're dual diagnosed, they are supposed to be able to all work together, even with their health care providers. So HIPPA, if everybody's trained and you have permission, you absolutely share information. So you could.

Charlotte Williams: It could happen.

Cassie Sellards-Reck: Absolutely. If your clinic, everybody's HIPPA trained and your patient signs a release, you all work together, especially in Washington. They're having those two be together because so many of our people are dual diagnosed. So they can work together.

Charlotte Williams: They can if the patient will sign that.

Cassie Sellards-Reck: And most of them do, because it becomes part of their team. Their treatment team. And you want your health care provider included in that because, so you can look at their medications.

Kevin Collins: So under HIPPA, medical and mental health can talk to each other somewhat, but chemical dependency is under 42. CFR42 which makes it a lot more stringent in its regulations and its ability to communicate with other programs. So I think there's movement afoot to rewrite 42 part 2, according to the EHR. But it's yet to happen. So for every patient for every instance, a release needs to be signed and it gets to be real cumbersome.

Cassie Sellards-Reck: Well, but within our clinics, we can create that, and we have sovereign government. We can put out a consent. And with our clinics, we can have them talk because you know, we just have a consent that allows that. There's no reason within tribal clinics with our Self-Governance and everything else, that you wouldn't have them communicating, even at the level within the county. I saw the alcohol chemical dependency Board and the mental health Board in Clark County. And they're working together. So I guess maybe I don't understand the issue, because we don't have these issues at my clinic.

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Jim Roberts: You're right on the HIPPA thing. It's also programmatic. So a lot of times the Tribes --

And your Tribe might be different where everything's integrated into one system, Cassie. But some of the Tribes break up Behavioral Health from medical. And that's also a problem because the Behavioral Health side doesn't recognize the releases that are issued by medical or vice versa.

Kevin Collins: So the CFR is so specific in the way it's written that the releases are mandated to be a seven point document. And so you have to designate exactly what information is going to be released. It's not an open door. And exactly who that information is going to be released to. So if you walk into a room as a chemical dependency counselor or provider, you can't talk to everybody unless the release -- unless there are several releases for everyone in the room. It's pretty specific, and it's incredibly cumbersome. And I think it was written probably 30 years ago when it made sense, when the stigma around chemical dependency was so much more than it is now. It was written to protect patients, but I think it needs to be revisited so that integration can truly happen, because we've been mandated to integrate without the tools to be able to do so.

Cheryle Kennedy: Thank you. Those are good responses, and I think the way that clinics are set up really allow for some flexibility and if everything is separate, then you know, you have to jump through some extra hoops to allow your patient to get the full one approach to health care advantage. So that was a good dialogue.

I have a question here. There's a beautiful pink pen up here.

Cheryl Sanders: That's mine! I got it at the dollar store.

-

Cheryle Kennedy: So I'll give the report on the legislative committee. I'm not sure, Jim and Joe who are taking notes, who all was there. I didn't see that roster to report on. The attendees were myself, Kim Zillyet-Harris, Pearl Capoeman-Baller, Jeff Lorenz Jeff wasn't here.

Jim Roberts: No, I didn't have the list of the --

Cheryle Kennedy: Leslie Wosnig, Ed Fox, Joe Finkbonner, Jim Rogers, and there were a whole lot more than that. But I'm not sure who has that sign-in sheet. Anyhow, there were a lot of people who participated.

What we talked about was the preparation for the White House missions meeting, and

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of course you heard Jim earlier ask for our input in the full body, and we gave our recommendations. He's somewhat refine it Are you going to send that out? OK. So he will be sending that out to all the Delegates of the Tribe.

The preparation for the 2016 legislative plan, he presented as well. Do you want to make any further comment about that, Jim? All right. And we do have resolutions. We had three resolutions, it looks like 4. And I'm going to ask Joe to go ahead and come and walk through those resolutions that were proposed. They were all fully supported by the committee itself with the dialogue. And I believe that's where -- I have copies of them right there.

Joe Finkbonner: Am I prefacing -- you want me to do the resolutions now and then we'll vote on those as part of the support?

Cheryle Kennedy: Right.

Joe Finkbonner: OK.

Resolutions:

1. 16-01-01 Interview Project with People who Inject Drugs

[Reading description.]

[Motion is made by Cheryl Sanders and seconded by Shawna Gavin motion to approve this resolution. Motion is voted on and passed.]

2. 16-01-02 Tribal Exemption from the Patient Protection and Affordable Care Act Employer Shared Responsibility Mandate

[Reading description.]

[Motion is made by Cheryl Sanders and seconded by Shawna Gavin, motion to approve this resolution. Motion is voted on and passed]

Jim Roberts: I just propose we make an amendment. This is a resolution that was made at ANTI So "therefore be it resolved," where it says that, that used to say "that ATNI does hereby support the recommendations developed by the Northwest Portland Area" What I would say is let's revise that to say "the Northwest Portland Area Indian Health Board respectfully requests IRS" So of course -- what it's saying is that we support our own recommendation, and of course we do that. If we can make that clear?

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Cheryle Kennedy: OK. So for the one who made the motion, is that acceptable? The one who seconded?

Marilyn Scott: Cheryl? I have a comment. At the NCAI subcommittee, this resolution did not get approved. It was tabled. But there was a lot of discussion about -- the discussion was around the employer response, you know the exemption for employer shared responsibility mandate. And the discussion was around tribal governments and tribal member employees, and non-Native employees, you know. There was a lot of discussion about that, whether the Tribes were asking for the employer shared responsibility mandate exempting Tribes and tribal organizations. So I just wanted to share that. That was a discussion, and I think it was tabled, but it was forwarded to the Executive Committee of NCAI to further consider submitting a letter of support to the IRS.

Cheryle Kennedy: Thank you, Marilyn.

Jim Roberts: Did you talk about the Cadillac exemption on the SS tax? Or the employer mandate?

Marilyn Scott: It was that second day

Cheryle Kennedy: Any more discussion or comment?

[Motion was voted on and passed.]

3. 16-01-03 Western Tribal Diabetes Special Diabetes Program for Indians Grant.

[Reading description.]

[Motion is made by Cheryl Sanders and seconded by Shawna Gavin, motion to approve this resolution. Motion is voted on and passed]

Cheryle Kennedy: That concludes the legislative committee report.

FEMALE SPEAKER: We got one more.

Cheryle Kennedy: We got one more? Where is it? OK, Jim

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4. 16-01-04 Northwest Portland Area Support for Congress to Pass S.1964, Family Stability and Kinship Care Act (S.1964)

[Reading description.]

[Motion is made by Cheryl Sanders, Lummi Nation and seconded by Brent Simcosky, Jamestown, to approve this resolution. Motion is voted on and passed.]

Cheryle Kennedy: OK, that pretty much concludes --

Pearl Capoeman-Baller: Oh Cheryl, I have a quick question about the Executive Committee report. Maybe Joe can answer, or Cheryl. Are we not going to be giving college credits anymore from the Northwest College that we used to sign up for every meeting? Or was that a one-time thing that we just signed up for?

Joe Finkbonner: We absolutely can do it, but what we're trying to do is get some funding from the Appendix X casinos in order to bring those efforts here. It wasn't much money that we used up to bring Julie on to coordinate a lot of that activity. And as well, some other things. So we're definitely going to go after some more funding to do that to bring her on Board, but we can as well. What she did largely was got the agendas, got the files of the speakers and submitted it just like you would for continuing education. So that was the type of effort she put into it, and so we felt like she had to be compensated for that extra work that she did, so that's why we're pursuing some additional money to be able to continue that services. So the answer is we're definitely working on it.

Cheryle Kennedy: Thank you.

Pearl Capoeman-Baller: Cheryl, one more thing -- I just wanted to say to Shawna that I really enjoyed coming here to Umatilla even though I didn't make it to the museum yet. You know, as I was driving here, and it is a long drive from home, further from Makah, so I can't complain too much. But you know, as I was driving here and visiting your casino here, in my mind I asked myself "how on Earth did the government ever find these Umatilla Indians?" Because as you look out, you see nothing but open roads! You would never think there was a village of Indians down here. It just surprises me that they found you guys! Thank you for your hospitality.

Shawna Gavin: It was wonderful to have you all here, and I think probably how they found us, they heard everyone laughing.

Cheryle Kennedy: That's probably true! OK, moving on to unfinished business. We tabled the approval of the minutes. We've gone through the resolutions. But we need

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to approve the financial report. It's not on our agenda, but we need to do that.

Financial Report

[Motion is made (by Shawna Gavin) and seconded (by Marilyn Scott) to approve this report. Motion is voted on and passed.]

Cheryle Kennedy: I really appreciate, well he's gone now, but I did enjoy the report and the way that he put that together. Our future Board meetings, January 19th to the 21st, is going to be held up at, with the Lummi Nation. April 19th to the 21st is Nez Perce. So they'll be all getting this information. August 2016, Colville. In October 18-20th is Yakima. And Andy was telling me that the reason for the August change was the Stampede. So that Board members on Thursday night might be able to participate in the Stampede that they have up there.

So at this time, we've concluded all of our agenda items. Is there a motion to adjourn?

[Motion to adjourn by Pearl Capoeman-Baller, seconded by Brent Simcosky motion is voted and passed.]

We'll see you all at the next Board meeting.

[Meeting adjourned.]

INDIAN HEALTH SERVICE PORTLAND AREA DIRECTOR'S UPDATE



Dean M Seyler - Area Director
October 27, 2015
NPAIHB Quarterly Board Meeting
Wildhorse Casino




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

Governing Board Meetings

- ❖ All Six Service Units
- ❖ Bi-annual – Department Best Practices
- ❖ Future Presentations At QBM
- ❖ All Five DST Councils invite To Every Meeting

IHS Director's Listening Session

- ❖ Corrective Action Plan
- ❖ Expect To Hear From Mr. McSwain




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

Public Health Service Update

- ❖ Transition of HR Support to Coast Guard.
- ❖ No New Orders after November 13th Through January 1st
- ❖ New Commissioned Corps Liaison For Portland Area
- ❖ Commissioned Officers Effective Report (COER) Deadlines




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

- ❖ **Office of the Assistant Secretary for Planning and Evaluation Site Visit**
 - ❖ November 4th, 5th, 6th
 - ❖ Deputy Assistant Secretary for Health Policy
 - ❖ Associate Deputy Assistant Secretary for Health Policy
 - ❖ Senior Program Analyst
 - ❖ Site Visit Locations:
 - ❖ NARA
 - ❖ Siletz Tribal Health Care Program
 - ❖ Western Oregon Service Unit



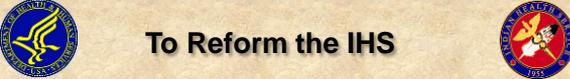

Renew And Strengthen Our Partnership With Tribes and Urban Indian Health Programs

- ❖ **PUBLIC HEALTH EMERGENCY MANAGEMENT**
 - ❖ **Emergencies/Disasters, 2015**
 - ❖ Northwest Drought and Wildfires
 - ❖ Roseburg Shooting Incident
 - ❖ **IHS Actions**
 - ❖ Tribal inclusion on State and Federal declarations
 - ❖ Provided technical assistance and expertise
 - ❖ Critical medical supplies, public and behavioral health services and environmental equipment to impacted Tribes
 - ❖ **FY16 INITIATIVES**
 - ❖ Injury Prevention Projects
 - ❖ Environmental Health Program Capacity Development
 - ❖ Study of Environmental Exposures in Child Care Settings



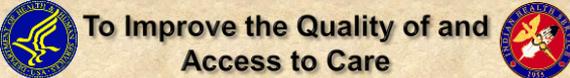

Improve The Quality Of And Access To Care

- ❖ **CHEF Balance Remains at 4 Million as of 10/23/15**
 - ❖ 59 PA CHEF Cases Submitted & 16 Amended Cases
 - ❖ \$2,469,211.33 submitted for reimbursement
 - ❖ \$1,704,802.00 funded thus far
- ❖ New CHEF guidelines will be released mid-November
 - ❖ Webinar will be scheduled by the Area PRC Manager
- ❖ **ICD10**
 - ❖ Roll-out October 1, 2015
 - ❖ Minimal issues so far



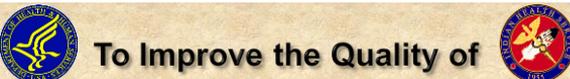
To Reform the IHS

- ❖ **ICD10**
 - ❖ Roll-out October 1, 2015
 - ❖ Minimal issues so far
 - ❖ CMS Certified Coder Training Aug 3-14
 - ❖ 25 IT/U in attendance
- ❖ **FOIA Data Base**
 - ❖ 16 Tribal RPMS Sites (for ICD10 Prep)
 - ❖ PCC& CHS (anything that touches a diagnosis code)
 - ❖ 28 EHR Sites:
 - ❖ Patches 14, 15, & 16 loaded
 - ❖ 47 additional add on patches uploaded in September
 - ❖ Completed 25 Sites so far 3 remaining



To Improve the Quality of and Access to Care

- ❖ **Portland Area Facilities Advisory Committee (PAFAC)**
 - ❖ Developing a Project Proposal that Demonstrates Readiness for Implementation.
 - ❖ Location
 - ❖ POR/PJD/Business Plan
 - ❖ Tribal Support.
 - ❖ The PAFAC is Meeting Regularly and Developing Recommendations to Strengthen the Project Proposal.



To Improve the Quality of and Access to Care

- ❖ **Fall 2015 Portland Area Clinical Director's Meeting**
 - ❖ November 5-6, 2015
 - ❖ Northwest Portland Area Indian Health Board (NPAIHB)
- ❖ **Spring 2016 Portland Area Clinical Director's Meeting (tentative)**
 - ❖ April 7-8, 2016 in Portland
 - ❖ Follows the NPAIHB Clinicians Cancer Update (April 6, 2016)
- ❖ **IHS Essential Training on Pain and Addiction**
 - ❖ Repeat virtual session offered Nov. 18, 2015 at 8:00 am PT

Connection Information

Go to: <http://ihs.adobeconnect.com/painandaddiction/>

Select the "Enter as a Guest" option

Enter your name, first and last, with designation in the box designated Name (ex: Jane Doe, MD).

Enter the passcode : **addiction**

Click on the "Enter Room" button




To Improve the Quality of and Access to Care

- ❖ **Special Diabetes Program for Indians (SPDI)- FY2016**
 - ❖ Diabetes Prevention and Healthy Heart grants have ended.
 - ❖ Funding for "Data Grants" will be an Area-level decision.
 - ❖ Funding has been reallocated to existing programs.
 - ❖ Urban Projects- \$1 million increase
 - ❖ Community-Directed Grants- \$25,552,678 increase
 - ❖ Portland Area- \$1,198,021 increase (\$6,932,564 total)
 - ❖ National funding formula remained the same, though with more recent data on User Population (2012) and disease burden (prevalence).
- ❖ Selected grantees will be announced in December.
- ❖ Portland Area Funds Distribution




Ensure that our work is transparent, accountable, fair, and inclusive

- ❖ **FY18 Budget Formulation Meeting**
 - ❖ November 10, 2015
 - ❖ Embassy Suites at Portland Airport
- ❖ **Area Office Staffing Update**
 - ❖ Selected Area Dental Officer-withdrew acceptance
 - ❖ Martha Young retired effective Sept 30th
 - ❖ Area Diabetes Officer –expect advertisement within next six months




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.



Indian Health Service Integrated Data Collection System Data Mart

Introduction

Updated: October 2015

Agenda

- **Thanks**
- **Updates**
 - Drought and wildfire response
 - July 2015 Listening Session for IHS Portland Area action items
- **IHS current performance reporting process**
- **New system: Integrated Data Collection System Data Mart**
- **Key points**
- **Contact information**
- **Comments and questions?**



Current Performance Reporting

- GPRA
- GPRAMA

Reporting Process	Limitations
National performance results are <u>only</u> reported from the Resource and Patient Management System	Performance results reflect only those sites using RPMS
Data must be manually aggregated at the national level	Reports can only be run three times a year and national results are delayed 8-9 weeks after the end of each quarter



New System: Data Mart

- Allows Tribes and Urban programs with commercial Electronic Health Record systems to include their data in national results
 - Improves accuracy and completeness of performance data
 - Reports will be available at the national, Area and Service Unit levels
- Automated system built into National Data Warehouse
 - Improves timeliness of reporting



Launch Timeline for the Data Mart

- 2015-2016
 - Tribal consultation and Urban confer sessions
 - Build and test the system
- 2017
 - Monitor results
- 2018
 - Official results available
 - IHS will begin to use results, starting with the fiscal year 2020 Congressional Justification



Key Points

- IDCS allows non-RPMS users to submit data for IHS national performance results
 - Urban programs will be included in reporting
- Results will be available at the national, Area and Service Unit levels
- Tribal programs may opt out





Questions?

For Data Mart comments and questions, also contact the
IHS Office of Public Health Support at
(301) 443-0222
or by email at
HQ_OPHSidcs@ihs.gov



Executive Director Report

Wildhorse Resort & Casino

Pendleton, OR

October 27, 2015

Joe Finkbonner, RPh, MHA



Personnel

- New Employees:

Nanette Star Yandell, MPH -Project Director & Epidemiologist, WEAVE-NW

Celena McCray (Promotion) Thrive Assistant to Coordinator

- Resignations

Amanda Gaston, IYG Project Manager

Jenna Charlie, On-Call Front Office

Elaine Dado, Executive Assistant



Events

July 2015

➤ Portland Area 638 Training/ All Tribes Meeting, Issaquah, WA

➤ 2015 Portland Area Dental Meeting, Tulalip, WA



Events

August 2015

- PHAB Accreditation Meeting – Alexandria VA
- NPAIHB Annual Staff Picnic, Oaks Park



Events Cont...

• September 2015

- Nike Native Fitness, Nike HQ
- ATNI, Spokane, WA
- NIHB Annual Conference, Washington DC
- WDSF Retreat, Seattle, WA
- Indian Day Celebrations (September 25)



Events Cont...

• October 2015

- KPCF Committee Meeting
- NWI Fountain Meeting, Bellingham, WA
- Washington Centennial Accord, Shelton, WA
- NCAI, San Diego, CA



Upcoming

- Idaho Tribes Quarterly Meeting, Boise, ID (Nov. 5)
- FY2018 Budget Formulation Meeting, Portland, OR (Nov. 10)
- PHAB Accreditation Meeting, Alexandria, VA
- NPAlHB Staff Retreat, Lincoln City, OR (Nov 17-18)
- WDSF Meeting, Seattle, WA (Dec. 3-4)
- NPAlHB Staff Holiday Party (Dec.7)
- PHAB Board Meeting, TBD (Dec. 9-10)



Strategic Planning -

NPAIHB 2010 STRATEGIC 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)
<p>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</p>	<p>Number of Quarterly Board Meetings Held</p> <p>Number of Resolutions passed</p>	<p>October 2010 to October 2015</p>	<p>Twenty one Quarterly Board meetings were held between October 2010 to October 2015, inclusive.</p> <p>During the rating period, three collaborative meetings were held with the California Rural Indian Health Board (CRIHB), two in California and one in Washington.</p> <p>During the rating period 102 resolutions were developed and passed by the Board.</p>
<p>2. NPAIHB will support tribal delegates in regional & national AI/AN healthcare discussions, by providing them with orientation, training & assistance</p>	<p>Training will be provided in the form of new delegate orientation</p>	<p>October 2010 to October 2015</p>	<p>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.</p> <p>The orientation manual was updated regularly, including input from Board Secretary & Treasurer</p> <p>The updated orientation manual is also posted to the delegates iPad</p>
<p>3. NPAIHB will maintain effective communication channels to inform tribal delegates & tribal decision-makers about emerging public health topics</p>	<p>Issues of Health News and Notes will be developed quarterly</p> <p>A weekly e-mail correspondence to tribal leadership will be undertaken</p>	<p>October 2010 to October 2015</p>	<p>During the period of October 2010 to 2015, 21 issues of health news and notes were developed.</p> <p>During the rating period of October 2010 to 2015, over 250 postings and updates were provided to tribal leadership.</p> <p>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</p>

			<p>IT: 4 tribal health director meeting presentations with MU updates</p> <p>NWTEC Staff developed numerous fact sheets on disease specific concerns at the regional and local level for tribes in the Northwest.</p>
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	<p>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</p> <p>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,</p> <p>During the rating period, six trainings on Public Health Emergency management were held.</p> <p>NPAIHB provided Public Health Accreditation 101 training multiple times.</p> <p>NPAIHB provided understanding data training to 30 participants in 2015. This training will be provided again.</p> <p>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.</p> <p>Additionally, during the rating period NPAIHB provided host facilities for numerous IHS trainings, including EHR training, and ICD-10 training.</p>
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	<p>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.</p> <p>Staff provided TA to delegates of the Board to a variety of HHS standing committees:</p>

<p>opportunities align with the priorities, needs and organization capacities of the NW tribes</p>	<p>evaluation</p> <p>Provide membership and staffing to tribal advisory committees to HHS</p>		<p>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</p>
<p>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</p>	<p>Number of employees</p> <p>Number of employees hired</p> <p>Longevity of staff</p> <p>Number of staff utilizing wellness benefits; including wellness time, baby friendly workplace policies, and education leave</p> <p>Number of staff utilizing Board provided scholarships for training (NARCH scholars and fellows)</p>	<p>October 2010 to October 2015</p>	<p>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</p> <p>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</p> <p>The majority of staff have taken classes at the Summer Institute, sponsored by NARCH, to continue their professional development.</p> <p>Twelve employees have taken advantage of the paid education leave to continue their education in health related course (2010-2015)</p> <p>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</p> <p>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</p> <p>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.</p> <p>The wellness benefits of the Board's employees continue to be acknowledged as being</p>

			<p>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.</p> <p>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.</p>
<p>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</p>		<p>October 2010 to October 2015</p>	<p>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.</p> <p>THRIVE has held 5 Youth Specific Trainings between 2010 and 2015. A total of 359 youth have attended.</p> <p>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.</p>

GOAL 2: The NPAIHB will strengthen regional and national partnerships to ensure access to the best possible health resources & services.

<p>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</p>		<p>October 2010 to October 2015</p>	<p>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.</p> <p>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</p> <p>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</p> <p>Conducted DMS training for IHS Areas including Aberdeen, Alaska, Albuquerque, Billings, Nashville, Oklahoma, Phoenix</p> <p>IT: Partnership with WIREC/Qualis Health on Security Risk Analysis services</p> <p>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.</p>
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<p>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</p>		<p>October 2010 to October 2015</p>	<p>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</p> <p>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)</p> <p>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</p> <p>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</p> <p>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)</p>
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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.

<p>1. NPAIHB will facilitate 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</p>		<p>October 2010 to October 2015</p>	<p>Communication has been facilitated via e-mail, newsletter, videoconferencing, face to face meetings and position papers.</p>
<p>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)</p>		<p>October 2010 to October 2015</p>	<p>Analysis performed and extensive comments submitted during public comment period for MU Stage 2 Final Rule.</p> <p>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.</p>
<p>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</p>		<p>October 2010 to October 2015</p>	<p>NPAIHB has provided annual budget analysis to all tribal delegates and congressional staff for advocacy.</p> <p>IHS Budget evaluation Active in National Budget formulation</p> <p>Instrumental in reinstatement of All Tribes Meeting in 2015</p> <p>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.</p>
<p>4. NPAIHB will analyze new & existing healthcare delivery systems & will advocate for tribal consultation & participation in their development</p>		<p>October 2010 to October 2015</p>	<p>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.</p>

<p>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)</p>		<p>October 2010 to October 2015</p>	<p>Formal grant application for planning submitted to IHS in 2014 unfortunately was not funded.</p> <p>Plan for functions for potential assumption has been outlines with key positions identified.</p> <p>Further work needed in this area.</p>
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GOAL 4: The NPAIHB support health promotion and disease prevention activities occurring among the Northwest Tribes.

<p>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</p>	<p>Number of resolutions passed and project during the rating period</p> <p>Number of new project funding received in the period</p> <p>Types of funding received</p>	<p>October 2010 to October 2015</p>	<p>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.</p> <p>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.</p> <p>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.</p>
<p>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</p>	<p>Number of trainings in rating period</p> <p>Number of TA responses and percentage of tribes requesting TA from the</p>	<p>October 2010 to October 2015</p>	<p>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.</p> <p>Sexual Assault Prevention Project: Provided 6 Sexual Assault Response & Resource Circle trainings; 2 Sexual</p>

	EpiCenter		<p>Assault Nurse Examiner trainings; 1 Tribal Sexual Assault Advocacy training; 12 Tribal Sexual Assault Dynamics trainings & 4 Risky Business trainings to the NW tribes</p> <p>Western Tribal Diabetes Program: Responded to well over 100 requests for TA on an annual basis.</p> <p>IDEA-NW: Responded to over 30 requests for data & TA annually from NW tribes, NPAIHB programs, urban programs, state partners & others</p> <p>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</p> <p>Grant evaluation and TA was provided as requested.</p> <p>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.</p>
<p>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</p>	<p>Number of initiatives developed with culturally rooted evidence based practices and policies during the rating period.</p>	<p>October 2010 to October 2015</p>	<p>Developed & modified multiple training curriculums to be relevant to tribes, tribal organizations & tribal practices</p> <p>Public Health Improvement Program: Supported the implementation of the public health accreditation tribal standards via trainings, TA & outreach</p>
<p>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</p>		<p>October 2010 to October 2015</p>	<p>Sexual Assault Prevention Project: In collaboration with Project THRIVE developed a Sexual Assault Prevention media campaign that has been distributed & promoted nationwide</p> <p>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</p>

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	<p>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.</p> <p>Public Health Improvement Program: Provided 4 public health accreditation trainings; 1 quality improvement basics, 1 Cherokee Nation Lessons Learned, 2 Digital Storytelling</p> <p>During the reporting period 5 emergency preparedness trainings were held and the Board participated in Cross Boarders Emergency Response Training.</p>

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	<p>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</p> <p>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.</p>
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	<p>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</p> <p>Improving Data and Enhancing Access – Northwest (IDEA-NW):</p> <p>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</p> <p>Analyzed linkage corrected data to respond to over 50 data requests, prepared journal articles for publication, prepared data reports/fact sheet</p>

			<p>series & prepare state/local level tribal health profile reports</p> <p>Worked with Indian Health Service, tribes & urban Indian clinics to expand the representativeness of the NW Tribal Registry.</p> <p>Obtained access to IHS EpiDataMart in 2014 through a data sharing agreement with Indian Health Service.</p> <p>Developed regional AI/AN Health Profiles for Idaho, Oregon and Washington States.</p> <p>Obtained/accessed state & federal data sources for analysis (e.g., BRFSS, PRAMS, OPHAT, CHAT)</p> <p>Maintained list of data sources/resources for NW tribes.</p> <p>Provided planning/biostatistician support for specific groups (Adult Immunization project, MCH analyses)</p> <p>Wellness for Every American Indian to Achieve and View Health Equity (WEAVE NW):</p> <p>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.</p>
<p>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.</p>		<p>October 2010 to October 2015</p>	<p>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</p> <p>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.</p> <p>Lead development of the cross Tribal Epidemiology Center publication “Best Practices in American Indian Alaska Native Public Health” 2013.</p>
<p>4. The NW Tribal EpiCenter will protect the rights & wellbeing of the NW tribes &</p>		<p>October 2010 to</p>	<p>All NPAIHB, Tribal Epidemiology Center research projects have been reviewed & approved by the PA IHS IRB. Many projects have also required</p>

<p>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</p>		<p>October 2015</p>	<p>state IRB approval.</p> <p>Tribes participating in projects at the NPAIHB that involve data exchange have data sharing agreements.</p>
<p>5. The NW Tribal EpiCenter will provide the NW tribes with capacity building assistance (including training, TA & resource development) on epidemiologic skills & research methods</p>		<p>October 2010 to October 2015</p>	<p>The NARCH program has continued to provide Summer Institute Training in research, public health and statistics. Each summer approximately 100 individuals attend this training.</p> <p>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,</p> <p>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</p> <p>Created a “Linkage Resources” on project website</p>



Northwest Tribal Epidemiology Center
(*The EpiCenter*)
July-September 2015 Quarterly Report



Northwest Tribal Epidemiology Center Projects' Reports Include:

-  **Adolescent Health**
-  **Epicenter Biostatistician**
-  **Injury Prevention Program (IPP)**
-  **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
 Amanda Gaston, IYG Project Manager
 David Stephens, Multimedia Project Specialist
 Mattie Tomeo-Palmanteer, VOICES Coordinator
 Tommy Ghost Dog, Project Red Talon Assistant
 Celena McCray, THRIVE Project Assistant

*Students: Jenna Charlie, VOICES Data Entry Temp; Lauren Adrian, VOICES MPH Intern;
 Steven Hafner, Harvard PhD Student Intern; Patty Yao, OHSU PhD Student Intern*

Quarterly Report: July – September 2015

Technical Assistance and Training

Tribal Site Visits

- Warm Springs - Meeting: Tribal Best Practices, Oregon, August 5, 2015.
- Spokane Tribe - Presentation: *We R Native*, UNITY Conf, August 12-13.
- Suquamish - Meeting: NW Native Adolescent Health Alliance Meeting, August 21, 2015.

Project Red Talon / We R Native / Native VOICES

During the quarter, Project Red Talon staff participated in twelve planning calls, ten partner meetings, and presented at four conferences/webinars, including:

- Advisory Webinars: IRB and Policy Panel – ETHICS Curricula, UW. August 2015.
- Attended: National Native American Journalist Media Conference, Washington DC. Attended by 5 We R Native Youth Ambassadors.
- Booth: IHS Behavioral Health Integration Conference, Phoenix, AZ, August 4-6. Distributed We R Native, Native VOICES, and THRIVE media campaign materials. Attendees: 200 tribal health staff and clinicians
- Booth: NIHB Annual Conference, Washington DC, Sept 21-24, 2015. Distributed We R Native, Native VOICES, and THRIVE media campaign materials. Attendees: 750 tribal administrators and decision-makers.
- Meeting: NW Native Adolescent Health Alliance Meeting, Suquamish, WA. August 21, 2015. Participants: 23 attendees, representing 10 NW tribes.
- Meeting: SMAHRT Team, Seattle, WA, Sept 15, 2015.
- Meeting: Tribal Best Practices, Warm Springs Oregon, August 5, 2015.
- Presentation: *We R Native*, @ UNITY, Washington DC. Attended by 5 We R Native Youth Ambassadors and over 200 AI/AN teens.
- Presentation: *We R Native*, UNITY Conf, Worley, ID, August 12-13. Workshop attendees: 200 AI/AN high school students. Booth: 300 youth.
- Webinar: Native STAND Implementation Sites, August 19, 2015.
- Webinar: Social Marketing and Media Webinar with U of OK, Sept 14, 2015.
- White House Tribal Youth Gathering, Washington DC. Attended by 5 We R Native Youth Ambassadors and over 1,200 AI/AN teens from across the U.S.

Native It's Your Game

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



- Webinar: Dissemination Advisory Workgroup, Sept 30, 2015.
- Kick-off Event: Shoshone-Bannock, ShoBan High School, Fort Hall, ID, September 15, 2015.
- Kick-off Event: Shoshone-Bannock, Mountain View Middle School, Pocatello, ID,
 - September 16, 2015.
 - September 23, 2015.
 - September 29, 2015.
- Kick-off Event: Shoshone-Bannock, Pocatello School District, Pocatello, ID, Sept 23, 2015.

Quality Improvement

During the quarter, STD/HIV QI staff participated in sixteen planning calls, ten Adobe meetings, and presented at one conference, including:

- Conference: Sacramento IPCMS, August 24-29, 2015
- HIV Team Meeting: HCV presentation, SMAIF response, July 9, 2015.
- Planning Meeting for SMAIF Funding and Programing FY 2017, Washington DC.
- ANTHC and Cherokee Nation Collaboration, Anchorage, AK, July 22, 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
TESTED. PROUD.**

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

WE R NATIVE

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

The mobile site launched on September 28, 2013

In September, the site received:

Page views	8,829
Sessions	3,548
Percentage of new visitors	77.5%
Average visit duration	2:28
Pages per visit	2.49

- Over 350 health/wellness pages are on the website.
- We have just hired a new web developer 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 2,798 active subscribers.

Twitter: Followers = 2,277

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

The project currently has 315 uploaded videos, has had 34,699 video views.

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

By the end of the month, the page had 26,419 Likes.

Instagram: <http://instagram.com/wernative>

By the end of the month, the page had 1,764 followers.

We R Native Contests: The September contest focused on: Hold up your Suicide Sign.



Native It's Your Game: We continue to provide TA to 4 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. 😊😊😊

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. Data coding is now being done.

Violence Prevention Messages: We R Native has partnered with Steven Hafner to carry out formative research to design a violence prevention intervention that will be delivered to Native young men via Facebook. 6 out of 15 interviews with young men 18-24 have been collected.

STD/HIV Measures Project: The project is monitoring STD/HIV GPRAs 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

- Published:
 - Markham, C. M., S. Craig Rushing, et al. "Factors Associated With Early Sexual Experience Among American Indian and Alaska Native Youth." *Journal of Adolescent Health* 57(3): 334-341. DOI: [10.1016/j.jadohealth.2015.06.003](https://doi.org/10.1016/j.jadohealth.2015.06.003)
- Native VOICES Article for PRC Newsletter
- Accepted for publication: Native VOICES Adaptation paper
- Working on Native VOICES Outcomes paper
- Working on *Texting 4 Sexual Health* papers (x3)
- We R Native article in [UW's We R Public Health](#)

Reports/Grants

- ITCA Quarterly Report
- Submitted and received MSPI grants, including We R Native objectives
- Completed and sent a [Community Report](#) to all Native VOICES study sites.

Epicenter Biostatitician

Nancy Bennett

Conference Calls:

- ✚ Wrap up and planning for next years Emergency Preparedness Conf

NPAIHB Meetings:

- ✚ All staff meeting - monthly
- ✚ Tribal Health Profiles meeting bi-monthly
 - Continue working on population and demographic data
- ✚ Data meeting bi-monthly

- Discuss THP report
- Discuss Brfss data
- Discuss immunization data
- Discuss text in THP reports
- ✚ Immunization project
 - Weekly meetings
 - Monthly webinars
 - Begin collection of baseline and monthly data
 - Site visit at Banewah
- ✚ Assisted in preparation of Indian day Pow Wow
- ✚ Art committee meeting
 - Priced all art for insurance purposes

Conferences/QBMs/Out of area Meetings

- ✚ Macro 1 SAS class, Chicago, IL
- ✚ Western Users SAS group conference, San Diego, CA
- ✚ Macro 2 SAS class, Minneapolis, MN

Miscellaneous

- ✚ CPR/First aide certification class

Reports:

Site Visits:

- ✚ Benewah, Coeur d'Alene, ID – Immunization project

Injury Prevention Program

Bridget Canniff, Project Director

Luella Azule, Project Coordinator

Conference Calls

- 7/15 TIPCAP Admin conference call
- 7/20 TIPCAP Advisory Committee conference call (Luella)
- 7/24 Econometrica evaluator conference call (Luella)

Meetings/Conferences/Presentations

- 7/7-10 Attended Joint QBM, Lincoln, California
- 7/13, 8/3, 9/8 All Staff meetings
- 7/17, 7/21, 8/11, 9/2, 9/22 IPP meetings
- 8/3 EpiCenter Meeting
- 8/18-21 Traumatic Brain Injury Conference, Albuquerque NM—Bridget and Sujata presented
- 9/18 IPP closeout/planning meeting w/ project officer Celeste Davis (Bridget)

Trainings/Webinars

- 6/29-7/1 NPAIHB Summer Research Institute: Indigenous Ways of Knowing
- 7/13 **Webinar:** Sedentary Work: Implications and Interventions for Worker Safety & Health (Luella)
- 7/24 **Webinar:** Naming & addressing Racism (Luella)

- 8/6 First Aid/CPR training
- 8/12 **Webinar:** CoIIN Orientation
- 8/29 St. Vincent Hospital Child Passenger seat check—completed 3 of 5 check-offs required for CPS recertification (Luella)
- 9/29 **Webinar:** Hot Topics: Evaluating Injury & Violence Prevention Initiatives (Luella)

Funding

- July – notified that AOA proposal (joint with NWWIHB) for Elder Falls Prevention was not funded
- August – Notified that IHS proposal for Injury Prevention Toolkit expansion was funded: \$20,000 per year for 5 years beginning September 1, 2015
- September –Response to weaknesses submitted 9/29 for new IPP/Toolkit project grant

Core Activities

July

- **Resources:** Prescription Drug Community Action tool Kit
- **2 E-mails to Tribal IP Contacts:** SafeKids July 2015 newsletter, Drug overdose tool kit

August

- **Resources:** Parents Central videos: How to install RF only infant car seats using LATCH
- **6 E-mails to Tribal IP Contacts:** Child Safety CoIIN invitation, ODOT Safe and Courteous Driver inventory (free materials), Social Media Countdown images in support of 2015 CPS week, Prescription Drug Community Action toolkit from National Safety Council, Adolescent Health, News and Notes , SafeKids worldwide e-newsletter

September

- **Resources:** NCOA (4 ways to Celebrate Life), IHS IP fellowship presentations, June/July IHS TIPCAP e-newsletter, Guila Muir—presentation training (Ferrari), CDC tribal Road Safety/video, Ted Med—Rebecca Adamson speech (Finding Innovation in Traditional Values), WA State Disaster Response Documents
- **6 E-mails to Tribal IP Contacts:** Making an Impact e-newsletter, Aging in Stride, Prescription Drug Community Action kit, CDC toolkit To Help Prevent Crash Related Injuries & Deaths in Tribal Communities, Falls prevention Awareness Day—Take a Stand to Prevent Falls; NHTSA drunk driving talking points

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 be 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 a 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 awarded 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, ending our agreement with current contractor and recruiting a new contractor. We also worked with the tribal site content experts to finalize specific dissemination modules. Co-Investigator Lutz presented study design and results and dissemination plan at the nation Kids In Motion Conference in Orlando, FL.

PTOTS Study

Background

American Indian youth experience the highest rates of childhood overweight and early childhood caries of any US population. Overweight is a major risk factor for type 2 diabetes, which is now occurring in American Indian youth as well as adults. The greatest dietary shift over the last 20 years has been the replacement of water, milk, and juice with soft drinks and other sugared beverages, and this shift has coincided with the increases in energy consumption leading to childhood overweight and early childhood caries.

The PTOTS Project is a federally funded NIH health research project sponsored by the National Heart Lung and Blood Institute (NHLBI). The Northwest Portland Area Indian Health Board (NPAIHB) has joined again with our TOTS Study academic partners Kaiser Permanente Center for Health Research (KPCHR) along with five northwest tribal partners to conduct the research study. The PTOTS Project aimed to implement a comprehensive intervention than the piloted TOTS study, with interventions focused on nutrition, feeding practices, breastfeeding, drinking water and physical activity. In addition the PTOTS tribal control sites received the control condition which consisted toddler dental exams.

Specific Aim of PTOTS

The overall aim of this project is to test whether community and family-based interventions can alter feeding practices (breastfeeding, sugared beverage consumption, timing and type of introduction of solids, and influence parenting to reduce sedentary lifestyles (eg. limiting introduction of television/video viewing, encouraging development of motor skills and creating safe play opportunities) and whether such behavioral changes can impact childhood obesity and early childhood tooth decay.

The intervention framework is the social ecology model for health promotion that targets health behaviors at multiple levels.

Project News & Activities

No new activity

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 has been working hard on getting all supplies, training material, implementation tools and documents ready for Fall Dental Screening. Co-PI also worked on responding to secondary IRB and submitting to two secondary IRBs. We hope to begin study data collection the first week of November 2015.

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, Jul-Aug (Tam, Nicole, Candice)
- Meeting: EpiCenter Staff, Aug, Sept (Tam, Nicole, Candice)
- Meeting: Project Directors, Jul, Sept (Tam)
- Meeting: Data Cmte, AugSept (Nicole)
- Meeting: Indian Day Planning Committee Mtg, Jul-Sept, (Candice)
- Meeting: Wellness Cmte, Jul-Sept, (Tam, Candice)
- Meeting: NIKE Native Fitness, Sept (Nicole)
- 403(b) Trustees meeting, Sept, (Nicole)
- Indian Day at Pioneer Square, Sept, (Tam, Nicole, Candice)

Program Support or Technical Assistance

- Indian Day Celebration Preparation, Jul-Sept (Candice)
- Plan Nutrition presentation for Nike Native Fitness with Nora, Jul, (Nicole)
- Health literacy training curriculum review and development with Jenine, Aug, (Nicole)
- Nike Native Fitness Nutrition curriculum development with Nora, Aug, (Nicole)
- Data literacy training – talk on Native CARS , Sept (Nicole)
- Nike Native Fitness – Taught nutrition/cooking class with Nora, Sept (Nicole)

PTOTS and TOTS to Tweens

Meetings - Conference Calls – Presentations – Trainings

- Project Meetings, Sept (Tam, Tom, Nicole, Julia, Candice and Investigators)
- Staff Meeting, Jul-Sept, every Wednesday, (Tom, Tam, Julia, Candice)
- Meeting with Dr Ash at Lummi, Aug (Tam)
- Meeting with Lummi Legal Aid, Aug (Tam)
- Meeting with Maxine Janis, Aug (Tam)

Program Support or Technical Assistance

- Updated Lummi/Quinault/Makah tribal resolutions, Jul (Tam, Candice)
- Prepared material for Lummi Council Meeting, Jul (Tam)
- Received updated study logo from Jefferson Greene, Jul (Candice)
- Child questionnaire edits, Jul (Nicole)
- Dental database development, Jul (Nicole)
- Drafted child assent form, Jul-Aug (Tam)
- Completed all paperwork and forms for IRB submission, submitted to IRB, Jul (Tam)
- Database and questionnaire coding – Dental, Child & KAB, Aug (Nicole)
- KAB Questionnaire formatting, Aug (Candice)
- Review and feedback to forms, Aug (Tam)
- Received Final High Res Logos, Aug (Candice)
- Drafted child assent form, Aug (Tam, Candice)
- IRB corrections and revisions to forms, Aug (Julia, Tam, Candice)
- IRB corrections and revisions to protocol, Aug (Tam, Candice)
- NWIC IRB proposal, Aug-Sept (Tam)
- Coordinated meetings and minutes, Jul-Aug (Julia)
- Oral cancer Native-specific literature review for Tom Becker, Aug (Julia)
- Organizing and ordering incentives for study participants, Jul-Aug (Candice)
- Begin contacting site coordinators for community screening dates, Aug-Sept (Julia, Tam)
- IRB contingency response, Sept (Tam)
- Dental, KAB, Child questionnaire testing and database revisions, Sept (Tam, Nicole, Candice, Julia)
- Meeting coordination, minutes and action item documentation, Sept (Julia)
- New content for Site Coordinator training manuals, Sept (Julia)
- Review and finalize Training materials, Sept (Tam)
- Study participant tracking sheet, Sept (Tam, Julia)
- Participant files for Nez Perce research participants, Sept (Julia)
- Prepared/created research files for Site coordinators, Sept (Julia)
- Database and questionnaire coding – Dental, Child & KAB, Sept (Nicole, Candice)
- KAB Questionnaire formatting, Sept (Candice)
- Review and feedback to forms, Sept (Tam)

- Processed contractor invoice for G. Maupome, Sept (Candice)
- IRB corrections and revisions to forms, Sept (Tam, Julia, Candice)
- IRB corrections and revisions to protocol, Sept (Tam, Julia, Candice)
- NWIC IRB proposal, Sept (Tam)
- Ordered incentive items for study participants, Sept (Candice)
- TOTS data recovery, Sept (Tam, Nicole)
- Purchase project supplies, lab coats and scrubs for screening, Sept (Candice)
- Developed budget, budget sheet and budget justification for continuation revision, Sept (Tam)

CARS

Meetings - Conference Calls – Presentations – Trainings

- Staff Meetings, Jul-Sept – each Monday (Jodi, Tam, Nicole, Candice)
- Site Coordinator Conference Call, Jul-Sept (Tam)
- Individual Site Coordinator Meetings via Phone, Jul-Sept (Tam)
- Kidz in Motion Conference, Aug (Tam, Candice)
- Met with individual potential partners at KIM conference, Aug (Tam)
- Meeting with web developer, Sept (Tam, Jodi, Nicole, Candice)

Program Support or Technical Assistance

- Completed travel logistics for Kidz in Motion Conference, Jul (Candice)
- Drafted presentation for KIM conference, Jul (Nicole, Tam)
- Documented and backed up all Native CARS Atlas files, Jul (Nicole)
- Terminated contract with KAT & received all completed work product, Jul-Aug (Tam, Jodi)
- Researched web hosting, web design firms, Jul (Tam, Jodi, Nicole)
- Set up social media accounts for Native CARS ATLAS on Twitter and Facebook, Jul (Candice)
- Module 7: Revised module content, and Teacher's Guide and Student Manual, Jul (Julia)
- Completed Shoshone Bannock and Nez Perce contract addendums, Jul (Candice)
- Completed all outstanding invoice payments, Jul (Candice)
- Kidz in Motion Presentation Preparation, Aug (Nicole, Tam)
- Practice ran and revised presentation, Aug (Tam)
- Worked with Chris to get KAT product moved over, Jul (Tam, Nicole)
- Processed VOPPT travel reports, Aug (Julia)
- Edited, re-formatted and revised content development on Becca's Teacher's Guide, Aug (Julia)
- Completed invoice payment to Colville Site Coordinator, Aug (Candice)
- Wrote and submitted abstract for Lifesavers Conference, Sept (Tam, Nicole)
- Meeting coordination, minutes and action item documentation, Sept (Candice)
- Completed invoice payments CARS sites, Sept (Candice)
- Processed Nez Perce contract addendum, Sept (Candice)

Site Visits

Travel

- Kidz in Motion Conference, August 11-15, Orlando, FL

(Tam, Candice)

Project contact information

Jodi Lapidus, Principal Investigator

Lapidusj@ohsu.edu



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Candice Jimenez, Research Assistant
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Julia Putman, Temp Project Coordinator
jputman@npaihb.org

Tom Becker, Co-PI
tbecker@npaihb.org

Medical Epidemiologist

Thomas Weiser, Epidemiologist (IHS)

Projects:

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

Opportunities:

- *Received IRB approval from Great Plains IRB for Adult Immunization Project
- *Traveled to Benewah for site visit. Other sites will be scheduled for September, October
- *Oral presentation accepted for OPHA regarding methods used for planning for 2015-2016 influenza season
- *Site visit will be scheduled for Fort Hall October 2015. Looking at November for Fort Thompson
- *Poster presentation accepted for American College of Epidemiology Diabetes Hospitalization study
- *Assist with evaluation of HCV tracking and Linkage to Care project, provided feedback on IHS HCV draft policy

Meetings/Conference Calls:

- Meetings:
- *Portland Area IRB meeting, July 14, 2015
 - *Immunization Coordinators Call, July 20, 2015
 - *Infant Mortality Collaborative Learning Session, Boston, MA, July 27-28, 2015
 - *Portland Area IRB meeting, August 11, 2015

- *COIN Learning Session, August 13, 2015
- *Hepatitis Epi Profile Stakeholders meeting, August 13, 2015
- *Immunization Coordinators Call, August 20, 2015
- *IPC 2.0 planning session (IHS), August 21, 2015
- *Presented on National Influenza Planning Call, August 21, 2015
- *American College of Epidemiology Annual Meeting, September 28-29, 2015

Clinic Duty: Chemawa, July 6-7, 2015
 Wellpinit, July 13-17, 2015
 Wellpinit, August 24-28, 2015
 Chemawa, September 25, 2015

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 primarily related to NARCH 7.

The Summer Research Training Institute planning ended in July, and we welcomed 94 tribal guests from around the country to our summer training at the Board. Our last effort was the 11th such effort sponsored by the Board, with input from OHSU faculty and staff, as well as a host of consultants. We were successful in filling up our course instructors in just a few weeks prior to this reporting period—Ms. Zaback did a masterful job at getting the advertisements around the country. As earlier reported, we have implemented a new course this year, in indigenous ways of knowing, under the guidance of June Strickland, PhD. We also had a data linkage course, under the guidance of Dr. David Espey and Melissa Jim. We continue to hire tribal instructors whenever possible.

Also 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 very successful overall. We expect 7 American Indian or Alaska Native graduates this year. We have this past month added three new fellows who will receive partial or full scholarships...one MPH student (Makah) and two PhD students (Choctaw and Navajo). 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 has been awarded and is progressing as we expected. We have sent in our non-competing renewal request this past month for both of our Narch grants, are expecting to be refunded for the upcoming year. At present, we have one new fellow application who is waiting for funding starting 2016 (so a year from this fall). We expect additional applicants if funding allows. At present, however, we have removed our advertisements from the website until we assess our funding status with the new round of funds from the Indian Health Service and NIH.

Dr. Becker will attend the NARCH directors' meeting in Washington DC next week. He will present on the history of the NARCH program in the Northwest. Apparently we are the 'poster child' for success in the national NARCH program and we hope to retain that distinction as we move forward in the next cycle of funding.

Northwest Tribal Comprehensive Cancer Control Project

Kerri Lopez, Director

Eric Vinson, Project Specialist

Meetings/Conferences

- All Staff meeting (3)
- Data Meeting (3)
- Staff project meeting
- Oregon Tobacco Program Meeting – Tribal TPEP coordinators
 - Contract SOW - submitted
- Health Promotion and Chronic Disease Prevention Grantees and Contractors Annual Meeting

Training/Site Visits

- Colville – Women's Health Conference
- Native Project – hosted training for tobacco – clinic tour
- Warm Springs – Clinic and Community Programs Visit. Honoring ceremony for 40 years of service for clinic physician
- Burns – attended health fair - dropped kiki for partnership event
- Spokane – cancer and tobacco update

Technical assistance via telephone/email

- Burns – met in Madras for Kiki travel to Burns
- Colville – Women's Health Conference followup data entry form, mini grant
- Cow Creek – Coalition meeting support for local host
- Makah – Information about Appointment Companion
- Nez Perce – Cancer Research Information
- Shoshone Bannock tribes – Information about fraudulent Dr. Wallach
- Warm Springs – November Coalition meeting information for travel justification and travel reimbursement assistance

Special projects

- Completed year end report in MIS
- November 9&10 Northwest Tribal Cancer Coalition prep
 - Coordination with IHS and Cow Creek for training and recruitment
 - Sent out to coalition – emphasis Oregon tribes
 - Next Northwest Tribal Cancer Coalition prep
 - Looked into potential meeting locations
 - Tobacco cessation materials information
- Disseminated 2015-16 Local Tribal Cancer Plan Implementation Funding Requests for Application

- Follow-up on 2014-15 Reports
- Attended national tobacco conference – Albuquerque
 - Attended basic tobacco intervention training
- Nicotine dependence training
 - Basic Tobacco Intervention Skills and Instructor Certification for Native Communities – Spokane
 - 2 day training and certification for tobacco cessation (2 staff)
- Follow up - June 25th Cancer Risky Business
 - 39 Participants from 14 Tribes
 - Travel reimbursement
 - Hotel master bill and food reconciliation
- Presentation at NARCH cancer class
 - Cancer activities; brfss, Oregon tribal polices, resources, tribal activities with implementation funds
- CCCP Among Tribes in Washington State: History, Issues and Programs
- Presented on NACDD webinar
- Attended Oregon Health Promotion Chronic Disease Prevention Grantee/Contract Annual meeting in Warm Springs
 - Tribal meeting
 - Plenary – policy, systems and environment
- Annual Cancer Education meeting
 - Registered and setup travel
- Ordered 20 copies of materials for Basic Tobacco Intervention Skills Instructor training
- Second Wind Training
 - Follow-up on survey to determine if participants have utilized curriculum
 - Response rate 80%
 - Will follow up with MCH team in OR
 - Disseminate survey to determine if participants have utilized curriculum
- Attended Good health and Wellness in Indian Country Conference
 - MI, Policy, sessions
 - Plenaries
- Edit CDC WEAVE-NW Tobacco Supplement grant
 - Edit, stats and final read
 - Set up template
 - Lit search for updated statistics
- Technical Support for DPP and HH webinars
 - Set up second HH session
- Data health Literacy training support
- Send out monthly materials to NNN
- Tobacco Quit line information
 - Received data from Oregon
- Waiting on requested information about cessation reimbursement for Oregon Pharmacists
 - Followed up at Oregon Tobacco Program meeting
- Create Tobacco Cessation spread sheet on GPRA data for OR, WA, ID.
- Send out sponsorships packets for Indian Day Committee
- Nike Native Fitness Support
- BRFSS:

- –continue working on tribal reports
- -finalized coquille brfss instrument on CAPI
 - Contract received for reimbursement
- Makah and Nooksack – further analysis
- Working on aggregate data for cdc report
 - Met with intern working on aggregating brfss data
 - Set up secure drop box
- Send out NNN newsletter/upcoming webinar

Conference / Webinar calls

- CDC project officer (2)
- Quarterly/Monthly NNN Partners meeting/call (3)
- Washington State Cancer Survivorship Workgroup Call
- Tobacco Use Among American Indian/Alaska Native Adults and Youth
- NNN webinar: NNN Cancer Risk Reduction in Indian Country
- Webinar: Enabling Digital Engagement: Best Practices For Creating Digital Consumer Engagement
- Health Promotion and Chronic Disease Prevention webinar
- CPCRNP HPV vaccination project calls
- National Native Network Cancer Risk Reduction: A Double Dose of Preventative Care: FluFIT/FluFOBT
- GW Cancer Institute: Tobacco Cessation Resources for Cancer Patients & Survivors
- R2R Cyber Seminar; Harnessing the Power of Storytelling to Improve Cancer Control Practice
- National Native Network Technical Assistance Webinar; Cancer Risk Reduction
- Monthly NNN Partners Call (3)
- HPV Roundtable - National Campaign Task Group Teleconference
- COIN Maternal Smoking Cessation Call

Northwest Tribal Dental Support Center

Joe Finkbonner, Executive Director

Tacey Casey, Project Manager

Bonnie Bruerd, Prevention Consultant

Bruce Johnson, Clinical Consultant

Kathy Phipps, Epidemiology Consultant

The Northwest Tribal Dental Support Center (NTDSC) continued providing services as specified in the contract and we are currently in our 15th year of operation. We applied for another five-year grant/program award and have been notified we were awarded funds for the next five years.

The overall goal of NTDSC is to address the broad challenges and opportunities associated with the 34 IHS and Tribal dental programs utilizing the combined resources and infrastructure of IHS Headquarters and IHS Portland Area, indirectly improving the oral health of the Native American people in the Pacific Northwest. NTDSC activities are listed in categories corresponding to the current grant objectives.

Provide clinical and preventive program support.

- No clinical or prevention site visits were provided this quarter. NTDSC has completed site visits, including reports, at 6 Portland Area dental programs this fiscal year, meeting the yearly objective. NTDSC has exceeded this objective yearly during this grant cycle.
- NTDSC developed a format to assist programs in developing a formal Quality Improvement Project. During the Area Dental Meeting, dental staff participated in an activity to develop QI objectives. This objective has been met for this grant period.
- NTDSC staff and consultants have been working in collaboration with WA Dental Services Foundation (Delta Dental) to meet some identified mutual objectives. Seven dental programs are 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 show a large increase in dental access for 0-5 year olds at the 7 dental programs participating in this project. There will be 4-5 new sites added this year.
- Portland Area met all 3 dental GPRA objectives this past year.
- NTDSC provides technical assistance to all Portland Area dental programs as appropriate.

Implement an Area-wide surveillance system to track oral health status

- Portland Area completed the Basic Screening Survey for 1-5 year olds this fall, collecting survey data from 18 clinics for 1,308 1-5 year olds. There was a 11% decrease in dental caries experience and a 27% decrease in the number of children needing dental treatment. Oral health is improving for young AIAN children in the Portland Area.

Provide continuing dental education opportunities

NTDSC hosted the annual dental meeting July 28-29, 2015 at Tulalip Resort. There was a total of nearly 80 participants and 69 dental staff representing all but two dental programs in the Portland Area. After this meeting, there were additional sessions for Dental Directors and Baby Teeth Matter participants. During the past year, NTDSC has provided a total of 4,648 continuing dental education credits to the dental staff in the Portland Area.

Work with IHS Headquarters and other Dental Support Centers towards meeting national HP/DP objectives.

- NTDSC Prevention Consultant serves as the Portland Area dental representative on the national HP/DP Committee.
- NTDSC consultants participate in email correspondence, national conference calls, and respond to all requests for input on national issues.

GPRA

**The Portland Area met all of their dental GPRA objectives!
Congratulations to all of the local dental staff in the Portland Area!**

[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

Our summer maternal and child health intern (Kalina Wong) completed her internship in August. During her internship, she assisted by cleaning, coding, and merging birth certificates from Idaho and Oregon, and analyzing these data to understand maternal risk factors for late or no prenatal care and inadequate prenatal care.

Our manuscript “Using Record Linkage to Improve Race Data Quality for American Indians and Alaska Natives in Two Pacific Northwest State Hospital Discharge Databases” published in a special issue of the journal Health Services Research. Kristyn Bigback (Project Biostatistician) was the lead author on this manuscript.

We hosted our first Health Data Literacy Training on September 10-11th at the NPAIHB offices. We had about 28 attendees at the workshop, with most attendees from our member Tribes. We received positive evaluations and feedback from the training, and will look for opportunities to provide the training again in 2016.

We submitted a brief proposal to the Robert Wood Johnson Foundation’s “Data Across Sectors for Health” grant opportunity. Out of 409 submissions, our proposal was one of 31 proposals selected as semifinalists. We will submit a full proposal for this opportunity in October 2015.

Current status of data linkage, analysis, and partnership activities

- *Northwest Tribal Registry (NTR) data linkages*
 - Oregon DMAP linkage – created and provided encrypted NTR file to Taylor Doren for linkage with Oregon Health Plan enrollment roster
 - Requested data from Portland Area IHS, NARA and Seattle Indian Health Board for annual update of the Northwest Tribal Registry
- Tribal Health Profiles (THP) project
 - CHSDA THPs
 - Completed first draft of THP report for the Confederated Tribes of Umatilla Indian Reservation
 - Completed internal review and revisions
 - Sent to Tribe for review and feedback
 - Finalized and sent to printers
 - Continued work on indicators and reports for Colville and Nez Perce Tribes
- *Cancer Registry Data and Cancer Fact Sheets*
 - Continued updating tribal cancer profiles with data from 2008-2012
 - Completed Idaho, Oregon, and most Washington CHSDA profiles
 - Sent profiles to Eric Vinson (Northwest Tribal Cancer Control Project) for review and feedback

- *Hospital discharge data*
 - Finalized Oregon and Washington fact sheets on preventable hospitalizations among AI/AN, posted to website, and mailed to Tribes and other stakeholders
- *Death certificate Data*
 - Completed cleaning and coding 1997-2013 Oregon death certificate data
 - Merged Oregon records with 3-state analytic dataset
 - Updated 1997-2013 Oregon deaths and 3-state deaths codebooks
- *Birth certificate data*
 - Finished coding and merging Idaho (2006-2012) and Oregon (2008-2010) birth certificate data into a single dataset; created data dictionary
 - Completed descriptive statistics, logistic regression, and write up of paper on maternal factors associated with late/no prenatal care and inadequate prenatal care
 - Received Washington birth certificate records (1997-2013)
- *Yellowhawk Cancer Data Review*
 - Worked with Jeff Soule (Oregon State Cancer Registry) and Angie Dearing (Yellowhawk Tribal Clinic) on defining scope of project/completing proposal for Oregon Public Health's Project Review Team
 - Ran preliminary cancer incidence numbers for data request (Union, Umatilla, Morrow, and Walla Walla Counties)
- *Health Data Literacy Training*
 - Worked with Jenine Dankovchik on planning, outreach, and logistics for first Health Data Literacy Training
 - Worked on slides/content for misclassification exercise and data presentation module
 - Held workshop on September 10-11 and NPAIHB offices
- *Data requests/Technical assistance*
 - Sent Colbie (THRIVE Project) updated demographic data and age-specific suicide data for grant applications
 - Worked with Oregon DMAP to obtain numbers of AI/AN enrolled and served by IHS/Tribal providers in the Oregon Health Plan for Dr. Joan O'Connell (University of Colorado)
- *Institutional Review Board (IRB) applications and approvals/Protocol development*
 - Received continuation approval from Washington State IRB for WSCR Linkages
 - Received continuing review and protocol modification approvals from Portland Area IRB
 - Received signed Data Exchange Agreement for 2015 from Portland Area IHS
 - Finalized and received signed data sharing agreement for Oregon DMAP linkage
- *Grant Administration and Reporting*
 - Wrote and submitted brief grant proposal for RWJF Data Across Sectors for Health Program; received invitation to submit full proposal; began work on full proposal
 - Received Notice of Award for Year 4 of OMH grant

- Completed OMH Progress Report and PDS report for Year 3 Quarter 4
- *Collaborations with other programs and other activities*
 - Reviewed and provided input on Oregon Child and Family Well-being workgroup draft report
 - Continued working with CSTE Tribal Epi Workgroup on data sharing manuscript - sent draft of background, reviewed aggregated survey results, reviewed and edited results section
 - Work with Bridget Canniff (Injury Prevention Project) on presentation and statistics for Traumatic Brain Injury Conference presentation

Data dissemination

- Manuscript “Using Record Linkage to Improve Race Data Quality for American Indians and Alaska Natives in Two Pacific Northwest State Hospital Discharge Databases” published in Health Services Research
- Emailed and posted fact sheets on preventable hospitalizations among Oregon and Washington AI/AN
- Presented to Shoshone Bannock Tribal Business Council on projects/data resources
- Presented “Epidemiology of Traumatic Brain Injuries among Northwest AI/AN” at the TBI and Native American conference in Albuquerque, NM
- Held first data literacy training at NPAIHB offices

Travel

Linkages

- None

Site visits

- Site visit to present to Shoshone Bannock Tribe’s Business Council 8/11-8/12

Meetings, Trainings, and Conferences

- Joint NPAIHB/CRIHB Meeting & Health Conference (Lincoln, CA) 7/6-7/9
- Traumatic Brain Injuries and Native Americans Conference in Albuquerque, NM 8/18 – 8/21

Other Meetings, Calls and Trainings

- Call with OMH grant evaluators 7/10
- CSTE BRFSS Small Area Estimation Webinar 7/16
- CSTE Tribal Epi Manuscript Workgroup call 7/21
- Presentation to WEAVE-NW project officers (SJ) 9/3
- Presentation to CDC MCH Bureau (SJ) 9/15
- Data Visualization Workshop (SJ, KB) 9/16
- Skillpath Leadership & Management Training (KB) 9/17-18
- Grant Training Center Workshop (KB) 9/28-30
- Meeting with Kerri, Eric V., and Nanette re: DSAs with Tribes 9/25

- Indian Day Celebration in the Square 9/25
- Data Meetings Ongoing
- Adult Composite Immunization Measure Project meetings Ongoing

THRIVE (Tribal Health: Reaching out InVolves Everyone)

Colbie Caughlan, Project Manager

Celena McCray, Project Assistant

Site Visits

Tribal Site Visits

- Shoalwater Bay Tribe, Shoalwater, WA – July 21
- Warm Springs Tribe, Warm Springs, OR – August 5
- Coeur d'Alene Tribe, Worley, ID- August 11-12
- Suquamish Tribe, Suquamish, WA-August 20-21
- Yakama Indian Nation, Toppenish, WA – September 18
- Coquille Tribe, Coos Bay, OR – September 22
- Kalispel Tribe, Airway Heights, WA- September 30

Out of Area Tribal Site Visits

- None during this reporting period

Technical Assistance & Training

During the quarter, project staff:

- Participated in 35 meetings and conference calls with program partners.
- Completed development of the new suicide prevention media campaign for AI/ANs and disseminated materials to over 120 Tribes or tribal organizations the week before September 10, World Suicide Prevention Day.
- Hosted a suicide prevention booster training for the Healing of the Canoe curriculum training for three tribal subcontract sites and four additional NW Tribes who attended with their own dollars.
- Interviewed, recorded, edited, and finalized three *Lived Experience* videos with three NW Native youth and one NW Native adult who have all been affected by or attempted suicide. These videos were created in hopes to help others thinking about suicide, you can view the **We Need You Here** videos on the *WeRNative* youtube channel at <https://www.youtube.com/user/weRnative/videos>.

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

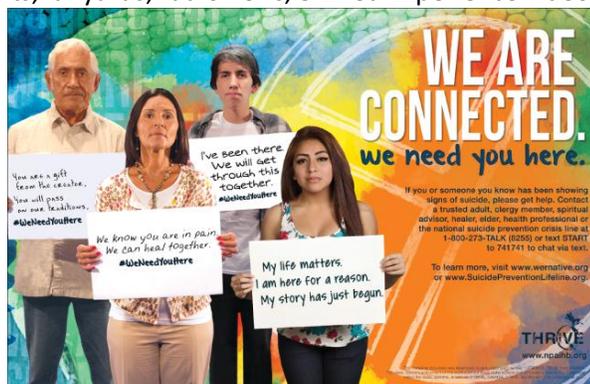
- Presentations (2)– THRIVE/PRT staff presented THRIVE and WRN resources at the UNITY Youth Conference, 200+teens , Washington D.C.–July 12-13
- Booth – THRIVE/PRT staff shared WRN and suicide prevention resources at the UNITY Youth Conference, 150 + teens , Washington D.C.–July 12-13
- Booth – Shared suicide prevention materials at the Shoalwater Health Walk, 45 attendees, Shoalwater Bay, WA – July 21
- Presentation – *Zero Suicide Model* co-presentation with the Suicide Prevention Resource Center, IHS Behavioral Health Integration Conference, 80 attendees, Phoenix, AZ – August 6

- Presentation- THRIVE/PRT staff presented THRIVE and WRN resources at the Northwest UNITY Week-150 teens , Worley, ID – August 11-12
- Training & Presentation-THRIVE staff presented at the Healing of the Canoe Curriculum Training; -36 participants-Suquamish, WA-August 21
- Meeting & Presentation- NW Native Adolescent Health Alliance Meeting - THRIVE staff lead a group discussion regarding current adolescent programs, new THRIVE media campaign, social media content and violence prevention-20 attendees- Suquamish, WA-August 21
- Booth – Disseminated new THRIVE media campaign materials, Navajo Nation Fair, Window Rock, AZ, 500+ participants stopped by the booth– September 10-11
- Webinar Presentation – Social Marketing for an online health class at the University of Oklahoma – September 14
- Presentation – THRIVE/PRT/WRN for 3 CDC staff, NPAIHB Offices – September 15
- Facilitation- 2 QPR Trainings, Heritage University, Toppenish, WA, 53 attendees – September 18
- Facilitation – Joint Adolescent Health Alliance Meeting & OR 9 Tribes Prevention Meeting re: crisis response protocols, Coos Bay, OR, 21 attendees – September 22
- Booth– NIHB Consumer Conference, disseminated THRIVE/PRT/WRN resources and materials, Washington DC, 100+ participants stopped by the booth – September 22-23
- Presentation – NIHB Consumer Conference, re: Zero Suicide, THRIVE media campaign, and Social Media interventions, Washington DC, 20 attendees – September 23
- Presentation- 8th Annual Tree of Healing Conference re: THRIVE media campaign, Crisis Response Plan and Social Media interventions, Spokane, WA, 28 attendees – September 30

During the quarter, the MSPI project responded to 243 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 a ton of momentum especially the week of Suicide Prevention Week Sept. 7-11 when THRIVE officially launched the new campaign. A press release was circulated in early September and Indian Country Today,

<http://indiancountrytodaymedianetwork.com/2015/09/10/preventing-native-youth-suicide-weneedyouhere-campaign-spreads-love-and-help-161700>, wrote an article about the We Are Connected campaign and Lived Experience video that had been released on World Suicide Prevention

Day, September 10, 2015. The Indian Country Today article had 1.4K plus likes, 31 comments, and 903 shares on their Facebook page. On the WeRNative feeds where THRIVE posted the campaign in addition to other suicide prevention messages we had a total reach of over 40,000 per week in September!

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 SAMHSA's Garrett Lee Smith youth suicide prevention data and performance measures for quarter 3 (Apr – Jun) around July 28.
- Submitted grant applications for more suicide prevention dollars through the IHS's MSPI grant.
- Awarded 2 MSPI grants for 2016-2017 (continuation through 2020).

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 Wermey, National Evaluation Specialist

Meetings

Start Date	Short Summary	WEAVE-NW Staff	External Partners
07/02/15	WEAVE check in	NA, JD, VWM, BW	
07/02/15	Data Literacy Training planning	NA, JD	
07/06/15	Joint Quarterly Board Meeting	NA, VWM	CRIHB
07/08/15	WEAVE internal eval. Meeting	JD, BW	
07/08/15	Provided update; reviewed draft Logic Model	JD, BW	Lummi
07/08/15	Art Committee	BW	
07/08/15	Wellness Committee Meeting	BW	
07/09/15	GHWIC All-Hands Meeting	JD, BW	CDC, UIHI
07/15/15	GHWIC Monthly Evaluation Meeting	JD, BW	CDC, UIHI
07/16/15	WEAVE check in	NA, JD, VWM, BW	

07/17/15	GHWIC Performance Measures Workgroup	JD	UIHI
07/21/15	CollIN Initiative Conference Call	NA	
07/22/15	WEAVE internal eval. Meeting	JD, BW	
07/28/15	WEAVE Monthly Call	NA, VWM, BW	Sub Awardees
and C1 Grantees			
07/28/15	GHWIC National Meeting Update	NA	
07/29/15	Art committee	JD	
07/29/15	GHWIC Tobacco Supplement FOA	NA, JD, VWM	
07/29/15	Native Fitness Planning	NA	
08/03/15	Epicenter staff meeting	NA, JD, VWM, BW	
08/03/15	All staff meeting	NA, JD, VWM, BW	
08/04/15	Go over GENIUS individual & group nominations @ Work Steering	BW	OPHI - Wellness Committee
Meeting: GENIUS Awards			
Selection			
Committee Meeting			
08/05/15	Tobacco Supplemental Grant	NA, VWM	
08/05/15	PIC Meeting	BW	
08/06/15	GHWIC All hands call	VWM	
08/07/15	Indian Day Planning Meeting	BW	
08/07/15	FGC monthly meeting	NA	Future
Generations Collaborative			
(NAYA, NARA,			
MCHD, OHS)			
08/12/15	GHWIC National Resource Meeting Component 1 and	NA	National Component 2
grantees			
08/12/15	WEAVE internal evaluation meeting	JD, BW	
08/12/15	Wellness Meeting	BW	
08/19/15	GHWIC Evaluation Workgroup	JD, VWM, BW	CDC, UIHI, other
GHWIC grantees			
08/19/15	Tobacco Grant Meeting	NA	
Meetings			
08/19/15	CDC Site Visit Agenda Review	NA, JD, BW	
08/20/15	Discussed concerns with evaluation plan	JD, VWM	UIHI
08/20/15	GHWIC C2 ECHO Call	NA, JD, VWM, BW	CDC, UIHI and
other GHWIC C2			
grantees			
08/20/15	WEAVE Meeting	NA, JD, VWM, BW	
08/20/15	Tobacco Grant Writing	NA	

08/21/15	Tobacco Grant- Budget	NA, VWM	
08/24/15	NF Volunteer meeting	NA	
08/25/15	WEAVE Monthly Call Yellow hawk and	NA, BW	All subawardees, Nez Perce
08/26/15	WEAVE internal evaluation meeting	NA, JD, BW	
08/27/15	Data Literacy Workshop planning meeting	NA, JD	
08/27/15	Data meeting	JD	
09/08/15	All Staff Meeting	NA, VWM, NY	
09/16/15	GHWIC Evaluation Workgroup monthly call	VWM, NY	
09/17/15	ECHO Component 2 Call	NA, JD, VWM, NY	
09/17/15	WEAVE internal meeting	NA, JD, VWM, NY	
09/18/15	Evaluation Plan finalization	JD, NY	
09/22/15	WEAVE Monthly Call	NA, VWM, NY	
09/24/15	Conference call to discuss CHANGE tool	NA, JD, NY	Chehalis Tribe
09/28/15	Organizational Partner Strategic Planning Meeting Generations Collaborative-		NA Future NAYA, NARA,

PSU, DHS, MCHD

Total number of meetings this quarter: 50

Site Visits

Date(s)	Tribe	Short Summary	
WEAVE-NW Staff			
07/23/15	Grand Ronde Tribe	Evaluation meeting and initial site visit	NA
09/02/15	-	09/04/15	Grand
Ronde Tribe	CDC Site Visit	NA, JD, VWM, NY	
09/14/15	Chehalis Tribe	Initial Site Visit	NA,

JD

Total number of site visits this quarter: 3

Partnerships

Date Formed	Name of Partner	Type
7/23/2015	Grand Ronde Education organization	Tribal community
9/10/2015	OSCaR government	State or county
9/10/2015	Cowlitz Tribe organization	Tribal community

Total number of new partnerships this quarter: 3

Presentations

Date Given: 7/8/2015 **Type:** Tribal Community Presentation (include QBMs)

Title: Policy, Systems, and Environment

Presented at: Native Health Conference/Joint QBM

Location: Lincoln, Ca

Total number of presentations 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)
- Project directors meeting (3)
- NF volunteer meeting
- Data meeting (3)
- Nutrition Council of Oregon

Training

- DMS Training, 22-24, 2015
 - 9 Participants
- Native Fitness – September 1 and 2nd, 2015
 - 165 participants attended
 - Excellent evaluations
 - Workshops: physical activity, motivational interviewing and healthy cooking
 - Resources on diabetes best practices, curriculums, data, and successful interventions
 - Session from previous attendees, how they have implemented NF into their community
 - Setting up picture web site for participants
 - PO for final invoice and sending certificates
 - Reviewed and made second draft for the trainer notes for Native Fitness
 - Final prep – resources, logistics, volunteer assignments, final order

Technical assistance via telephone/email

- IHS, IT with national office to correct the numbers for NW tribes Audit were incorrect
- Albuquerque Area Office, adc requested an updated version of the Shortcut & Reference Manual, as well as three physically sent to her
- Coquille, ta for audit from this year,
- Cow Creek, ta requested a copy of the QMAN exercises that we go over in class, QMAN search on patients for Hemoglobin A1c
- Gerald L. Ignace Indian Health Center, ta input foot, eye, and dental exams in EHR
- Makah DM grant submission Total population report via QMAN, how to obtain an electronic copy of audit
- NATIVE Health of Spokane, ta on chart review and medications for audit, ta how to capture medications for IHS audit after 6month time frame

- Quinault, ta GPRA “Dashboard” can it look like HSR??
- Siletz DM electronic audit numbers for the past 2years Helped enroll to IHS webAudit
- Skokomish, TA this year’s Audit, ta Visual DMS. And what dc needs to do
- Squaxin Island, ta audits for the last two years, with the Area and IHS results included, ta how to find patients between a certain age, created QMAN search
- OHSU, ta to OHSU creating a data share agreement with the VA. we generally do MOA, gave contact information to the VA Tribal Liaison for Region 10, Aug 26
- Grant ta for three tribes

Special projects

- Prepared HSR for NW Tribes
- DPP AdobeConnect Meeting
 - Set up
 - Prep with presenters – presentations
 - Presenters at NPAIHB – adobe call in
 - Created flyer for DPP & HHP meeting
 - How to set up DPP and HHP grant implementation
- Conference call for planning for calls (DPP and HHP)
- Indian Day Powwow
 - Organized the creation of Directional sign
 - Assisted with set up, all day activities and clean up
 - Photographer -
- July QBM joint meeting with CRIHB
 - Tribal health director meeting, NPAIHH, and Joint meeting
 - Presented PSE at California Health Conference
 - History of Policy in the NW
 - Current project
 - WTDP, NNN, WEAVE presented
 - WTDP update
 - Project activities and upcoming events
- Data meeting, IDEA and WEAVE director
 - Data sharing agreements and plan
 - Nashville and tribe
- Met with CRIHB IT specialists
 - Discussion centered around NextGen and diabetes audit
 - Possible training for specialists training
- Two interviews for WEAVE director
 - additional interviews (reopened)
- Completed resolution for SDPI grant – presented to executive committee
 - Resolution passed to apply for current funding amount

- Preparation for SDPI in addition to completing checklist (see conference calls also)
 - Audits, resume's, indirect cost agreement
 - Attended two webinars – community directed grant
- Informed not eligible to apply to SDPI as SDPI community grant
- NPAIHB/HPCDP contract meeting
 - Expanded SOW – tobacco cessation and tribal wellness policies
 - Increased funding for NPAIHB
- Created timetable for 2016 DMS trainings

Conference calls

- Improving Health Care Delivery Data Project: Steering Committee Meeting
- 2016 SDPI community grant kick off
- 2016 SDPI Community Directed Application Orientation
 - Project Narrative and pre grant checklist
- SDPI best practices
 - New best practices and comparison table to previous best practices
- GHWIC Tobacco Supplement Informational Zoom Meeting
- ColIN Tobacco Cessation Meeting – OHA, WS, Umatilla

IT Department Quarterly Report for July/August/September 2015

Overview

The Northwest Portland Area Indian Health Board has a high level of office automation and extensive information services. The staff uses desktop computers, laptops, PDAs and office equipment that require periodic maintenance. This is in addition to 11 servers and other electronic equipment housed in a secure and temperature-controlled server room. The Board also has a 24 station training room using Dell PCs and Microsoft Terminal Server technology. The purchase of technical equipment, configuration, and maintenance is handled by the department director and the network administrator. The Meaningful Use Project is now a part of the IT Department and its activities will be part of this report.

Strategic Priorities by Functional Area

Meetings Attended:

- Oral Health Web Page Development Meeting
- Performance Management System Demo
- Safety Committee Meeting Quarterly
- PIC Meeting

- Management Meeting Weekly national Clinical Application Coordinators call
- PHR Rollout weekly meetings
- Project Director Meeting
- NPAIHB Monthly Staff meetings
- National MU Team meetings (every 2 weeks)
- National Pharmacy Council monthly meeting
- E-Prescribing monthly status calls
- Pharmacy PSG monthly meetings
- Area CAC conference calls weekly
- Annual IHS Southwest Regional Pharmacy Conference
- Annual Face to Face Pharmacy Professional Services Group meeting
- Oregon Health Information Technology Oversight Council meeting
- IPC face to face meeting with Cow Creek
- NPAIHB Quarterly Board Meeting
- ICD10 Software training

Conferences and Trainings Supported/Provided:

- Northwest Tribal Dental Conference
- NARCH Summer Institute Classes
- RPMS Advanced Lab
- RPMS / Third Party Billing and Accounts Rec.
- All Tribes 638 Training/ Meeting in Issaquah
- RPMS/ IHS / ICD 10 Training-week1
- CPR/First Aid Training Class
- RPMS/ IHS / ICD 10 Training-week2
- RPMS Reminder Course Module Training
- RPMS / CHMS Training
- Winter Grant Writing Workshop
- Portland Area CAC Training
- Pharmacy Residency Informatics Course monthly session
- 2015 Annual Indian Day event
- RPMS/ IHS / iCare class
- RPMS - DMS Training
- RPMS Training for Staff
- MU – what to expect in 2015 for Portland Area

Presentations:

- MU Update for NPAIHB Quarterly Board Meeting

NPAIHB Activity:

- Prepared public comment on CMS Proposed Rules for MU Stage 3 and MU in 2015-2017
- Troubleshooting EHRp14 and ICD10 technical preparations
- Assist with qualification, registration, and attestation for MU for 2014 and 2015
- Discussions with Walgreens on providing pharmacy services to tribes
- DM Audit logic research and discussion with developers
- Recruiting at Pacific University Career Fair

- Learning about Camtasia in order to produce EHR RPMS training videos
- Set up and tested two new Apple Airport Extreme wireless access points for the network
- Set up new network and mail accounts
- Revisited MS Lync software and researched minimalist installation scenarios
- Provided IT support for the Seattle 638 training and All Tribes meeting in Issaquah, WA
- Researched Moodle hosting requirements and GoDaddy account features re: the new Native Cars web site for Nicole
- Researched the upcoming Windows 10 software – features, overall design, current issues
- Researched installation of VMWare Fusion “hypervisor” software for running virtualized Windows Servers
- Update property database
- Take tapes to safety deposit box
- New Wireless network routing design and configuration and testing
- Worked on creating a new project page (and subpages) on the web site for the Oral Health project per the document that Lisa/Pam/Chrisina supplied – still in progress
- Taking “Writing Web Content for the Internet” course
- Discussions with Walgreens on providing pharmacy services to tribes
- Setup new desktop PCs and workstations.
- Researched AAR software install for Lync Reverse Proxy server
- Posted updated hospital admissions data files to the Idea project reports page for Kristen

Outside contacts:

- Vicki French, MU Lead, USET-REC
- Jamie S. Squires, Portland Area Indian Health Service
- Peggy L. Ollgaard, Portland Area Indian Health Service
- Anna M Chamberland, Workforce Recruitment Consultant, Oregon Health Authority
- **Susan Perry**, Director, Enterprise Product Marketing | [Hootsuite](#)
- Elwood, Miranda, (IHS/NAV)
- Phyllis Williams, NextGen Healthcare
- Kimberlee Crespin-Richards, OIT Training Coordinator Contractor - DNC
- George C. Gallup RT(R)(CT), Radiology Manager, K'ima:w Medical Center
- Won, Roney (IHS/POR)
- Scott Dufour, anthc.org
- Dean Bloom, Sr. Account Manager/Corporate Sales Division, TigerDirect B2B
- Joanna Kelsey, BSN, RN, iCare Clinical Application Analyst, DNC Contractor
- Ian Lawson, CEO | Slickplan.com
- Andrea Vigil, dihfs.org
- JERALD JARVIS | SERVICE TECHNICIAN, Xerox

NPAIHB QBM



**THRIVE
PROJECT RED TALON
WE ARE NATIVE**

OCTOBER 2015

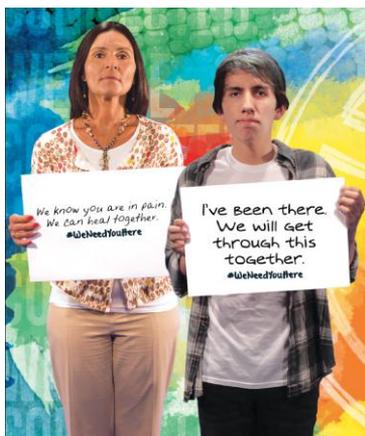


Meeting Agenda

- Update: #WeNeedYouHere Campaign
- Review: Suicide Crisis Protocol
- Project and Research Updates:
 - Social Media Focus Groups
 - HIV/HCV Clinical Services and PWID Study
- Coming Next: Zero Suicide Trainings





- Posters
- Blank Flyer
- Rack Card
- Tip Card
- Lanyard
- Flash Drives
- Radio PSAs
- T-shirts
- Lived Experience Videos
- THRIVE**

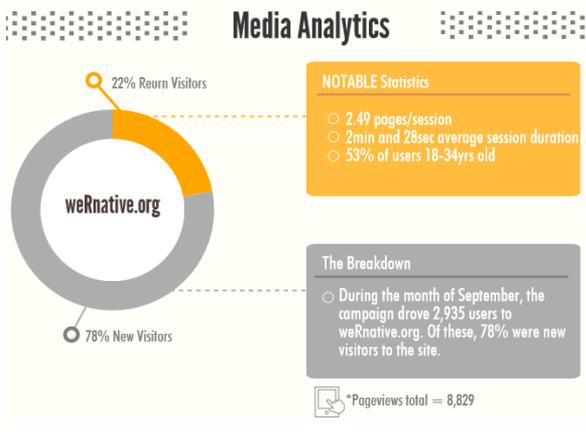


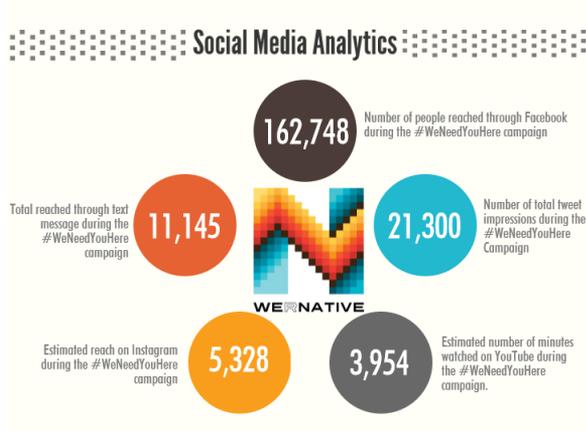
3 Lived Experience Videos

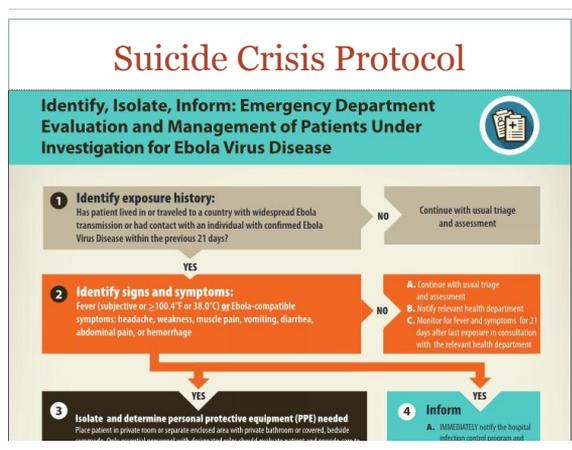


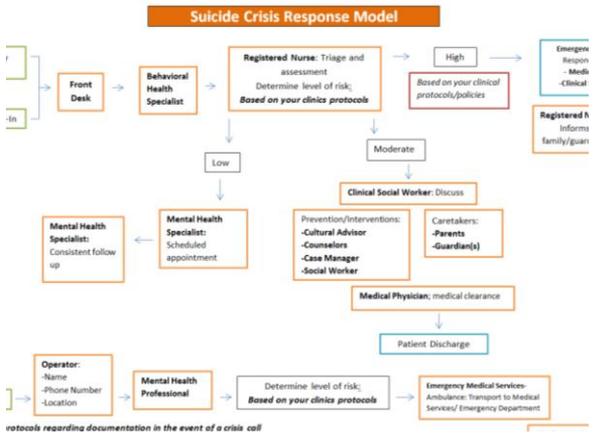
https://youtu.be/Q9D_1Gw5IOc











Keep These Q's in Mind

- Does your **clinic** have a suicide crisis protocol?
- What is most helpful on this draft?
- What can be removed from this draft?
- What is missing?
- Is there too much information for a 1 page resource?
- How do we avoid community members falling through the cracks?

Social Media Focus Groups

- **Goal:** Better understand Native adolescents' perspectives on concerning content (harm to oneself or others) posted on social media.
 - Develop culturally relevant strategies to help youth cope with and respond to such posts.
- Partnership with SMAHRT at Seattle Children's Hospital

Ideal Program Findings

- Facebook (68% of participants)
- Preferred Helpers :
 - family,
 - friends,
 - mental health professionals, and
 - health & safety programs.



Ideal Program Findings

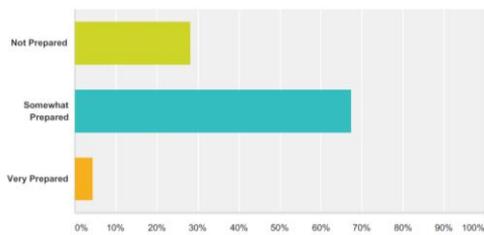
- Three themes emerged within the teens' suggestions for intervention resources:
 - inspirational videos
 - tips or guides on how to respond, and
 - Native specific resources (like www.weRnative.org).



Health Educator Feedback

Q5 How prepared do you feel to intervene to help a youth posting concerning content on social media?

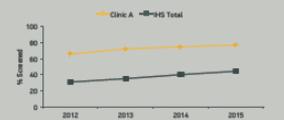
Answered: 46 Skipped: 4



Clinical Systems and Services Improvement HIV/STI/HCV

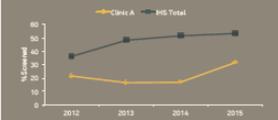
IHS HIV/STI/HCV Site Report: Clinic A 2015

HIV SCREENING FOR INDIVIDUALS 13 - 64 YEARS OLD



At Clinic A, 77% of people have ever been screened for HIV, up from 75% last year. This rate is leading IHS (national average is 45%) and above the IHS goal of 65%.

HIV TESTING OF ALL INDIVIDUALS WITH A SEXUALLY TRANSMITTED INFECTION (STI)



Clinic A tested 32% of STI Patients, (23/73). IHS national average is 53%, and the IHS national goal is 75%.

All persons diagnosed with an STI are

HCV Staging Using Remote EHR

Chronic Hepatitis C virus (HCV) infection affects millions of patients in the US. HCV related deaths due to liver disease are now effectively preventable with new breakthrough treatments. HCV patients with advanced liver disease are a priority.

PRT Staff can Provide:

- Remote technical and clinical assessment to sites, supporting linkage to care at a local level
- Identify the distribution of HCV genotypes and stage of HCV related liver disease
- Identify the proportion of patients who need follow up based on liver disease stage.

Sample Remote Staging Panel

										<0.5 Stage 1 or <1.45 Stage 1 or 2 >1.5 Stage 3 or >3.25 Stage 3 or 4 APRV = (AST Level (I/L)) / AST (Upper Lim) FIB 4 = ((Age in YRS) * AST Level (U/L)) / 1			
Hep C Antibody HCV RNA, PCR QN										labeled as ALI		high vira	
IS	Antibody	RNA	AST	AST UL	ALT	Platelets	APR	FIB 4	Viral Load				
52		2,240,479	72	37	112	149	0.32424293	2.39623867	high				
51		83,600	75	37	143	168	1.20656371	1.90394362	low				
36	Reactive	ant & c15 not detected	25	37	49	455	0.14850015	0.282574568	not detect				
50		8,237,234	33	37	42	275	0.32424292	0.97042571	high				
46	Reactive	443,000	38	37	58	301	0.33895281	0.757503778	low				
33	Reactive	<43	42	37	90	254	0.4469036	0.575185937	low				
43	Reactive	63254	121	37	259	188	1.73925266	1.719674979	low				
56	Reactive	116000	90	37	53	201	0.57869266	0.849464668	low				
48		<43	34	37	57	201	0.45717359	1.075441197	low				
54		ZHEP C VIRAL Load 248694	40	36	34	304	0.36549708	1.218542579	low				
38		<43	28	37	48	344	0.21698761	0.46619852	low				
49	Reactive		203	37	172	187	2.93394999	3.988194139					
31	Reactive per ne	see MD note 7/24/14					#DIV/0!	#DIV/0!					
12	Reactive	1021001	129	37	249	253	1.9382979	1.039095312	high				
58			90	37	61	126	1.09400191	1.524185266					
56	Reactive	<15 not detected	31	37	18	203	0.412728	2.01566071	not detect				
59		<15 not detected	28	37	32	245	0.30880031	1.59198003	low				
53	Reactive	3792046	37	37	52	125	0.8	2.17553417	high				
56	Reactive	<15 not detected	23	37	20	201	0.30926449	1.43288346	low				
40							#DIV/0!	#DIV/0!					
47		ZHEP C VIRAL Load <500	24	37	34	466	0.13919499	0.415129622					
41			16	37	19	464	0.09319664	0.324346382					
60							#DIV/0!	#DIV/0!					
58			73	37	107	283	0.69716359	1.446347101					
60			25	46	23	372	0.14609631	0.840783928					

Zero Suicide in the Pacific NW

31

- 3 Tribal Clinics using EHR
- Each site has a site coordinator, who is leading their clinic's efforts.
- We provide monthly/weekly training and TA to the site coordinators, to support their implementation efforts.

Zero Suicide in the Pacific NW

32

- Hosted a 2-day kick off training for clinic staff and community partners
- Each site completed an organizational assessment, a workforce survey, and selected a local Implementation Team

Coming Up: ZS Trainings

- Project will offer 3 ZS trainings (1-2 days) in the Spring 2016
- There will be a list of eligibility requirements
- THRIVE will provide post-training implementation technical assistance
- Quarterly check-in calls with THRIVE staff







- Website launched September 28, 2012
- Over 200,000 page views!
- Across all media channels, the service reaches on average 31,000 users per week
- Over 350 health/wellness pages, reviewed by AI/AN youth and topical experts.
- Special features include:
 - Discussion boards
 - Blogs
 - Videos
 - Free gear & Promo Kits



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Medical Marijuana and IHS Funding

Jim Roberts, Policy Analyst
NPAIHB Quarterly Board Meeting
October 24, 2015

Acknowledgement: I want to thank Lael Echo-Hawk, Attorney, Garvey Schubert Barer, for providing slides used in this presentation.

Purpose of Presentation

- ▶ Several Tribal leaders and Board delegates have requested presentation on:
 - What is the impact on Indian Health Service (IHS) and other federal funding if a Tribe legalizes marijuana
 - Could medical marijuana be allowed in IHS facilities if a state has legalized it for medical use?
 - What are the potential Tribal implications where states have legalized
 - Discuss potential issues from a non-legal basis with follow up at a future Quarterly Board Meeting

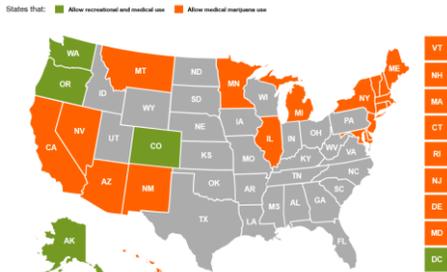
My Disclaimer:

- ▶ I am not an attorney and by no means should this be considered a legal analysis.
- ▶ The fact that I am doing this presentation should not be construed that I am an "expert" about the use [*medical or otherwise*] of marijuana by any means



Are you ready to begin?

States that have Legalized Marijuana



Across the Country...

- ▶ Four states have legalized **recreational** use of marijuana
- ▶ 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

Source: This slide courtesy of Lael Echo-Hawk, Attorney, Garvey Schubert Barer

Economic forecast – Marijuana

- ▶ Legal marijuana grew 74% last year 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*

Source: This slide courtesy of Lael Echo-Hawk, Attorney, Garvey Schubert Barer

Legalization of Marijuana pose several implications for Tribes

- ▶ Prohibit marijuana
- ▶ Legalize marijuana:
 - Medical
 - Recreational
 - Both
- ▶ All would require regulatory framework to develop Tribal laws, regulations, law enforcement, and courts systems
- ▶ Resources will be required
- ▶ Could there be a potential impact on federal funding?

Source: This slide courtesy of Lael Echo-Hawk, Attorney, Garvey Schubert Barer

What Tribes must consider:

- ▶ What must Tribes consider when deciding whether to legalize, decriminalize or prohibit marijuana in Indian Country?
- ▶ Government Issues –
 - Affect on other Federal Programs: 638 funding provided by IHS, BIA, HUD, ANA, etc.
 - Status of legality in your state – external politics
- ▶ Potential revenue source
- ▶ Cost of implementation
- ▶ Sales, Taxation, Licensing, Regulating & Enforcement

Source: This slide courtesy of Lael Echo-Hawk, Attorney, Garvey Schubert Barer

DOJ Policy Statement regarding marijuana

- ▶ December 11, 2014 DOJ issues Policy Statement Regarding Marijuana Issues in Indian Country (memo is dated Oct. 11, 2014)
- ▶ Following release invoked sensationalized press and media frenzy that may or may not have been accurate
- ▶ The DOJ Policy Statement "does not" legalize or condone marijuana in Indian Country
- ▶ The DOJ Policy Statement is supportive of Tribal Sovereignty to prohibit or legalize marijuana and encourages consultation
- ▶ The DOJ Policy Statement updates previous guidance regarding federal marijuana enforcement in states that had legalized marijuana - "Cole Memorandum", Aug. 29, 2013

What is the impact of HHS funding if a Tribe legalizes marijuana?

- ▶ This question has been posed by the HHS Secretary's Tribal Advisory Committee (STAC) to Sec. Sylvia Burwell (STAC letter June 30, 2015)
 - "Would HHS funding be jeopardized if a Tribe operated a marijuana grow or dispensary on its lands?"
 - "Would HHS funding be forfeited or at risk if a Tribe regulated a third party grow or dispensary on its lands?"
 - There are other important questions posed in STAC letter (refer to it)
- ▶ Sec. Burwell responded to STAC at September 15-16, 2015 meeting
- ▶ Sec. Burwell reported "...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."

Can medical marijuana be "allowed" in an IHS or Tribally-operated facility?

- ▶ Defining "allowed" means smoked, consumed, prescribed, or other related medical use
- ▶ Medical marijuana in Indian health programs is complicated; it is not as simple that a state has legalized medical marijuana to allow it in an Indian health program
- ▶ It will likely require approval from IHS and may need to be included in AFA language?
- ▶ Federal funding will likely not be allowed to used?
- ▶ This issue is implicated by the following:
 - 1970 Controlled Substance Abuse Act
 - DOJ Policy Statement Regarding Marijuana Issues in Indian Country
 - June 6, 2011, IHS Dear Tribal Leader Letter, "IHS Findings Medical Use of Marijuana", Dr. Susan Karol, Chief Medical Officer

Controlled Substances Abuse Act of 1970 (CSA)

- ▶ The CSA establishes federal regulatory system designed to combat recreational drug abuse by making it unlawful to manufacture, distribute, dispense, or possess any controlled substance
- ▶ The CSA reflects the federal government’s view that marijuana is a drug with “no currently accepted medical use”
- ▶ Incongruity between federal and state law regarding medical marijuana use
- ▶ Accordingly, the manufacture, distribution, or possession of marijuana is a federal criminal offense



CSA Schedule I Substances

- ▶ Schedule I substances are those that have the following findings:
 - The drug or other substance has a high potential for abuse.
 - The drug or other substance has no currently accepted medical use in treatment in the United States.
 - There is a lack of accepted safety for use of the drug or other substance under medical supervision.



DOJ Policy Statement Regarding Marijuana Issues in Indian Country

- ▶ Prior to the 2014 Tribal Policy Statement, in 2013 DOJ had issued a “Guidance Regarding Marijuana Enforcement” (Cole Memo) in response to legalization of production, processing, sale and possession of marijuana.
- ▶ Cole Memo articulated the enforcement priorities that had previously and would continue to guide DOJ enforcement of federal marijuana laws, regardless of state law.
- ▶ Those priorities were restated in the 2014 DOJ Tribal Policy Statement
- ▶ The 2014 DOJ Tribal Policy Statement clarifies that the federal enforcement priorities from the Cole Memo will also apply to enforcement in Indian Country



DOJ Policy Statement: "Priorities" to focus "investigative and prosecutorial resources"

- ▶ DOJ 2014 Tribal Policy Statement includes eight priorities:
 - Preventing the distribution of marijuana to minors;
 - Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels;
 - Preventing the diversion of marijuana from states where it is legal under state law in some form to other states;
 - Preventing state-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity;
 - Preventing violence and the use of firearms in the cultivation and distribution of marijuana;
 - Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
 - Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
 - *Preventing marijuana possession or use on federal property.*



Indian Health Service Findings Medical Use of Marijuana

- ▶ IHS Findings issued in June 6, 2011 DTLL
- ▶ "Federal law specifically prohibits the use of marijuana under al 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."*



Key Points of "IHS Findings Medical Use of Marijuana"

- ▶ The CSA lists marijuana as a Schedule I controlled substance that requires a special DEA registration for the investigational use and manufacture of the drug.
- ▶ The CSA continues to classify marijuana as a Schedule I controlled substance that has no medical benefit
- ▶ The IHS Manual "has provisions for investigational drugs, but not for Schedule I controlled substance as a matter of Agency policy."
- ▶ IHS will not use or approve Schedule I controlled substances
- ▶ A 1981 HHS ruling, prohibits reimbursement of unapproved drugs by the FDA, and the FDA considers marijuana as an unapproved drug and is ineffective through the "Drug Efficacy Study Implementation"
- ▶ Annual Funding Agreements require Tribal entities meet all applicable laws and the CSA is applicable to marijuana
- ▶ Not meeting federal statutes and regulations put providers outside their scope of employment and as a consequence FTCA coverage would not apply



Considerations for medical marijuana in Indian health programs

- ▶ DOJ Policy Statement priority number eight, *"preventing marijuana possession or use on federal property"* needs to be addressed
- ▶ Marijuana will need to be reclassified from a Schedule I substance under the Controlled Substances Act
- ▶ If marijuana can be reclassified than it would need to meet requirements under the Drug Efficacy Study Implementation and meet FDA approval
- ▶ If marijuana can be reclassified and be approved by the FDA, than the IHS position on Medical Use of Marijuana could be retracted
- ▶ There may be tribal government considerations on the legalization of medical marijuana
- ▶ If all these considerations are met, than it may be possible to allow medical marijuana in an Indian health program?

Federal Action regarding medical marijuana

- ▶ Legislation to reclassify Marijuana as a Schedule I substance or remove it from the CSA
- ▶ FY 2014 Omnibus bill: Section 538. None of the funds made available in this Act to the Department of Justice may be used, with respect to the States of [...], to prevent such States from implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana. Emphasis added.
- ▶ The Veterans Administration has issued a directive that allows veterans to use consume marijuana at facilities located in states that have legalized medical marijuana
- ▶ The VA may not prescribe marijuana in those states but veterans who are qualified patients are allowed to consume marijuana they have already obtained

Current Tribal Marijuana Activity

- ▶ Suquamish Tribe and Squaxin Island Tribe sign Marijuana Compacts under HB 2000
- ▶ Flandreau Santee Sioux announce marijuana resort. State AG has asked them to re-think.
- ▶ Passamaquoddy Tribe inks deal for marijuana operation.
- ▶ Other tribes exploring legalization.
- ▶but
- ▶ Alturas Rancheria, Pit River Rancheria marijuana raided by federal and state law enforcement
- ▶ Pinoleville Rancheria
- ▶ marijuana raids by State
- ▶ law enforcement.

Source: This slide courtesy of Lael Echo-Hawk, Attorney, Garvey Schubert Barer

The End!





JUN 6 2011

Dear Tribal Leader:

In response to an increasing number of inquiries from patients and health care providers regarding the legality and prudence of using medical marijuana, the Indian Health Service (IHS) has recently concluded an extensive review of this issue. Our findings have been provided for your review (see enclosure).

Federal law specifically prohibits the use of marijuana under all but very controlled, investigational circumstances. As IHS Chief Medical Officer, 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.

Any questions regarding this statement may be directed to CAPT Chris Watson, Principal Pharmacy Consultant, IHS. He can be reached by telephone at (301) 443-4330 or via e-mail at chris.watson@ihs.gov.

Sincerely,

/Susan Karol, M.D./
Susan Karol, M.D.
Chief Medical Officer

Enclosure

Indian Health Service Findings Medical Use of Marijuana

- From 1997 to 2007, the amount of oxycodone used in the United States increased by 1027 percent.ⁱ Americans are using 80 percent of the world's supply of all opioids and 99 percent of the world's hydrocodone.ⁱⁱ
- Findings from a study published in July 2006 showed that 9 percent of patients with chronic pain abused prescribed pain medications, and 16 percent utilized illicit drugs.ⁱⁱⁱ The National Survey on Drug Use and Health reported that 16.7 million Americans aged 12 years and older have used marijuana at least once the month prior to the survey, and youth aged 12 - 17 years have increased marijuana use from 6.7 percent in 2008 to 7.3 percent in 2009.^{iv}
- Seventeen (17) states and the District of Columbia have passed legislation regarding the use of medical marijuana in direct violation of the Federal Controlled Substances Act (CSA).^v States have the authority to regulate all things within their borders that have not specifically been assigned to Federal control. The CSA specifically assigns the regulation of controlled substances to the Drug Enforcement Administration (DEA). As such, this is a federally regulated area. States may be more restrictive in the regulation of controlled substances, but not more lenient.^{vi}
- The CSA lists marijuana as a Schedule I controlled substance.^{vii, viii} This requires a special DEA registration for the investigational use and manufacture of the drug. The DEA continues to actively prosecute CSA violators.^{ix, x, xi, xii}
- The IHS Health Manual (Part 3 - Professional Services, Chapter 7 - Pharmacy) has provisions for investigational drugs, but not for Schedule I controlled substances.^{xiii} The IHS Health Manual lists only schedules (II) - (V) as acceptable items for use within the Agency. That means that the IHS will not use Schedule I controlled substances as a matter of Agency policy. In a 1981 ruling, the U.S. Department of Health and Human Services prohibited reimbursement for unapproved drugs, or drugs listed by the Food and Drug Administration (FDA) as ineffective through the Drug Efficacy Study Implementation (DESI).^{xiv} The FDA considers marijuana an unapproved drug. This policy has been applied to Federal employees, facilities, and contractors.
- Tribal Annual Funding Agreements require the Tribal entity to meet all applicable laws. The CSA is also applicable here. Not meeting Federal statutes and regulations would put any provider outside the scope of his or her employment. As a consequence, the provider would not be covered under the Federal Tort Claims Act.^{xv}
- The National Organization for the Reform of Marijuana Laws (NORML), a medical marijuana advocacy organization, states that physicians may not prescribe medical marijuana without fear of losing his or her license. NORML also states that individuals should expect fines and or jail time if he or she is convicted of possession.^{xvi}

REFERENCE LISTING -- IHS Findings -- Medical Use of Marijuana

-
- i <http://www.drugabuse.gov/PDF/CEWG/CEWGJan09508Compliant.pdf>
- ii [Pain Physician 2007; 10:399-424; http://www.painphysicianjournal.com/2007/may/2007;10;399-424.pdf](#)
- iii <http://www.ncbi.nlm.nih.gov/pubmed/16886030>
- iv <http://www.drugabuse.gov/Infofacts/marijuana.html>
- v http://norml.org/index.cfm?Group_ID=4516
- vi <http://caselaw.lp.findlaw.com/data/constitution/article06/02.html#1>
- vii <http://www.deadiversion.usdoj.gov/21cfr/cfr/index.html>
- viii <http://www.deadiversion.usdoj.gov/21cfr/21usc/812.htm>
- ix http://www.deadiversion.usdoj.gov/fed_regs/notices/2001/fr0418/fr0418c.htm
- x http://www.deadiversion.usdoj.gov/fed_regs/notices/2001/fr0418/fr0418a.htm
- xi http://www.deadiversion.usdoj.gov/fed_regs/actions/2002/fr1220.htm
- xii http://www.deadiversion.usdoj.gov/fed_regs/actions/2007/fr05033.htm
- xiii http://home.pharmacy.ihs.gov/DOCS/docs_news_gen/1/Manualchapter7.pdf
- xiv https://www.cms.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp
- xv <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=29833157cbd65f9b7e69ad6cf10103a7&rgn=div6&view=text&node=25:2.0.4.10.1.13&idno=25>
- xvi <http://norml.org>



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- iii <http://www.ncbi.nlm.nih.gov/pubmed/16886030>
- iv <http://www.drugabuse.gov/Infofacts/marijuana.html>
- v http://norml.org/index.cfm?Group_ID=4516
- vi <http://caselaw.lp.findlaw.com/data/constitution/article06/02.html#1>
- vii <http://www.deadiversion.usdoj.gov/21cfr/cfr/index.html>
- viii <http://www.deadiversion.usdoj.gov/21cfr/21usc/812.htm>
- ix http://www.deadiversion.usdoj.gov/fed_regs/notices/2001/fr0418/fr0418c.htm
- x http://www.deadiversion.usdoj.gov/fed_regs/notices/2001/fr0418/fr0418a.htm
- xi http://www.deadiversion.usdoj.gov/fed_regs/actions/2002/fr1220.htm
- xii http://www.deadiversion.usdoj.gov/fed_regs/actions/2007/fr05033.htm
- xiii http://home.pharmacy.ihs.gov/DOCS/docs_news_gen/1/Manualchapter7.pdf
- xiv https://www.cms.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp
- xv <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=29833157cbd65f9b7e69ad6cf10103a7&rgn=div6&view=text&node=25:2.0.4.10.1.13&idno=25>
- xvi <http://norml.org>



THE UNITED STATES ATTORNEY'S OFFICE
EASTERN DISTRICT *of* CALIFORNIA

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Department of Justice

U.S. Attorney's Office

Eastern District of California

FOR IMMEDIATE RELEASE

Wednesday, July 8, 2015

**Federal and Local Law Enforcement Execute Search
Warrants at Large Scale Commercial Marijuana
Cultivation Facilities on Tribal Lands**

**Commercial Cultivation and Distribution of Marijuana Violates Federal Law,
California's Compassionate Use Act, and Locally Enacted Marijuana
Regulations**

SACRAMENTO, Calif. — Earlier today, special agents with the Bureau of Indian Affairs (BIA) and the Drug Enforcement Administration (DEA), assisted by other federal and state agencies and the Modoc County Sheriff's Office, conducted a search of two large-scale marijuana cultivation facilities located on federally recognized tribal lands at the Alturas Indian Rancheria and the XL Ranch in Modoc County, United States Attorney Benjamin B. Wagner announced. At both sites, law enforcement seized a total of at least 12,000 marijuana plants and over 100 pounds of processed marijuana. Other than contraband marijuana and items of evidentiary value, no tribal property was seized, and no federal charges are pending.

The search warrants are part of an ongoing investigation relating to the financing and management of the commercial marijuana-cultivation projects. The search warrant affidavits were unsealed today. While it is generally the policy of the U.S. Attorney's Office to decline commenting upon ongoing investigations, exceptions are sometimes made when a matter has received substantial publicity and there is a need to inform the community regarding law enforcement actions taken in furtherance of particular public interests. The marijuana grows in question have received substantial attention in Modoc County, as has the U.S. Department of Justice's guidance relating to marijuana cultivation on tribal lands.

The cultivation facility at the Alturas Indian Rancheria was located within the tribe's former Event Center, within approximately 100 yards of the tribe's publicly operated gaming facility, the Desert Rose Casino. The facility on the XL Ranch was immediately adjacent to Highway 395 and the banks of the Pit River, and it consisted of 40 newly constructed greenhouse structures, each of

which was capable of accommodating approximately 1,000 marijuana plants, and an additional gable-roofed structure that boosted the square footage of roof-covered structures by another 50 percent. Both of the grow operations, which appear to have been operating in conjunction with each other, were well in excess of the locally enacted marijuana cultivation limits applicable to county land. The volume of marijuana that the XL facility alone was capable of producing, estimated at approximately 40,000-60,000 plants, far exceeds any prior known commercial marijuana grow operation anywhere within the 34-county Eastern District. According to tribal representatives, all of the marijuana cultivated at both facilities was intended to be distributed off tribal lands at various unidentified locations. As indicated in the search warrant affidavits, the investigation to date indicates both operations may have been financed by a third-party foreign national.

The United States Attorney's Office follows Department of Justice guidelines in exercising its prosecutorial discretion and evaluating the need for investigative and enforcement action with respect to potential violations of federal law. The investigation of the cultivation facilities searched today indicates that both are commercial marijuana cultivation projects operated with the intent to transport large quantities of marijuana off tribal lands for distribution at various locations yet to be identified by the tribes. These facts raise multiple federal enforcement concerns, including the diversion of marijuana to places where it is not authorized and potential threats to public safety, both of which are listed priorities in Department of Justice guidelines. These concerns are only heightened when the activity occurring off tribal lands is not subject to effective state or local regulation.

Consistent with Department of Justice guidelines and the federal government's trust relationship with recognized tribes, the U.S. Attorney's Office consulted with members and representatives of both tribes on multiple occasions before today's action. The U.S. Attorney's Office reminded the tribes that the cultivation of marijuana is illegal under federal law and that anyone engaging in such activity did so at the risk of enforcement action. The U.S. Attorney's Office also expressed concern that large-scale commercial marijuana grows on tribal lands have the potential to introduce quantities of marijuana in a manner that violates federal law, is not consistent with California's Compassionate Use Act, and undermines locally enacted marijuana regulations. The U.S. Attorney's Office stated that this potential was a concern for local law enforcement throughout the Eastern District and potentially warranted federal action. [search warrant](#) (1.63 MB)

Drug Trafficking
[Download search warrant](#) (1.63 MB)

[USAO - California, Eastern](#)

Updated July 8, 2015

EDMUND G. BROWN JR.
Attorney General



DEPARTMENT OF JUSTICE
State of California

**GUIDELINES FOR THE SECURITY AND NON-DIVERSION
OF MARIJUANA GROWN FOR MEDICAL USE**

August 2008

In 1996, California voters approved an initiative that exempted certain patients and their primary caregivers from criminal liability under state law for the possession and cultivation of marijuana. In 2003, the Legislature enacted additional legislation relating to medical marijuana. One of those statutes requires the Attorney General to adopt “guidelines to ensure the security and nondiversion of marijuana grown for medical use.” (Health & Saf. Code, § 11362.81(d).¹) To fulfill this mandate, this Office is issuing the following guidelines to (1) ensure that marijuana grown for medical purposes remains secure and does not find its way to non-patients or illicit markets, (2) help law enforcement agencies perform their duties effectively and in accordance with California law, and (3) help patients and primary caregivers understand how they may cultivate, transport, possess, and use medical marijuana under California law.

I. SUMMARY OF APPLICABLE LAW

A. California Penal Provisions Relating to Marijuana.

The possession, sale, cultivation, or transportation of marijuana is ordinarily a crime under California law. (See, e.g., § 11357 [possession of marijuana is a misdemeanor]; § 11358 [cultivation of marijuana is a felony]; Veh. Code, § 23222 [possession of less than 1 oz. of marijuana while driving is a misdemeanor]; § 11359 [possession with intent to sell any amount of marijuana is a felony]; § 11360 [transporting, selling, or giving away marijuana in California is a felony; under 28.5 grams is a misdemeanor]; § 11361 [selling or distributing marijuana to minors, or using a minor to transport, sell, or give away marijuana, is a felony].)

B. Proposition 215 - The Compassionate Use Act of 1996.

On November 5, 1996, California voters passed Proposition 215, which decriminalized the cultivation and use of marijuana by seriously ill individuals upon a physician’s recommendation. (§ 11362.5.) Proposition 215 was enacted to “ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person’s health would benefit from the use of marijuana,” and to “ensure that patients and their primary caregivers who obtain and use marijuana for

¹ Unless otherwise noted, all statutory references are to the Health & Safety Code.

medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction.” (§ 11362.5(b)(1)(A)-(B).)

The Act further states that “Section 11357, relating to the possession of marijuana, and Section 11358, relating to the cultivation of marijuana, shall not apply to a patient, or to a patient’s primary caregiver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or verbal recommendation or approval of a physician.” (§ 11362.5(d).) Courts have found an implied defense to the transportation of medical marijuana when the “quantity transported and the method, timing and distance of the transportation are reasonably related to the patient’s current medical needs.” (*People v. Trippet* (1997) 56 Cal.App.4th 1532, 1551.)

C. Senate Bill 420 - The Medical Marijuana Program Act.

On January 1, 2004, Senate Bill 420, the Medical Marijuana Program Act (MMP), became law. (§§ 11362.7-11362.83.) The MMP, among other things, requires the California Department of Public Health (DPH) to establish and maintain a program for the voluntary registration of qualified medical marijuana patients and their primary caregivers through a statewide identification card system. Medical marijuana identification cards are intended to help law enforcement officers identify and verify that cardholders are able to cultivate, possess, and transport certain amounts of marijuana without being subject to arrest under specific conditions. (§§ 11362.71(e), 11362.78.)

It is mandatory that all counties participate in the identification card program by (a) providing applications upon request to individuals seeking to join the identification card program; (b) processing completed applications; (c) maintaining certain records; (d) following state implementation protocols; and (e) issuing DPH identification cards to approved applicants and designated primary caregivers. (§ 11362.71(b).)

Participation by patients and primary caregivers in the identification card program is voluntary. However, because identification cards offer the holder protection from arrest, are issued only after verification of the cardholder’s status as a qualified patient or primary caregiver, and are immediately verifiable online or via telephone, they represent one of the best ways to ensure the security and non-diversion of marijuana grown for medical use.

In addition to establishing the identification card program, the MMP also defines certain terms, sets possession guidelines for cardholders, and recognizes a qualified right to collective and cooperative cultivation of medical marijuana. (§§ 11362.7, 11362.77, 11362.775.)

D. Taxability of Medical Marijuana Transactions.

In February 2007, the California State Board of Equalization (BOE) issued a Special Notice confirming its policy of taxing medical marijuana transactions, as well as its requirement that businesses engaging in such transactions hold a Seller’s Permit. (<http://www.boe.ca.gov/news/pdf/medseller2007.pdf>.) According to the Notice, having a Seller’s Permit does not allow individuals to make unlawful sales, but instead merely provides a way to remit any sales and use taxes due. BOE further clarified its policy in a

June 2007 Special Notice that addressed several frequently asked questions concerning taxation of medical marijuana transactions. (<http://www.boe.ca.gov/news/pdf/173.pdf>.)

E. Medical Board of California.

The Medical Board of California licenses, investigates, and disciplines California physicians. (Bus. & Prof. Code, § 2000, et seq.) Although state law prohibits punishing a physician simply for recommending marijuana for treatment of a serious medical condition (§ 11362.5(c)), the Medical Board can and does take disciplinary action against physicians who fail to comply with accepted medical standards when recommending marijuana. In a May 13, 2004 press release, the Medical Board clarified that these accepted standards are the same ones that a reasonable and prudent physician would follow when recommending or approving any medication. They include the following:

1. Taking a history and conducting a good faith examination of the patient;
2. Developing a treatment plan with objectives;
3. Providing informed consent, including discussion of side effects;
4. Periodically reviewing the treatment's efficacy;
5. Consultations, as necessary; and
6. Keeping proper records supporting the decision to recommend the use of medical marijuana.

(http://www.mbc.ca.gov/board/media/releases_2004_05-13_marijuana.html.)

Complaints about physicians should be addressed to the Medical Board (1-800-633-2322 or www.mbc.ca.gov), which investigates and prosecutes alleged licensing violations in conjunction with the Attorney General's Office.

F. The Federal Controlled Substances Act.

Adopted in 1970, the Controlled Substances Act (CSA) established a federal regulatory system designed to combat recreational drug abuse by making it unlawful to manufacture, distribute, dispense, or possess any controlled substance. (21 U.S.C. § 801, et seq.; *Gonzales v. Oregon* (2006) 546 U.S. 243, 271-273.) The CSA reflects the federal government's view that marijuana is a drug with "no currently accepted medical use." (21 U.S.C. § 812(b)(1).) Accordingly, the manufacture, distribution, or possession of marijuana is a federal criminal offense. (*Id.* at §§ 841(a)(1), 844(a).)

The incongruity between federal and state law has given rise to understandable confusion, but no legal conflict exists merely because state law and federal law treat marijuana differently. Indeed, California's medical marijuana laws have been challenged unsuccessfully in court on the ground that they are preempted by the CSA. (*County of San Diego v. San Diego NORML* (July 31, 2008) --- Cal.Rptr.3d ---, 2008 WL 2930117.) Congress has provided that states are free to regulate in the area of controlled substances, including marijuana, provided that state law does not positively conflict with the CSA. (21 U.S.C. § 903.) Neither Proposition 215, nor the MMP, conflict with the CSA because, in adopting these laws, California did not "legalize" medical marijuana, but instead exercised the state's reserved powers to not punish certain marijuana offenses under state law when a physician has recommended its use to treat a serious medical condition. (See *City of Garden Grove v. Superior Court (Kha)* (2007) 157 Cal.App.4th 355, 371-373, 381-382.)

In light of California's decision to remove the use and cultivation of physician-recommended marijuana from the scope of the state's drug laws, this Office recommends that state and local law enforcement officers not arrest individuals or seize marijuana under federal law when the officer determines from the facts available that the cultivation, possession, or transportation is permitted under California's medical marijuana laws.

II. DEFINITIONS

A. **Physician's Recommendation:** Physicians may not prescribe marijuana because the federal Food and Drug Administration regulates prescription drugs and, under the CSA, marijuana is a Schedule I drug, meaning that it has no recognized medical use. Physicians may, however, lawfully issue a verbal or written recommendation under California law indicating that marijuana would be a beneficial treatment for a serious medical condition. (§ 11362.5(d); *Conant v. Walters* (9th Cir. 2002) 309 F.3d 629, 632.)

B. **Primary Caregiver:** A primary caregiver is a person who is designated by a qualified patient and "has consistently assumed responsibility for the housing, health, or safety" of the patient. (§ 11362.5(e).) California courts have emphasized the consistency element of the patient-caregiver relationship. Although a "primary caregiver who consistently grows and supplies . . . medicinal marijuana for a section 11362.5 patient is serving a health need of the patient," someone who merely maintains a source of marijuana does not automatically become the party "who has consistently assumed responsibility for the housing, health, or safety" of that purchaser. (*People ex rel. Lungren v. Peron* (1997) 59 Cal.App.4th 1383, 1390, 1400.) A person may serve as primary caregiver to "more than one" patient, provided that the patients and caregiver all reside in the same city or county. (§ 11362.7(d)(2).) Primary caregivers also may receive certain compensation for their services. (§ 11362.765(c) ["A primary caregiver who receives compensation for actual expenses, including reasonable compensation incurred for services provided . . . to enable [a patient] to use marijuana under this article, or for payment for out-of-pocket expenses incurred in providing those services, or both, . . . shall not, on the sole basis of that fact, be subject to prosecution" for possessing or transporting marijuana].)

C. **Qualified Patient:** A qualified patient is a person whose physician has recommended the use of marijuana to treat a serious illness, including cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief. (§ 11362.5(b)(1)(A).)

D. **Recommending Physician:** A recommending physician is a person who (1) possesses a license in good standing to practice medicine in California; (2) has taken responsibility for some aspect of the medical care, treatment, diagnosis, counseling, or referral of a patient; and (3) has complied with accepted medical standards (as described by the Medical Board of California in its May 13, 2004 press release) that a reasonable and prudent physician would follow when recommending or approving medical marijuana for the treatment of his or her patient.

III. GUIDELINES REGARDING INDIVIDUAL QUALIFIED PATIENTS AND PRIMARY CAREGIVERS

A. State Law Compliance Guidelines.

1. **Physician Recommendation:** Patients must have a written or verbal recommendation for medical marijuana from a licensed physician. (§ 11362.5(d).)

2. **State of California Medical Marijuana Identification Card:** Under the MMP, qualified patients and their primary caregivers may voluntarily apply for a card issued by DPH identifying them as a person who is authorized to use, possess, or transport marijuana grown for medical purposes. To help law enforcement officers verify the cardholder's identity, each card bears a unique identification number, and a verification database is available online (www.calmmp.ca.gov). In addition, the cards contain the name of the county health department that approved the application, a 24-hour verification telephone number, and an expiration date. (§§ 11362.71(a); 11362.735(a)(3)-(4); 11362.745.)

3. **Proof of Qualified Patient Status:** Although verbal recommendations are technically permitted under Proposition 215, patients should obtain and carry written proof of their physician recommendations to help them avoid arrest. A state identification card is the best form of proof, because it is easily verifiable and provides immunity from arrest if certain conditions are met (see section III.B.4, below). The next best forms of proof are a city- or county-issued patient identification card, or a written recommendation from a physician.

4. Possession Guidelines:

a) **MMP:**² Qualified patients and primary caregivers who possess a state-issued identification card may possess 8 oz. of dried marijuana, and may maintain no more than 6 mature or 12 immature plants per qualified patient. (§ 11362.77(a).) But, if “a qualified patient or primary caregiver has a doctor’s recommendation that this quantity does not meet the qualified patient’s medical needs, the qualified patient or primary caregiver may possess an amount of marijuana consistent with the patient’s needs.” (§ 11362.77(b).) Only the dried mature processed flowers or buds of the female cannabis plant should be considered when determining allowable quantities of medical marijuana for purposes of the MMP. (§ 11362.77(d).)

b) **Local Possession Guidelines:** Counties and cities may adopt regulations that allow qualified patients or primary caregivers to possess

² On May 22, 2008, California’s Second District Court of Appeal severed Health & Safety Code § 11362.77 from the MMP on the ground that the statute’s possession guidelines were an unconstitutional amendment of Proposition 215, which does not quantify the marijuana a patient may possess. (See *People v. Kelly* (2008) 163 Cal.App.4th 124, 77 Cal.Rptr.3d 390.) The Third District Court of Appeal recently reached a similar conclusion in *People v. Phomphakdy* (July 31, 2008) --- Cal.Rptr.3d ---, 2008 WL 2931369. The California Supreme Court has granted review in *Kelly* and the Attorney General intends to seek review in *Phomphakdy*.

medical marijuana in amounts that exceed the MMP's possession guidelines. (§ 11362.77(c).)

c) **Proposition 215:** Qualified patients claiming protection under Proposition 215 may possess an amount of marijuana that is “reasonably related to [their] current medical needs.” (*People v. Trippet* (1997) 56 Cal.App.4th 1532, 1549.)

B. Enforcement Guidelines.

1. **Location of Use:** Medical marijuana may not be smoked (a) where smoking is prohibited by law, (b) at or within 1000 feet of a school, recreation center, or youth center (unless the medical use occurs within a residence), (c) on a school bus, or (d) in a moving motor vehicle or boat. (§ 11362.79.)

2. **Use of Medical Marijuana in the Workplace or at Correctional Facilities:** The medical use of marijuana need not be accommodated in the workplace, during work hours, or at any jail, correctional facility, or other penal institution. (§ 11362.785(a); *Ross v. RagingWire Telecomms., Inc.* (2008) 42 Cal.4th 920, 933 [under the Fair Employment and Housing Act, an employer may terminate an employee who tests positive for marijuana use].)

3. **Criminal Defendants, Probationers, and Parolees:** Criminal defendants and probationers may request court approval to use medical marijuana while they are released on bail or probation. The court's decision and reasoning must be stated on the record and in the minutes of the court. Likewise, parolees who are eligible to use medical marijuana may request that they be allowed to continue such use during the period of parole. The written conditions of parole must reflect whether the request was granted or denied. (§ 11362.795.)

4. **State of California Medical Marijuana Identification Cardholders:** When a person invokes the protections of Proposition 215 or the MMP and he or she possesses a state medical marijuana identification card, officers should:

a) Review the identification card and verify its validity either by calling the telephone number printed on the card, or by accessing DPH's card verification website (<http://www.calmmp.ca.gov>); and

b) If the card is valid and not being used fraudulently, there are no other indicia of illegal activity (weapons, illicit drugs, or excessive amounts of cash), and the person is within the state or local possession guidelines, the individual should be released and the marijuana should not be seized. Under the MMP, “no person or designated primary caregiver in possession of a valid state medical marijuana identification card shall be subject to arrest for possession, transportation, delivery, or cultivation of medical marijuana.” (§ 11362.71(e).) Further, a “state or local law enforcement agency or officer shall not refuse to accept an identification card issued by the department unless the state or local law enforcement agency or officer

has reasonable cause to believe that the information contained in the card is false or fraudulent, or the card is being used fraudulently.” (§ 11362.78.)

5. **Non-Cardholders:** When a person claims protection under Proposition 215 or the MMP and only has a locally-issued (i.e., non-state) patient identification card, or a written (or verbal) recommendation from a licensed physician, officers should use their sound professional judgment to assess the validity of the person’s medical-use claim:

a) Officers need not abandon their search or investigation. The standard search and seizure rules apply to the enforcement of marijuana-related violations. Reasonable suspicion is required for detention, while probable cause is required for search, seizure, and arrest.

b) Officers should review any written documentation for validity. It may contain the physician’s name, telephone number, address, and license number.

c) If the officer reasonably believes that the medical-use claim is valid based upon the totality of the circumstances (including the quantity of marijuana, packaging for sale, the presence of weapons, illicit drugs, or large amounts of cash), and the person is within the state or local possession guidelines or has an amount consistent with their current medical needs, the person should be released and the marijuana should not be seized.

d) Alternatively, if the officer has probable cause to doubt the validity of a person’s medical marijuana claim based upon the facts and circumstances, the person may be arrested and the marijuana may be seized. It will then be up to the person to establish his or her medical marijuana defense in court.

e) Officers are not obligated to accept a person’s claim of having a verbal physician’s recommendation that cannot be readily verified with the physician at the time of detention.

6. **Exceeding Possession Guidelines:** If a person has what appears to be valid medical marijuana documentation, but exceeds the applicable possession guidelines identified above, all marijuana may be seized.

7. **Return of Seized Medical Marijuana:** If a person whose marijuana is seized by law enforcement successfully establishes a medical marijuana defense in court, or the case is not prosecuted, he or she may file a motion for return of the marijuana. If a court grants the motion and orders the return of marijuana seized incident to an arrest, the individual or entity subject to the order must return the property. State law enforcement officers who handle controlled substances in the course of their official duties are immune from liability under the CSA. (21 U.S.C. § 885(d).) Once the marijuana is returned, federal authorities are free to exercise jurisdiction over it. (21 U.S.C. §§ 812(c)(10), 844(a); *City of Garden Grove v. Superior Court (Kha)* (2007) 157 Cal.App.4th 355, 369, 386, 391.)

IV. GUIDELINES REGARDING COLLECTIVES AND COOPERATIVES

Under California law, medical marijuana patients and primary caregivers may “associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes.” (§ 11362.775.) The following guidelines are meant to apply to qualified patients and primary caregivers who come together to collectively or cooperatively cultivate physician-recommended marijuana.

A. Business Forms: Any group that is collectively or cooperatively cultivating and distributing marijuana for medical purposes should be organized and operated in a manner that ensures the security of the crop and safeguards against diversion for non-medical purposes. The following are guidelines to help cooperatives and collectives operate within the law, and to help law enforcement determine whether they are doing so.

1. **Statutory Cooperatives:** A cooperative must file articles of incorporation with the state and conduct its business for the mutual benefit of its members. (Corp. Code, § 12201, 12300.) No business may call itself a “cooperative” (or “co-op”) unless it is properly organized and registered as such a corporation under the Corporations or Food and Agricultural Code. (*Id.* at § 12311(b).) Cooperative corporations are “democratically controlled and are not organized to make a profit for themselves, as such, or for their members, as such, but primarily for their members as patrons.” (*Id.* at § 12201.) The earnings and savings of the business must be used for the general welfare of its members or equitably distributed to members in the form of cash, property, credits, or services. (*Ibid.*) Cooperatives must follow strict rules on organization, articles, elections, and distribution of earnings, and must report individual transactions from individual members each year. (See *id.* at § 12200, et seq.) Agricultural cooperatives are likewise nonprofit corporate entities “since they are not organized to make profit for themselves, as such, or for their members, as such, but only for their members as producers.” (Food & Agric. Code, § 54033.) Agricultural cooperatives share many characteristics with consumer cooperatives. (See, e.g., *id.* at § 54002, et seq.) Cooperatives should not purchase marijuana from, or sell to, non-members; instead, they should only provide a means for facilitating or coordinating transactions between members.

2. **Collectives:** California law does not define collectives, but the dictionary defines them as “a business, farm, etc., jointly owned and operated by the members of a group.” (*Random House Unabridged Dictionary*; Random House, Inc. © 2006.) Applying this definition, a collective should be an organization that merely facilitates the collaborative efforts of patient and caregiver members – including the allocation of costs and revenues. As such, a collective is not a statutory entity, but as a practical matter it might have to organize as some form of business to carry out its activities. The collective should not purchase marijuana from, or sell to, non-members; instead, it should only provide a means for facilitating or coordinating transactions between members.

B. Guidelines for the Lawful Operation of a Cooperative or Collective:

Collectives and cooperatives should be organized with sufficient structure to ensure security, non-diversion of marijuana to illicit markets, and compliance with all state and local laws. The following are some suggested guidelines and practices for operating collective growing operations to help ensure lawful operation.

1. **Non-Profit Operation:** Nothing in Proposition 215 or the MMP authorizes collectives, cooperatives, or individuals to profit from the sale or distribution of marijuana. (See, e.g., § 11362.765(a) [“nothing in this section shall authorize . . . any individual or group to cultivate or distribute marijuana for profit”].)

2. **Business Licenses, Sales Tax, and Seller’s Permits:** The State Board of Equalization has determined that medical marijuana transactions are subject to sales tax, regardless of whether the individual or group makes a profit, and those engaging in transactions involving medical marijuana must obtain a Seller’s Permit. Some cities and counties also require dispensing collectives and cooperatives to obtain business licenses.

3. **Membership Application and Verification:** When a patient or primary caregiver wishes to join a collective or cooperative, the group can help prevent the diversion of marijuana for non-medical use by having potential members complete a written membership application. The following application guidelines should be followed to help ensure that marijuana grown for medical use is not diverted to illicit markets:

a) Verify the individual’s status as a qualified patient or primary caregiver. Unless he or she has a valid state medical marijuana identification card, this should involve personal contact with the recommending physician (or his or her agent), verification of the physician’s identity, as well as his or her state licensing status. Verification of primary caregiver status should include contact with the qualified patient, as well as validation of the patient’s recommendation. Copies should be made of the physician’s recommendation or identification card, if any;

b) Have the individual agree not to distribute marijuana to non-members;

c) Have the individual agree not to use the marijuana for other than medical purposes;

d) Maintain membership records on-site or have them reasonably available;

e) Track when members’ medical marijuana recommendation and/or identification cards expire; and

f) Enforce conditions of membership by excluding members whose identification card or physician recommendation are invalid or have expired, or who are caught diverting marijuana for non-medical use.

4. **Collectives Should Acquire, Possess, and Distribute Only Lawfully Cultivated Marijuana:** Collectives and cooperatives should acquire marijuana only from their constituent members, because only marijuana grown by a qualified patient or his or her primary caregiver may lawfully be transported by, or distributed to, other members of a collective or cooperative. (§§ 11362.765, 11362.775.) The collective or cooperative may then allocate it to other members of the group. Nothing allows marijuana to be purchased from outside the collective or cooperative for distribution to its members. Instead, the cycle should be a closed-circuit of marijuana cultivation and consumption with no purchases or sales to or from non-members. To help prevent diversion of medical marijuana to non-medical markets, collectives and cooperatives should document each member's contribution of labor, resources, or money to the enterprise. They also should track and record the source of their marijuana.

5. **Distribution and Sales to Non-Members are Prohibited:** State law allows primary caregivers to be reimbursed for certain services (including marijuana cultivation), but nothing allows individuals or groups to sell or distribute marijuana to non-members. Accordingly, a collective or cooperative may not distribute medical marijuana to any person who is not a member in good standing of the organization. A dispensing collective or cooperative may credit its members for marijuana they provide to the collective, which it may then allocate to other members. (§ 11362.765(c).) Members also may reimburse the collective or cooperative for marijuana that has been allocated to them. Any monetary reimbursement that members provide to the collective or cooperative should only be an amount necessary to cover overhead costs and operating expenses.

6. **Permissible Reimbursements and Allocations:** Marijuana grown at a collective or cooperative for medical purposes may be:

- a) Provided free to qualified patients and primary caregivers who are members of the collective or cooperative;
- b) Provided in exchange for services rendered to the entity;
- c) Allocated based on fees that are reasonably calculated to cover overhead costs and operating expenses; or
- d) Any combination of the above.

7. **Possession and Cultivation Guidelines:** If a person is acting as primary caregiver to more than one patient under section 11362.7(d)(2), he or she may aggregate the possession and cultivation limits for each patient. For example, applying the MMP's basic possession guidelines, if a caregiver is responsible for three patients, he or she may possess up to 24 oz. of marijuana (8 oz. per patient) and may grow 18 mature or 36 immature plants. Similarly, collectives and cooperatives may cultivate and transport marijuana in aggregate amounts tied to its membership numbers. Any patient or primary caregiver exceeding individual possession guidelines should have supporting records readily available when:

- a) Operating a location for cultivation;
- b) Transporting the group's medical marijuana; and
- c) Operating a location for distribution to members of the collective or cooperative.

8. **Security:** Collectives and cooperatives should provide adequate security to ensure that patients are safe and that the surrounding homes or businesses are not negatively impacted by nuisance activity such as loitering or crime. Further, to maintain security, prevent fraud, and deter robberies, collectives and cooperatives should keep accurate records and follow accepted cash handling practices, including regular bank runs and cash drops, and maintain a general ledger of cash transactions.

C. **Enforcement Guidelines:** Depending upon the facts and circumstances, deviations from the guidelines outlined above, or other indicia that marijuana is not for medical use, may give rise to probable cause for arrest and seizure. The following are additional guidelines to help identify medical marijuana collectives and cooperatives that are operating outside of state law.

1. **Storefront Dispensaries:** Although medical marijuana “dispensaries” have been operating in California for years, dispensaries, as such, are not recognized under the law. As noted above, the only recognized group entities are cooperatives and collectives. (§ 11362.775.) It is the opinion of this Office that a properly organized and operated collective or cooperative that dispenses medical marijuana through a storefront may be lawful under California law, but that dispensaries that do not substantially comply with the guidelines set forth in sections IV(A) and (B), above, are likely operating outside the protections of Proposition 215 and the MMP, and that the individuals operating such entities may be subject to arrest and criminal prosecution under California law. For example, dispensaries that merely require patients to complete a form summarily designating the business owner as their primary caregiver – and then offering marijuana in exchange for cash “donations” – are likely unlawful. (*Peron, supra*, 59 Cal.App.4th at p. 1400 [cannabis club owner was not the primary caregiver to thousands of patients where he did not consistently assume responsibility for their housing, health, or safety].)

2. **Indicia of Unlawful Operation:** When investigating collectives or cooperatives, law enforcement officers should be alert for signs of mass production or illegal sales, including (a) excessive amounts of marijuana, (b) excessive amounts of cash, (c) failure to follow local and state laws applicable to similar businesses, such as maintenance of any required licenses and payment of any required taxes, including sales taxes, (d) weapons, (e) illicit drugs, (f) purchases from, or sales or distribution to, non-members, or (g) distribution outside of California.



The Deputy Attorney General

Washington, D.C. 20530

August 29, 2013

MEMORANDUM FOR ALL UNITED STATES ATTORNEYS

FROM: James M. Cole 
Deputy Attorney General

SUBJECT: Guidance Regarding Marijuana Enforcement

In October 2009 and June 2011, the Department issued guidance to federal prosecutors concerning marijuana enforcement under the Controlled Substances Act (CSA). This memorandum updates that guidance in light of state ballot initiatives that legalize under state law the possession of small amounts of marijuana and provide for the regulation of marijuana production, processing, and sale. The guidance set forth herein applies to all federal enforcement activity, including civil enforcement and criminal investigations and prosecutions, concerning marijuana in all states.

As the Department noted in its previous guidance, Congress has determined that marijuana is a dangerous drug and that the illegal distribution and sale of marijuana is a serious crime that provides a significant source of revenue to large-scale criminal enterprises, gangs, and cartels. The Department of Justice is committed to enforcement of the CSA consistent with those determinations. The Department is also committed to using its limited investigative and prosecutorial resources to address the most significant threats in the most effective, consistent, and rational way. In furtherance of those objectives, as several states enacted laws relating to the use of marijuana for medical purposes, the Department in recent years has focused its efforts on certain enforcement priorities that are particularly important to the federal government:

- Preventing the distribution of marijuana to minors;
- Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels;
- Preventing the diversion of marijuana from states where it is legal under state law in some form to other states;
- Preventing state-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity;

- Preventing violence and the use of firearms in the cultivation and distribution of marijuana;
- Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
- Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
- Preventing marijuana possession or use on federal property.

These priorities will continue to guide the Department's enforcement of the CSA against marijuana-related conduct. Thus, this memorandum serves as guidance to Department attorneys and law enforcement to focus their enforcement resources and efforts, including prosecution, on persons or organizations whose conduct interferes with any one or more of these priorities, regardless of state law.¹

Outside of these enforcement priorities, the federal government has traditionally relied on states and local law enforcement agencies to address marijuana activity through enforcement of their own narcotics laws. For example, the Department of Justice has not historically devoted resources to prosecuting individuals whose conduct is limited to possession of small amounts of marijuana for personal use on private property. Instead, the Department has left such lower-level or localized activity to state and local authorities and has stepped in to enforce the CSA only when the use, possession, cultivation, or distribution of marijuana has threatened to cause one of the harms identified above.

The enactment of state laws that endeavor to authorize marijuana production, distribution, and possession by establishing a regulatory scheme for these purposes affects this traditional joint federal-state approach to narcotics enforcement. The Department's guidance in this memorandum rests on its expectation that states and local governments that have enacted laws authorizing marijuana-related conduct will implement strong and effective regulatory and enforcement systems that will address the threat those state laws could pose to public safety, public health, and other law enforcement interests. A system adequate to that task must not only contain robust controls and procedures on paper; it must also be effective in practice. Jurisdictions that have implemented systems that provide for regulation of marijuana activity

¹ These enforcement priorities are listed in general terms; each encompasses a variety of conduct that may merit civil or criminal enforcement of the CSA. By way of example only, the Department's interest in preventing the distribution of marijuana to minors would call for enforcement not just when an individual or entity sells or transfers marijuana to a minor, but also when marijuana trafficking takes place near an area associated with minors; when marijuana or marijuana-infused products are marketed in a manner to appeal to minors; or when marijuana is being diverted, directly or indirectly, and purposefully or otherwise, to minors.

must provide the necessary resources and demonstrate the willingness to enforce their laws and regulations in a manner that ensures they do not undermine federal enforcement priorities.

In jurisdictions that have enacted laws legalizing marijuana in some form and that have also implemented strong and effective regulatory and enforcement systems to control the cultivation, distribution, sale, and possession of marijuana, conduct in compliance with those laws and regulations is less likely to threaten the federal priorities set forth above. Indeed, a robust system may affirmatively address those priorities by, for example, implementing effective measures to prevent diversion of marijuana outside of the regulated system and to other states, prohibiting access to marijuana by minors, and replacing an illicit marijuana trade that funds criminal enterprises with a tightly regulated market in which revenues are tracked and accounted for. In those circumstances, consistent with the traditional allocation of federal-state efforts in this area, enforcement of state law by state and local law enforcement and regulatory bodies should remain the primary means of addressing marijuana-related activity. If state enforcement efforts are not sufficiently robust to protect against the harms set forth above, the federal government may seek to challenge the regulatory structure itself in addition to continuing to bring individual enforcement actions, including criminal prosecutions, focused on those harms.

The Department's previous memoranda specifically addressed the exercise of prosecutorial discretion in states with laws authorizing marijuana cultivation and distribution for medical use. In those contexts, the Department advised that it likely was not an efficient use of federal resources to focus enforcement efforts on seriously ill individuals, or on their individual caregivers. In doing so, the previous guidance drew a distinction between the seriously ill and their caregivers, on the one hand, and large-scale, for-profit commercial enterprises, on the other, and advised that the latter continued to be appropriate targets for federal enforcement and prosecution. In drawing this distinction, the Department relied on the common-sense judgment that the size of a marijuana operation was a reasonable proxy for assessing whether marijuana trafficking implicates the federal enforcement priorities set forth above.

As explained above, however, both the existence of a strong and effective state regulatory system, and an operation's compliance with such a system, may allay the threat that an operation's size poses to federal enforcement interests. Accordingly, in exercising prosecutorial discretion, prosecutors should not consider the size or commercial nature of a marijuana operation alone as a proxy for assessing whether marijuana trafficking implicates the Department's enforcement priorities listed above. Rather, prosecutors should continue to review marijuana cases on a case-by-case basis and weigh all available information and evidence, including, but not limited to, whether the operation is demonstrably in compliance with a strong and effective state regulatory system. A marijuana operation's large scale or for-profit nature may be a relevant consideration for assessing the extent to which it undermines a particular federal enforcement priority. The primary question in all cases – and in all jurisdictions – should be whether the conduct at issue implicates one or more of the enforcement priorities listed above.

Memorandum for All United States Attorneys
Subject: Guidance Regarding Marijuana Enforcement

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As with the Department's previous statements on this subject, this memorandum is intended solely as a guide to the exercise of investigative and prosecutorial discretion. This memorandum does not alter in any way the Department's authority to enforce federal law, including federal laws relating to marijuana, regardless of state law. Neither the guidance herein nor any state or local law provides a legal defense to a violation of federal law, including any civil or criminal violation of the CSA. Even in jurisdictions with strong and effective regulatory systems, evidence that particular conduct threatens federal priorities will subject that person or entity to federal enforcement action, based on the circumstances. This memorandum is not intended to, does not, and may not be relied upon to create any rights, substantive or procedural, enforceable at law by any party in any matter civil or criminal. It applies prospectively to the exercise of prosecutorial discretion in future cases and does not provide defendants or subjects of enforcement action with a basis for reconsideration of any pending civil action or criminal prosecution. Finally, nothing herein precludes investigation or prosecution, even in the absence of any one of the factors listed above, in particular circumstances where investigation and prosecution otherwise serves an important federal interest.

cc: Mythili Raman
Acting Assistant Attorney General, Criminal Division

Loretta E. Lynch
United States Attorney
Eastern District of New York
Chair, Attorney General's Advisory Committee

Michele M. Leonhart
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Assistant Director
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Department of the Treasury Financial Crimes Enforcement Network

Guidance

FIN-2014-G001

Issued: February 14, 2014

Subject: BSA Expectations Regarding Marijuana-Related Businesses

The Financial Crimes Enforcement Network (“FinCEN”) is issuing guidance to clarify Bank Secrecy Act (“BSA”) expectations for financial institutions seeking to provide services to marijuana-related businesses. FinCEN is issuing this guidance in light of recent state initiatives to legalize certain marijuana-related activity and related guidance by the U.S. Department of Justice (“DOJ”) concerning marijuana-related enforcement priorities. This FinCEN guidance clarifies how financial institutions can provide services to marijuana-related businesses consistent with their BSA obligations, and aligns the information provided by financial institutions in BSA reports with federal and state law enforcement priorities. This FinCEN guidance should enhance the availability of financial services for, and the financial transparency of, marijuana-related businesses.

Marijuana Laws and Law Enforcement Priorities

The Controlled Substances Act (“CSA”) makes it illegal under federal law to manufacture, distribute, or dispense marijuana.¹ Many states impose and enforce similar prohibitions. Notwithstanding the federal ban, as of the date of this guidance, 20 states and the District of Columbia have legalized certain marijuana-related activity. In light of these developments, U.S. Department of Justice Deputy Attorney General James M. Cole issued a memorandum (the “Cole Memo”) to all United States Attorneys providing updated guidance to federal prosecutors concerning marijuana enforcement under the CSA.² The Cole Memo guidance applies to all of DOJ’s federal enforcement activity, including civil enforcement and criminal investigations and prosecutions, concerning marijuana in all states.

The Cole Memo reiterates Congress’s determination that marijuana is a dangerous drug and that the illegal distribution and sale of marijuana is a serious crime that provides a significant source of revenue to large-scale criminal enterprises, gangs, and cartels. The Cole Memo notes that DOJ is committed to enforcement of the CSA consistent with those determinations. It also notes that DOJ is committed to using its investigative and prosecutorial resources to address the most

¹ Controlled Substances Act, 21 U.S.C. § 801, *et seq.*

² James M. Cole, Deputy Attorney General, U.S. Department of Justice, *Memorandum for All United States Attorneys: Guidance Regarding Marijuana Enforcement* (August 29, 2013), available at <http://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf>.

significant threats in the most effective, consistent, and rational way. In furtherance of those objectives, the Cole Memo provides guidance to DOJ attorneys and law enforcement to focus their enforcement resources on persons or organizations whose conduct interferes with any one or more of the following important priorities (the “Cole Memo priorities”):³

- Preventing the distribution of marijuana to minors;
- Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels;
- Preventing the diversion of marijuana from states where it is legal under state law in some form to other states;
- Preventing state-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity;
- Preventing violence and the use of firearms in the cultivation and distribution of marijuana;
- Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
- Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
- Preventing marijuana possession or use on federal property.

Concurrently with this FinCEN guidance, Deputy Attorney General Cole is issuing supplemental guidance directing that prosecutors also consider these enforcement priorities with respect to federal money laundering, unlicensed money transmitter, and BSA offenses predicated on marijuana-related violations of the CSA.⁴

Providing Financial Services to Marijuana-Related Businesses

This FinCEN guidance clarifies how financial institutions can provide services to marijuana-related businesses consistent with their BSA obligations. In general, the decision to open, close, or refuse any particular account or relationship should be made by each financial institution based on a number of factors specific to that institution. These factors may include its particular business objectives, an evaluation of the risks associated with offering a particular product or service, and its capacity to manage those risks effectively. Thorough customer due diligence is a critical aspect of making this assessment.

In assessing the risk of providing services to a marijuana-related business, a financial institution should conduct customer due diligence that includes: (i) verifying with the appropriate state authorities whether the business is duly licensed and registered; (ii) reviewing the license application (and related documentation) submitted by the business for obtaining a state license to operate its marijuana-related business; (iii) requesting from state licensing and enforcement authorities available information about the business and related parties; (iv) developing an understanding of the normal and expected activity for the business, including the types of

³ The Cole Memo notes that these enforcement priorities are listed in general terms; each encompasses a variety of conduct that may merit civil or criminal enforcement of the CSA.

⁴ James M. Cole, Deputy Attorney General, U.S. Department of Justice, *Memorandum for All United States Attorneys: Guidance Regarding Marijuana Related Financial Crimes* (February 14, 2014).

products to be sold and the type of customers to be served (e.g., medical versus recreational customers); (v) ongoing monitoring of publicly available sources for adverse information about the business and related parties; (vi) ongoing monitoring for suspicious activity, including for any of the red flags described in this guidance; and (vii) refreshing information obtained as part of customer due diligence on a periodic basis and commensurate with the risk. With respect to information regarding state licensure obtained in connection with such customer due diligence, a financial institution may reasonably rely on the accuracy of information provided by state licensing authorities, where states make such information available.

As part of its customer due diligence, a financial institution should consider whether a marijuana-related business implicates one of the Cole Memo priorities or violates state law. This is a particularly important factor for a financial institution to consider when assessing the risk of providing financial services to a marijuana-related business. Considering this factor also enables the financial institution to provide information in BSA reports pertinent to law enforcement's priorities. A financial institution that decides to provide financial services to a marijuana-related business would be required to file suspicious activity reports ("SARs") as described below.

Filing Suspicious Activity Reports on Marijuana-Related Businesses

The obligation to file a SAR is unaffected by any state law that legalizes marijuana-related activity. A financial institution is required to file a SAR if, consistent with FinCEN regulations, the financial institution knows, suspects, or has reason to suspect that a transaction conducted or attempted by, at, or through the financial institution: (i) involves funds derived from illegal activity or is an attempt to disguise funds derived from illegal activity; (ii) is designed to evade regulations promulgated under the BSA, or (iii) lacks a business or apparent lawful purpose.⁵ Because federal law prohibits the distribution and sale of marijuana, financial transactions involving a marijuana-related business would generally involve funds derived from illegal activity. Therefore, a financial institution is required to file a SAR on activity involving a marijuana-related business (including those duly licensed under state law), in accordance with this guidance and FinCEN's suspicious activity reporting requirements and related thresholds.

One of the BSA's purposes is to require financial institutions to file reports that are highly useful in criminal investigations and proceedings. The guidance below furthers this objective by assisting financial institutions in determining how to file a SAR that facilitates law enforcement's access to information pertinent to a priority.

"Marijuana Limited" SAR Filings

A financial institution providing financial services to a marijuana-related business that it reasonably believes, based on its customer due diligence, does not implicate one of the Cole Memo priorities or violate state law should file a "Marijuana Limited" SAR. The content of this

⁵ See, e.g., 31 CFR § 1020.320. Financial institutions shall file with FinCEN, to the extent and in the manner required, a report of any suspicious transaction relevant to a possible violation of law or regulation. A financial institution may also file with FinCEN a SAR with respect to any suspicious transaction that it believes is relevant to the possible violation of any law or regulation but whose reporting is not required by FinCEN regulations.

SAR should be limited to the following information: (i) identifying information of the subject and related parties; (ii) addresses of the subject and related parties; (iii) the fact that the filing institution is filing the SAR solely because the subject is engaged in a marijuana-related business; and (iv) the fact that no additional suspicious activity has been identified. Financial institutions should use the term “MARIJUANA LIMITED” in the narrative section.

A financial institution should follow FinCEN’s existing guidance on the timing of filing continuing activity reports for the same activity initially reported on a “Marijuana Limited” SAR.⁶ The continuing activity report may contain the same limited content as the initial SAR, plus details about the amount of deposits, withdrawals, and transfers in the account since the last SAR. However, if, in the course of conducting customer due diligence (including ongoing monitoring for red flags), the financial institution detects changes in activity that potentially implicate one of the Cole Memo priorities or violate state law, the financial institution should file a “Marijuana Priority” SAR.

“Marijuana Priority” SAR Filings

A financial institution filing a SAR on a marijuana-related business that it reasonably believes, based on its customer due diligence, implicates one of the Cole Memo priorities or violates state law should file a “Marijuana Priority” SAR. The content of this SAR should include comprehensive detail in accordance with existing regulations and guidance. Details particularly relevant to law enforcement in this context include: (i) identifying information of the subject and related parties; (ii) addresses of the subject and related parties; (iii) details regarding the enforcement priorities the financial institution believes have been implicated; and (iv) dates, amounts, and other relevant details of financial transactions involved in the suspicious activity. Financial institutions should use the term “MARIJUANA PRIORITY” in the narrative section to help law enforcement distinguish these SARs.⁷

“Marijuana Termination” SAR Filings

If a financial institution deems it necessary to terminate a relationship with a marijuana-related business in order to maintain an effective anti-money laundering compliance program, it should

⁶ Frequently Asked Questions Regarding the FinCEN Suspicious Activity Report (Question #16), *available at*: http://fincen.gov/whatsnew/html/sar_faqs.html (providing guidance on the filing timeframe for submitting a continuing activity report).

⁷ FinCEN recognizes that a financial institution filing a SAR on a marijuana-related business may not always be well-positioned to determine whether the business implicates one of the Cole Memo priorities or violates state law, and thus which terms would be most appropriate to include (i.e., “Marijuana Limited” or “Marijuana Priority”). For example, a financial institution could be providing services to another domestic financial institution that, in turn, provides financial services to a marijuana-related business. Similarly, a financial institution could be providing services to a non-financial customer that provides goods or services to a marijuana-related business (e.g., a commercial landlord that leases property to a marijuana-related business). In such circumstances where services are being provided indirectly, the financial institution may file SARs based on existing regulations and guidance without distinguishing between “Marijuana Limited” and “Marijuana Priority.” Whether the financial institution decides to provide indirect services to a marijuana-related business is a risk-based decision that depends on a number of factors specific to that institution and the relevant circumstances. In making this decision, the institution should consider the Cole Memo priorities, to the extent applicable.

file a SAR and note in the narrative the basis for the termination. Financial institutions should use the term “MARIJUANA TERMINATION” in the narrative section. To the extent the financial institution becomes aware that the marijuana-related business seeks to move to a second financial institution, FinCEN urges the first institution to use Section 314(b) voluntary information sharing (if it qualifies) to alert the second financial institution of potential illegal activity. See *Section 314(b) Fact Sheet* for more information.⁸

Red Flags to Distinguish Priority SARs

The following red flags indicate that a marijuana-related business may be engaged in activity that implicates one of the Cole Memo priorities or violates state law. These red flags indicate only possible signs of such activity, and also do not constitute an exhaustive list. It is thus important to view any red flag(s) in the context of other indicators and facts, such as the financial institution’s knowledge about the underlying parties obtained through its customer due diligence. Further, the presence of any of these red flags in a given transaction or business arrangement may indicate a need for additional due diligence, which could include seeking information from other involved financial institutions under Section 314(b). These red flags are based primarily upon schemes and typologies described in SARs or identified by our law enforcement and regulatory partners, and may be updated in future guidance.

- A customer appears to be using a state-licensed marijuana-related business as a front or pretext to launder money derived from other criminal activity (i.e., not related to marijuana) or derived from marijuana-related activity not permitted under state law. Relevant indicia could include:
 - The business receives substantially more revenue than may reasonably be expected given the relevant limitations imposed by the state in which it operates.
 - The business receives substantially more revenue than its local competitors or than might be expected given the population demographics.
 - The business is depositing more cash than is commensurate with the amount of marijuana-related revenue it is reporting for federal and state tax purposes.
 - The business is unable to demonstrate that its revenue is derived exclusively from the sale of marijuana in compliance with state law, as opposed to revenue derived from (i) the sale of other illicit drugs, (ii) the sale of marijuana not in compliance with state law, or (iii) other illegal activity.
 - The business makes cash deposits or withdrawals over a short period of time that are excessive relative to local competitors or the expected activity of the business.

⁸ Information Sharing Between Financial Institutions: Section 314(b) Fact Sheet, *available at*: http://fincen.gov/statutes_regs/patriot/pdf/314bfactsheet.pdf.

- Deposits apparently structured to avoid Currency Transaction Report (“CTR”) requirements.
 - Rapid movement of funds, such as cash deposits followed by immediate cash withdrawals.
 - Deposits by third parties with no apparent connection to the accountholder.
 - Excessive commingling of funds with the personal account of the business’s owner(s) or manager(s), or with accounts of seemingly unrelated businesses.
 - Individuals conducting transactions for the business appear to be acting on behalf of other, undisclosed parties of interest.
 - Financial statements provided by the business to the financial institution are inconsistent with actual account activity.
 - A surge in activity by third parties offering goods or services to marijuana-related businesses, such as equipment suppliers or shipping servicers.
- The business is unable to produce satisfactory documentation or evidence to demonstrate that it is duly licensed and operating consistently with state law.
 - The business is unable to demonstrate the legitimate source of significant outside investments.
 - A customer seeks to conceal or disguise involvement in marijuana-related business activity. For example, the customer may be using a business with a non-descript name (e.g., a “consulting,” “holding,” or “management” company) that purports to engage in commercial activity unrelated to marijuana, but is depositing cash that smells like marijuana.
 - Review of publicly available sources and databases about the business, its owner(s), manager(s), or other related parties, reveal negative information, such as a criminal record, involvement in the illegal purchase or sale of drugs, violence, or other potential connections to illicit activity.
 - The business, its owner(s), manager(s), or other related parties are, or have been, subject to an enforcement action by the state or local authorities responsible for administering or enforcing marijuana-related laws or regulations.
 - A marijuana-related business engages in international or interstate activity, including by receiving cash deposits from locations outside the state in which the business operates, making or receiving frequent or large interstate transfers, or otherwise transacting with persons or entities located in different states or countries.

- The owner(s) or manager(s) of a marijuana-related business reside outside the state in which the business is located.
- A marijuana-related business is located on federal property or the marijuana sold by the business was grown on federal property.
- A marijuana-related business's proximity to a school is not compliant with state law.
- A marijuana-related business purporting to be a "non-profit" is engaged in commercial activity inconsistent with that classification, or is making excessive payments to its manager(s) or employee(s).

Currency Transaction Reports and Form 8300's

Financial institutions and other persons subject to FinCEN's regulations must report currency transactions in connection with marijuana-related businesses the same as they would in any other context, consistent with existing regulations and with the same thresholds that apply. For example, banks and money services businesses would need to file CTRs on the receipt or withdrawal by any person of more than \$10,000 in cash per day. Similarly, any person or entity engaged in a non-financial trade or business would need to report transactions in which they receive more than \$10,000 in cash and other monetary instruments for the purchase of goods or services on FinCEN Form 8300 (Report of Cash Payments Over \$10,000 Received in a Trade or Business). A business engaged in marijuana-related activity may not be treated as a non-listed business under 31 C.F.R. § 1020.315(e)(8), and therefore, is not eligible for consideration for an exemption with respect to a bank's CTR obligations under 31 C.F.R. § 1020.315(b)(6).

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FinCEN's enforcement priorities in connection with this guidance will focus on matters of systemic or significant failures, and not isolated lapses in technical compliance. Financial institutions with questions about this guidance are encouraged to contact FinCEN's Resource Center at (800) 767-2825, where industry questions can be addressed and monitored for the purpose of providing any necessary additional guidance.



October 15, 2015

Secretary Sylvia Mathews Burwell
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Re: Secretary's Tribal Advisory Committee Follow up items from September meeting

Dear Secretary Burwell,

On behalf of the Secretary's Tribal Advisory Committee (STAC), we thank you and your staff for the productive meeting that was held from September 15-16, 2015. The agency's willingness to hear our concerns and address key issues in a responsive, and frank manner is always appreciated and we look forward to working with you to advance many of these priorities in the months to come.

The following letter presents the STAC's key issues from the September meeting. While there are many other topics that are important, these we feel are the top priorities.

Inter-Agency and Inter-Departmental Cooperation

In June 2013, President Obama announced the establishment of the historic White House Council on Native American Affairs. According to Executive Order 13647 which created this body, "The Council shall improve coordination of Federal programs and the use of resources available to tribal communities." Yet, two years later, Tribes still experience federal departments that do not appear to be coordinating in several key areas including alcohol and substance abuse; marijuana policy; implementation of the Employer Mandate under the Affordable Care Act; implementation of P.L. 102-477 programs; and Indian Child Welfare Act enforcement.

- Please provide STAC with information on how HHS works with other agencies to address issues that are cross-departmental such as the Affordable Care Act (ACA) employer mandate and excise tax, alcohol and substance abuse, suicide prevention, and implementation of the ACA.
- How can Tribes be more heavily involved in the actions of the agencies to work jointly to administer federal programs to Indian Country?
- How can STAC and other Indian Country tribal leaders interact directly with the White House Council on Native American Affairs and its subcommittees?

Mental Health and Suicide Epidemic

In the STAC's follow-up letter to our June meeting, dated June 30, 2015, the Committee expressed several priorities and concerns relating to effective treatment and prevention of mental health in Indian Country. We listed priority areas such as implementation of traditional healing methods, deployment of Commissioned Corps officers to Indian Country for mental health and additional research on the impacts of historical trauma in Tribal communities. We also noted inter-departmental and inter-agency coordination as key concerns for addressing this epidemic in Indian Country.

We appreciate the detailed and thoughtful response given by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the response letter provided to the STAC on September 16, 2015, however, STAC was hoping to also hear responses from other Department of Health and Human Services (HHS) agencies who have jurisdiction over these key issues (such as the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), National Institutes of Health (NIH), and the Indian Health Service (IHS)). This only serves to emphasize our request that the Secretary exercise her authority to break down silos within HHS, to increase flexibility in use of program funds and lessen the tribal administrative burden to permit tribal control, and to decrease the conveyance of funds by competitive grant to the fullest extent possible. As the Tribal advisory committee for all of HHS, STAC requests that responses are conducted in a coordinated, and thoughtful way by all relevant agencies of jurisdiction.

- We request that STAC receive responses from all relevant agencies of jurisdiction on suggestions made in the June 30, 2015 letter to HHS.
- Can HHS detail how it plans to address mental health/ suicide crisis in Indian Country through inter-agency cooperation?
- How can tribal leaders work with HHS break down barriers between agencies and departments to ensure that the mental health crisis in Indian Country is being tackled from all areas of the federal government?

Arizona Medicaid Expansion Waiver – Centers for Medicare and Medicaid Services

In March, Arizona passed SB 1092, which will require the Director of Arizona's Medicaid program, Arizona Health Care Cost Containment System (AHCCCS), to apply for an 1115 waiver to the Centers for Medicare and Medicaid Services (CMS) by March 30 of each year for permission to institute cost-sharing requirements, work requirements and lifetime limits for adults receiving AHCCCS benefits.

Some of the requirements of SB 1092 include the following:

1. Institute a work requirement for all able-bodied adults receiving AHCCCS services, excluding long term care, to become employed, actively seek employment, attend school or a job training program, or both at least 20 hours a week, and to verify compliance with this requirement and any change in family income.
2. AHCCCS will verify when a person is seeking employment and to confirm changes of family income and re-determine eligibility for services
3. AHCCCS can ban an eligible person for one year if the individual knowingly fails to report family income changes or makes a false statement regarding work related requirements
4. Place a five-year lifetime limit of benefits on able-bodied adults that begins on the effective date of the waiver or amendment to the current waiver, excluding any previous time a person received AHCCCS benefits.

These requirements will have lasting negative and devastating impacts on the American Indian population in Arizona and adversely affect 100,000 Tribal members in Arizona who are currently enrolled in the AHCCCS, as there are few job opportunities and employment resources for Tribes in Arizona. Imposing these requirements on the most impoverished areas in the State only compounds the hopelessness and lack

of adequate health care that prevail. In the response letter provided to STAC, CMS noted that the waiver was currently undergoing review. However, we believe that this review should absolutely include thorough and meaningful Tribal consultation.

- Please comment on CMS' plan to consult with Tribes in Arizona as they review the implications of this 1115 waiver request by the state of Arizona.

Federal Medical Assistance Percentage (FMAP) Expansion

The States of South Dakota and Alaska have submitted proposals asking CMS to expand the current policy on 100% FMAP to Purchased & Referred Care (PRC). CMS has conducted two All Tribes Calls and held a consultation session the National Indian Health Board's Annual Conference in September 2015. During these consultation sessions, CMS explained that Alaska has requested 100% FMAP for emergency and non-emergency medical transport and transportation-related expenditures as well as for services provided through PRC referrals; and that South Dakota has requested 100% FMAP for telehealth services, specialty services provided through collaborative arrangements, and services provided by community health representatives. We applaud CMS for reconsidering its past policy position that 100% federal reimbursement only applied to care provided inside the four walls of IHS facilities. Section 1905(b) of the Social Security Act provides that it applies to all services "received through," the IHS or tribal health facilities, and the PRC program is a program provided through the IHS and tribal health facilities. Expanding CMS's existing interpretation to cover PRC services will benefit IHS and Tribal health programs by allowing States to expand coverage for AI/ANs, either by covering additional population groups or additional services.

- We respectfully request that CMS approve the 100% FMAP proposals for Alaska and South Dakota, as well as the rest of the Indian health system.

Employer Mandate in the Affordable Care Act

Tribal governments continue to seek relief from the employer mandate in the Affordable Care Act. The Employer Shared Responsibility Rule, otherwise known as the Employer Mandate, states that all employers must offer health insurance to their employees or pay a penalty. Tribal governments are currently counted as large employers for application of this rule. American Indians and Alaska Natives (AI/ANs) are exempt from the Individual Mandate to purchase health insurance. This is in recognition of the fact that AI/ANs should not be forced to purchase healthcare that is obligated by the federal government's trust responsibility and which is delivered through IHS. Requiring Tribal employers to provide AI/ANs with such coverage anyway, and penalizing them if they do not, functionally invalidates the AI/AN exemption from the individual mandate by shifting the penalty from the individual to the Tribe itself.

While the vast majority of Tribal employers have always provided health insurance to employees, and will continue to do so, for several Tribal employers, this is an impossible choice. Because Tribes do not have the luxury of raising prices or taxes to offset costs, many Tribes are left deciding to lay off workers, cut services, or pay unaffordable fines. STAC recognizes that the HHS and the Department of Treasury

both have jurisdiction over this issue, and therefore, encourage HHS to take the lead in initiating an inter-departmental effort to provide relief for Tribes.

While the Internal Revenue Service (IRS) does not believe it has the legal authority to issue such an exemption through the regulatory process, tribes believe HHS and IRS possess all necessary authority to interpret provisions of the ACA favorably for tribes that would fully or partially mitigate the consequential burden on tribes that was unintended by the Congress. The recent district court decision in *Northern Arapaho Tribe v. Burwell* (Case No. 14-CV-247-SWS) that noted the employer mandate does apply to Tribes is both not directly on point and represents the significantly high threshold that must be overcome for a court to overrule the administration's interpretation of statute. The HHS and IRS and tribes in consultation may collaborate to implement the ACA through readily applicable interpretations of its provisions in regulation without injuring tribal interests by issuing a clarifying regulation.

- STAC requests the HHS and IRS work together in consultation with tribes to clarify regulations that appropriately interpret Tribal employers in the Employer Mandate in the Affordable Care Act.
- We request that HHS and IRS collaborate to delay the enforcement of the employer mandate provision for one year so that there is more time for the agencies to consult with Tribes and determine a path forward.

Winnebago Service Unit CMS Certification Termination

On July 23, 2015, CMS terminated certification for the Winnebago Service Unit which serves the Winnebago and Omaha Tribes, making the facility ineligible to bill Medicare or Medicaid for services provided. This CMS termination was a direct result of the findings of a series of successive CMS investigations into the IHS's management and operation of this facility. In fact, during the course of successive CMS surveys, there were deaths at the hospital which CMS found to be directly related to the Winnebago Hospital's failure to provide adequate medical care.

All of Indian Country stands in unity with the Winnebago and Omaha Tribes as they seek to find a solution to this problem. It is nothing short of unacceptable that American Indians and Alaska Natives should have to suffer this standard of care at the hands of an IHS-run hospital. STAC calls upon the Indian Health Service working with HHS and CMS to take all necessary steps to correct deficiencies at the Winnebago Hospital, keep the Winnebago and Omaha Tribes fully informed of its plans and actions, and to include the Tribes as fully as they wish to be in all aspects of the operation and improvement of the Winnebago Hospital, including the financial status of the Hospital.

- Please provide a detailed outline of how HHS will exercise its leadership to coordinate an improvement plan at the Winnebago Service Unit so that no person's life is put at risk again.
- STAC requests regular updates to Tribes of any information or assessments it may have regarding any deficiencies, risks to certification, consideration of substantive changes in operations, or other matters that could affect quality of care at, access to, and financial viability of, any other hospital operated by the Indian Health Service.

Employee Contract Settlement – Indian Health Service

On May 22, Acting Director of the IHS Principal Deputy Director Robert McSwain notified Tribes that the Indian Health Service had reached an agreement with employee unions. On July 29, an update letter was sent by IHS to the Tribes. In the response to STAC on September 16, IHS noted that most of the settlement payment was borne largely by the service units. While STAC recognizes the need to provide settlement funds, Tribes where the facilities are in question are still concerned about the amount of funds that would be used to pay the settlement. Tribes are also concerned about what purpose the extra funds were intended to be used for at the service unit level when IHS is funded at only 59% of actual need.

- Please provide a detailed account about where the settlement funds came from, and the response each unit provided IHS of what each service unit had intended the unobligated balances to be used for.

Contract Support Costs – Indian Health Service

The STAC is highly encouraged by the actions of the Administration to move forward on full-funding of contract support costs (CSC). The budget proposal this year to enact mandatory appropriations for CSC is an important first step in ensuring that these costs are fully funded. The IHS' CSC workgroup has also been working to come to an agreement on how we work on issues around incurred cost mythology. Tribes would like to initiate a pilot project to would allow agency to determine best way to reconcile CSC on a contract by contract basis and consider imposing CSC for 3-5 years.

- Please discuss the feasibility of this suggested pilot project and how we can move forward in a collaborative way.

Marijuana Policy

As noted in our previous letter, Tribes continue explore pathways to pursuing both medical and recreational marijuana enterprises on Tribal lands. Congress has provided that states are free to regulate in the area of controlled substances, including marijuana, provided that state law does not positively conflict with the Controlled Substances Act (CSA) (21 U.S.C. § 903). States have not “legalized” medical marijuana, but instead exercised each state’s reserved powers to not punish certain marijuana offenses under state law when a physician has recommended its use to treat a serious medical condition.

State laws qualify for prosecutorial discretion from the U.S. Department of Justice (DOJ) when robust regulatory regimes are implemented, and not all states regulations are suitable in the view of DOJ. DOJ issued memoranda and guidelines for tribes, postulated as eight law enforcement priorities directed to marijuana activities on tribal lands, however, these application of these priorities remains unclear, especially in the context of consequences for tribes’ HHS funding, and tribes continue to seek specific answers from HHS and DOJ. We appreciate your response that the Department of Justice has primary jurisdiction on enforcement and are encouraged by your confirmation that Tribal HHS would not be adversely impacted if they operated a marijuana grow or dispensary on Tribal lands as long as federal funding was not used. The 2011 letter from IHS Chief Medical Officer issued “findings” on the medical uses of marijuana. These “findings” mischaracterized applicable law in a “finding” that under Article 6 of the Constitution, States are violating federal law by legalizing medical marijuana, and in asserting that

health care providers at IHS-funded facilities would not be covered by the Federal Tort Claims Act (FTCA) if they failed to meet the requirements of the Controlled Substances Act. This statement does not accurately reflect the case law on applicability of the FTCA. HHS has a key role in how a drug can be rescheduled in the CSA. HHS FDA would recommend rescheduling and provide a scientific and medical evaluation of the drug. The Drug Enforcement Administration (DEA) must find that the drug does not meet the requirements for inclusion in any schedule. DEA would then engage in rulemaking to remove or reclassify the drug from its schedule. In 2011, the Governors of the states of Washington and Rhode Island petitioned HHS to have marijuana rescheduled as a Schedule II drug.

- STAC urges HHS to engage in conversations with DOJ to determine how it would enforce marijuana on Tribal lands.
- STAC also encourages HHS to engage jointly with DOJ in Tribal consultation with those Tribes who intend to legalize marijuana.

Implementation and Expansion of P.L. 102-477

Since 1992, the 477 program has allowed Tribes and tribal organizations to consolidate programmatic employment related funding from the Departments of Interior, HHS, Labor, while streamlining program approval, accounting and reporting mechanisms, thus offering a model for Administrative flexibility. The law allows for increased efficiency, decreased administrative burdens, and empowers self-determination. STAC was pleased to hear the agency confirm that the Community Services Block Grant is eligible for the 477 program. However, we were disappointed to hear that HHS considers LIHEAP and Head Start funds to not be eligible for 477.

- Please provide legal justification as to why the determination was made not to add LIHEAP and Head Start to the 477 program.

Head Start – Administration for Children and Families

Head Start programs provide vital services to Tribal communities, despite the fact that only 16 percent of age-eligible Indian child population is enrolled in Head Start. Only about 188 Tribes have access to the program, and few of those programs actually have sufficient funding to implement the necessary program improvements that would result in better outcomes for our young people. The Indian Head Start programs are on the frontline in the struggle to preserve Native language and culture, which have proven to be key elements in Native student confidence and success in later years.

STAC echoes the recommendations of the National Indian Head Start Directors Association outlined in their Comments on RIN 0970-AC63, “Head Start Performance Standards.” These recommendations include concern over the loss of slots that will occur due to the cost of the Proposed Rule’s mandates, particularly, the full-day and full-year requirements. Several of the proposed requirements are not compatible with distinct cultures and needs of our communities. Several areas are drafted in a state-centered way, creating requirements that are not consistent with the unique government-to-government relationship between Tribes and the federal government. Finally, the Indian Head Start Directors Association and STAC are concerned that several provisions in this Proposed Rule call for research-based practices, yet research-based practices have not been developed for AI/AN communities and existing research has excluded AI/AN children and families.

- We urge the Office of Head Start to revise the Proposed Rule so that it is compatible with the distinct needs of Indian Head Start programs and adopt Indian-specific exemptions where appropriate.
- We urge the Office of Head Start to maintain flexibility and local control of Indian Head Start programs in order to honor the unique needs of Native communities, families and children.

Effective Implementation of the Indian Child Welfare Act – Administration for Children and Families

Today, AI/AN children still face serious obstacles to receiving the full protections provided under the Indian Child Welfare Act (ICWA). AI/AN children are disproportionately represented nationally at 2.0 times their population rate and among individual state foster care systems as much as 10 times their population rate.¹ While no single federal agency is provided full responsibility to monitor and ensure compliance with ICWA, the Administration for Children and Families (ACF) has oversight over much of state child welfare practice, including data collection, ensuring appropriate outcomes, and assisting states to improve their practice and policies to be in compliance with federal law. ACF has a critical role in helping collect important data, promoting effective tribal/state collaborations, assisting states as they build capacity to comply with ICWA, and reversing the inequities and disparate treatment that can occur when ICWA is not followed. In order to support the Administration's priority to improve ICWA implementation and related HHS activities we note the following priorities of STAC.

- We are pleased that ACF has committed to establishing new ICWA related data elements in Adoption and Foster Care Analysis and Reporting System (AFCARS) and the development of a report detailing how states are doing in implementing the Title IV-B requirement that requires them to consult with Tribes on measures to comply with ICWA. These efforts will contribute significantly to an increased understanding of how AI/AN children are doing in state child welfare systems, areas where improvements need to be made, and the status of state and tribal relationships with regard to implementing ICWA. However, we are very concerned at the slow pace at which these initiatives are moving ahead. The intent to publish an AFCARS Supplemental containing proposed ICWA data elements was published in the Federal Register on April 2, 2015, which included a statement that ACF has determined that it has authority under Title IV-E to collect this data. This followed a general AFCARS notice of proposed rulemaking (NPRM) where several Tribes and Indian organizations provided strong support for including ICWA data elements in AFCARS and comments on suggested ICWA data elements to be included. Furthermore, the American Public Human Services Association, which is a membership organization of state human services programs, has previously gone on record to support the addition of ICWA related data elements in AFCARS. If the AFCARS Supplemental is not published very soon it is at serious risk of not being able to become a Final Rule during this Administration. These are the top two priorities of STAC related to improving ICWA implementation and we appreciate your efforts to make these initiatives a priority in this quarter.
- The report on how states are doing in meeting their obligations under Title IV-B to consult with Tribes regarding ICWA implementation has been in process for over a year and was originally promised to be released at the June STAC meeting. This is a report that contains public information

¹ Summers, A., Woods, S., & Donovan, J. (2013). Technical assistance bulletin: Disproportionality rates for children of color in foster care. National Council of Juvenile and Family Court Judges: Reno, NV.

derived from existing aggregate data that ACF tracks and which does not contain any new policy interpretation or guidance. As with the AFCARS data initiative, this is a high priority for STAC, so we urge ACF to have the report disseminated before the next STAC meeting so tribal leadership may have time to review and participate in dialogue with ACF at the next STAC meeting.

- Consult with Tribes on efforts between the DOJ, Department of Interior (DOI), and HHS regarding the Attorney General's ICWA initiative and Administration's priority on improving ICWA compliance. The Attorney General's ICWA initiative acknowledges the need for greater federal collaboration on efforts to ensure compliance with ICWA and the disastrous effects that ICWA non-compliance has had on AI/AN children, families, and communities. We appreciate the updates on what HHS is doing with regards to ICWA implementation, but would like to hear more on how the work HHS is doing with the DOI and DOJ, and other activities that are being discussed. We also encourage having DOI and DOJ appear at STAC to provide updates as well.

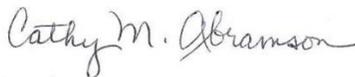
Timeliness in Response

As noted above, STAC appreciates the work done by HHS to respond thoroughly and thoughtfully to respond to STAC's letters at the conclusion of each meeting. These letters make it possible for the Committee to track key issues and understand the latest status on a variety of topics. We use the information provided in the response letters to determine our priorities to address at each meeting. However, the last response letter was not received until almost immediately before the STAC met with the Secretary. This does not give STAC members and technical advisors adequate time to read the response letter and adjust our requests accordingly.

- STAC requests that any response to this letter be received in the preparation materials that are provided at the STAC meeting, and at a minimum, a full 24 hours in advance of the STAC meeting commencing. This will enable STAC to utilize our limited time more effectively and to make measurable progress issues that are important to the health and well-being of Indian Country.

In conclusion, we would like to reiterate our appreciation for your willingness to work with us and for your prioritization of issues in Indian Country. We look forward to continuing a strong relationship with you and to hearing your response to these requests.

Sincerely,



Cathy Abramson
Chairperson
Secretary's Tribal Advisory Committee

**Tribes and Marijuana
Affiliated Tribes of Northwest Indians**

February 4, 2015



**GARVEY
SCHUBERT
BARER**



COAST SALISH CONSULTING LLC
HONORING TRIBAL SOVEREIGNTY

Speakers



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Overview

- Introduction – DOJ Memo
- Cannabis overview
- Recent history of marijuana legalization
- What does this mean for my Tribe?
- What steps should my Tribe take?
- Wrap up and questions

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.

DOJ Policy Statement Regarding Marijuana Issues in Indian Country

- NOT a blanket authorization to begin operations or to legalize marijuana on tribal land.
- Guidance ONLY
- Not a coordinated policy position across federal family
 - “Checkerboard on checkerboard”

DOJ Policy Statement Regarding Marijuana Issues in Indian Country

- Unclear coordination with DOJ HQ & District Office.
- Restates illegality of marijuana federally.
- Includes a disclaimer that the DOJ can still choose to enforce federal law.

7



What is Cannabis?

8

Cannabinoids: CBD and THC



- Cannabis plants produce chemicals called cannabinoids
- There are 85 different cannabinoids
- Only THC is psychoactive

9

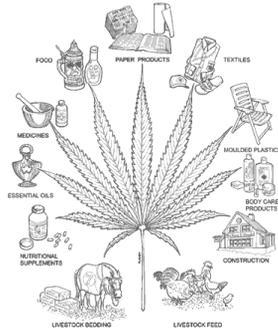
Industrial Hemp

- Industrial Hemp is a distinct variety of the cannabis sativa species
 - <.3%THC → NOT psychoactive
 - Tall, slender, fibrous
 - Uses: Paper, textiles, plastics, construction, health food, animal feed, fuel, etc.
- 2013 Farm Bill, Sec. 7606, Legitimacy of Industrial Hemp Research
 - Defines industrial hemp (<.3%THC) and authorizes institutions of higher education or State departments of agriculture, in states where hemp is legal, to grow hemp for research or agricultural pilot programs.

10

Marijuana Products

- Clones/Clippings/Seeds
- Dried Flower (includes pre-rolled joints)
- Concentrates
 - Bubble hash, shatter, wax, oil, tinctures, capsules
- Topicals
- Infused Edibles
- Infused Liquids



11

Federal Law

The possession, distribution, and manufacturing of marijuana, and aiding and abetting such offense, is a violation of the federal Controlled Substances Act.

21 U.S.C. § 841(a)

It is unlawful to knowingly lease any place for the purpose of distributing a controlled substance.

21 U.S.C. § 856

Property involved in the sale and distribution of marijuana may be subject to seizure by, and forfeiture to, the federal government.

21 U.S.C. § 881(a)

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The Controlled Substances Act (1970s)
21 U.S.C.13 § 801 et seq.

- Marijuana is a “Schedule I” Controlled Substance
 - High potential for abuse.
 - No currently accepted medical use in treatment.
 - Lack of accepted safety for use of the drug under medical supervision.

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Possession			
Any amount (first offense)	misdemeanor	1 year	\$ 1,000
Any amount (second offense)	misdemeanor	15 days*	\$ 2,500
Any amount (subsequent offense)	misdemeanor or felony	90 days* - 3 years	\$ 5,000
* Mandatory minimum sentence			
Sale			
Less than 50 kg	felony	5 years	\$ 250,000
50 - 99 kg	felony	20 years	\$ 1,000,000
100 - 999 kg	felony	5 - 40 years	\$ 500,000
1000 kg or more	felony	10 years - life	\$ 1,000,000
To a minor or within 1000 ft of a school, or other specified areas carries a double penalty. Gift of small amount -- see Possession			
Cultivation			
Less than 50 plants	felony	5 years	\$ 250,000
50 - 99 plants	felony	20 years	\$ 1,000,000
100 - 999 plants	felony	5 - 40 years	\$ 500,000
1000 plants or more	felony	10 years - life	\$ 1,000,000
Paraphernalia			
Sale of paraphernalia	felony	3 years	\$ 0

14

NORML, available at <http://norml.org/laws/item/federal-penalties-2#mandatory> (Sept. 2, 2014)



Federal Enforcement and Policy Developments

2009 Ogden Memo; 2012 and 2013 Cole Memos; FinCEN; Dept. of Reclamation

15

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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Across the Country...

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

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Across the Country...

Hemp

- 16 states have passed pro-hemp legislation.
- 8 states have removed barriers to hemp production or research.



18

Ogden Memo (10/19/2009)

Memo from Deputy Attorney General, David Ogden to US Attorneys

- US Attorneys “should not focus federal resources . . . on individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana.” (Emphasis added)
- In contrast, “prosecution of commercial enterprises that unlawfully market and sell marijuana for profit continues to be an enforcement priority.”

19

Ogden Memo (10/19/2009)

- The following conduct is NOT in clear and unambiguous compliance:
 - Unlawful possession or use of firearms;
 - Violence;
 - Sales to minors;
 - Financial and marketing activities inconsistent with state law, including evidence of money laundering activity and/or financial gains or excessive amounts of cash;
 - Amounts of marijuana inconsistent with state law;
 - Illegal possession or sale of other controlled substances; and
 - Ties to other criminal enterprises.
- **Memo is Guidance only.** does not “legalize” medical marijuana or “provide a legal defense to a violation of federal law.”

20

Cole Memo (6/29/2011)

- Memo from Deputy Attorney General James Cole to US Attorneys
- Provide “guidance regarding Ogden Memo” in light of “Green Rush.”

“[W]ithin the past 12 months, several jurisdictions have considered or enacted legislation to authorize multiple large-scale, privately-operated industrial marijuana cultivation centers... [with] revenue projections of millions of dollars. . . .”

“The Ogden [Memo] was never intended to shield such activities from federal enforcement action and prosecution, even where those activities purport to comply with state law.” pg. 2. (Emphasis added)

21

Cole Memo (8/29/2013)

- In light of WA's and CO's new laws, DOJ identified 8 federal enforcement priorities to preventing:
 - Distribution to minors;
 - Revenue from going to criminal enterprises, gangs, and cartels;
 - Diversion to other states;
 - State-authorized activity from being used as a cover for the trafficking of other drugs or illegal activity;
 - Violence and the use of firearms;
 - Drugged driving and the exacerbation of other adverse public health consequences;
 - Growing of marijuana on public lands; and
 - Possession or use on federal property.

22

Cole Memo (8/29/2013)

- DOJ's guidance relies upon expectation that state governments "implement strong and effective regulatory and enforcement systems," with "robust controls and procedures on paper," and "effective in practice." "If state enforcement efforts are not sufficiently robust to protect against [8 enforcement priorities] the federal government may seek to challenge the regulatory structure."
- Reversal of earlier Cole Memo: The size of an operation is no longer a "proxy" for determining whether the operation implicates DOJ's enforcement priorities.

NOTE - Guidance only, individual prosecutors have discretion to deviate from federal enforcement priorities

23



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FinCEN Memo (2/14/2014)

- The Financial Crimes Enforcement Network (FinCEN) published guidelines for banks providing financial services for marijuana-related businesses.
- The current Banking Security Act (BSA), requires financial institutions to file Suspicious Activity Reports (SARs) on businesses they suspect to be engaged in potentially illegal activity.

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FinCEN Memo (2/14/2014)

- Under the new guidelines, Banks must continue to file SARs:
 - (1) “Marijuana Limited” SAR – businesses that appear to be operating legally, and not engaging in activities that will interest federal prosecutors (as detailed in the [Cole Memo](#) of August 29, 2013),
 - (2) “Marijuana Priority” SAR – businesses that appear to be in violation of state law or interfering with federal enforcement priorities (Emphasis added)
 - (3) “Marijuana Termination” SAR – where a financial relationship with a marijuana-related business is terminated due to suspected violations.

26

Casinos – Financial Institution

- **FinCEN's guidance applies to all financial institutions covered under FinCEN regulations, including casinos.**
- How can Tribes with a casino participate in the Cannabis industry?

27

2014 Federal Spending Bill

- In the very same federal spending bill that Congress is using to block DC's recreational marijuana ballot initiative, Congress is treating medical marijuana very differently.
- New spending law will **prohibit** the Department of Justice — including DOJ's Drug Enforcement Administration — **from using federal funds to interfere with states' implementation of their own medical marijuana laws.**

Sec. 538. None of the funds made available in this Act to the Department of Justice may be used, with respect to the States of ..., to prevent such States from implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana.

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Changes?

- New President, 2016
- Republican controlled Congress, 2015
- New U.S. Attorney General (Eric Holder resigning)
- New U.S. Deputy Attorney General (James Cole resigning)
- New U.S. Attorney for Western Dist. of WA (Jenny Durkan resigning)
- Nebraska and Oklahoma's suit against Colorado alleging federal preemption

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What does this mean for my tribe?

30

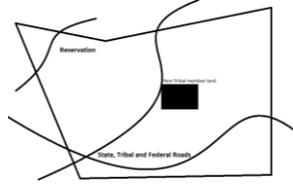
What should my Tribe consider when deciding whether to legalize or prohibit marijuana in Indian Country?

- Historical substance abuse on reservations.
- Consider community concerns for or against
 - Possible directive from general membership
- Other affected Federal Programs: HUD, IHS, 638, USDA, ICW
- Employment, including federal program employees
- Revenue source
 - Sales
 - Taxation

31

What should my Tribe consider when deciding whether to legalize or prohibit marijuana in Indian Country?

- What additional resources are required if the Tribe decided to:
 - Legalize marijuana in some manner?
 - Prohibit marijuana?
- Reservation border or Fee-to-Trust within reservations boundaries activity if disapproved
- PL 280 state civil & criminal jurisdiction over tribal members
- Other statutes giving state jurisdiction over tribal lands



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Legal Options

Doing nothing should NOT be an option.

1. **Prohibition**
2. **Authorize limited adult, individual possession**
3. **Authorize medical cultivation and use only**
4. **Authorize recreational, medical cultivation, and distribution**
5. **Participate in state licensed recreational industry**
 - Licensing window closed in Dec. 2013, unknown when it will open again.
 - Although tribes may acquire majority interest in currently licensed entity, state laws would not allow all tribal members to receive share in profits (anyone who shares in profits must qualify and be approved by LCB).
 - Participation requires **robust** regulatory framework

33



What steps should my tribe take?

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1. Consult with your U.S. District Attorney

- Authorization of marijuana will require consultation with DOJ.
- Prohibition of marijuana will require consultation with DOJ.
- DC Headquarters will need to ensure consistency in District-Tribal consultation process.
- Diverse Tribal interests in each District.

35

2. Make a Decision & Adopt As Tribal Law

- Gather information before making a decision
 - Transparency - Share information with community
 - Consider social impacts
 - General membership involvement
 - Consider your State's authorization or lack thereof
 - Jurisdiction & resources to implement
 - Political discourse & effects
- Memorialize the decision (prohibitive or permissive) in Tribal law
 - Some tribes may have to obtain federal approval of their ordinance by BIA.

36

If Tribe Decides to Allow – Development of Robust Regulatory Framework Required

What to Consider:

• Rules which protect against the 8 federal enforcement priorities (Cole Memo):

- Distribution to minors;
- Funding criminal enterprises, gangs, and cartels;
- Interstate distribution;
- Trafficking other illegal drugs or illegal activity;
- Violence and use of firearms;
- Drugged driving and other public health consequences;
- Growing on public lands; and
- Possession or use on federal property.

37

If Tribe Decides to Allow – Development of Robust Regulatory Framework Required

• What those rules will likely need to include

- Some method for tracing product from seedling through sale, to prevent product from diverting into black market
- Security requirements
- Distance buffer from facilities with children
- Criminal background checks on managers and investors
- Advertising and packaging restrictions to protect minors
- Quantity limits on consumer sales
- Public safety regulations on acceptable extraction methods
- Required testing of product for potency and mold, etc.
- Independent, policing, enforcement division

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3. Coordinate Law Enforcement

- MOU and/or Non-Prosecution Agreements with law enforcement agencies
 - Department of Justice
 - BLM/Park Rangers
 - State, County, City
 - BIA
- Consider PL-280 state challenges
- Consider federal challenge for BIA

39

4. If Applicable, Carefully Vet Potential Partners

Given the vagueness of the policy & lack of federal unanimity:

- Caution when approached by “gold rushers”
- Look to the past & present-
 - Gaming management
 - Natural resources today (oil boom)
 - On-line lending
- Do homework first –
 - Community involvement
 - Legal implications relative to your State & US district
 - PLAN
- Then, if appropriate, choose partners who are thoroughly vetted

40

Lessons Learned

- Whether a prohibitive or permissive decision, action is required!
- Do your homework
- Don't reinvent the wheel – look to States experience. States are forging through & resolving issues from which Tribes may benefit
- If only legalize medical - develop robust medical regulations and carefully consider (1) who can authorize the medical use of marijuana; and (2) what medical conditions must be diagnosed.

41

Lessons Learned

- Either medical or recreational legalization will require a robust regulatory scheme that encompasses similar controls as state regulations
- Be prepared for mixed responses from the different federal government agencies
- Appreciate challenges in banking and lending
- Take a conservative approach, slow down and consider the risk management
- Be wary and prepare for “gold rush” mentality

42

Whether a prohibitive or permissive decision, action is necessary!



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Questions

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44

Cannabis in Indian Country



GARVEY
SCHUBERT
BARER

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National Indian Cannabis Coalition

- www.niccdc.com

Email today for more information. | info@niccdc.org



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OUR MISSION... to educate tribal leaders and elected officials on the emerging regulated cannabis industry while advocating for parity on behalf of Indian Country.

Recent Tweets



#MJBizDaily
<http://t.co/YtwVTS3lUk>
1 month ago



@NICC_Info : #MJBizDaily
Co-founder Jeff Doctor discusses trends with Demetri Downing and Lael Echo-Hawk.
<http://t.co/m00n5ijXHH>
1 month ago



NICC Executive Director Jeff Doctor presenting at

Gov't Removes MMI Research

From 'Cash Teams' to Security

Living the High Life at the U.S.'s

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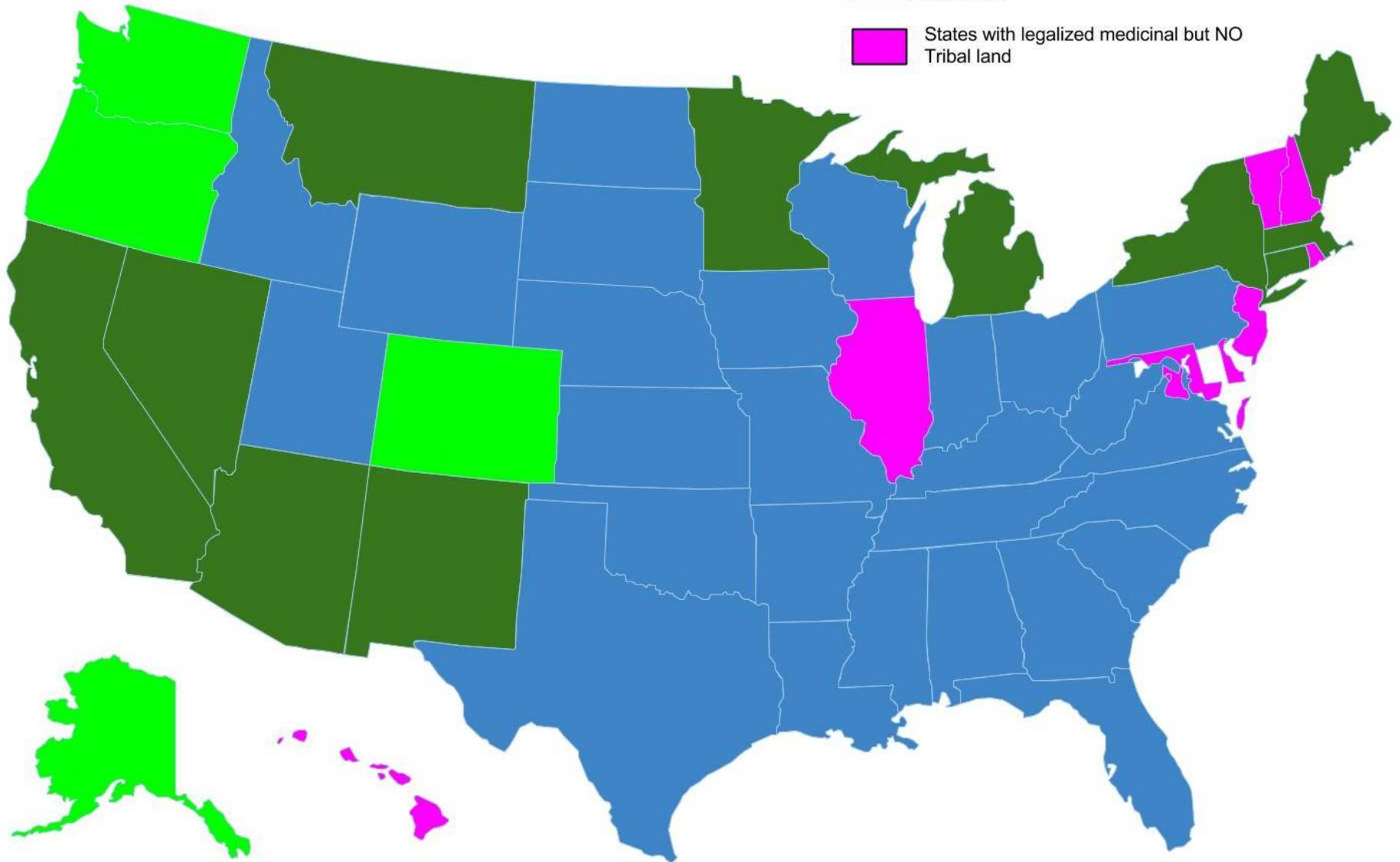
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 - 2012: Connecticut, Massachusetts
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 - 2014: Maryland, Minnesota, New York

Across the Country...

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

Tribes and Marijuana

-  States with legalized recreational & medicinal marijuana AND Tribal land
-  States with legalized medicinal marijuana AND Tribal land
-  States with legalized medicinal but NO Tribal land



Across the Country...

- What is Hemp? – cannabis plant but less than .3% THC
 - Classified as Schedule 1 Controlled Substance
- 2014 Federal spending act prohibits DEA from prosecuting industrial hemp research in states that have legalized.
- 2014 Farm Bill allows industrial hemp production by universities and state agriculture departments for research in states that have legalized.
- 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



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

HEMP HOMES

- * 7X STRONGER THAN CONCRETE, 1/2 AS LIGHT, 3X MORE ELASTIC (EVEN EARTHQUAKES CAN'T CRACK THESE STRUCTURES.)
- * SELF INSULATED.
- * RESISTANT TO ROT, BUGS, FUNGUS, MOLD, RODENTS, FIRE PROOF, WATERPROOF.
- * IF LEGAL IN THE U.S. HEMP WOULD BE THE CHEAPEST SOURCE FOR BUILDING MATERIAL.
- * BREATHABLE WALLS IMPROVE AIR QUALITY ALL AROUND THE BUILDING.

1 ACRE OF HEMP PRODUCES CELLULOSE FIBER = 4.1 ACRES OF TREES!

Hemp Building & Insulation: the raw materials

Hemp Wool

shives for concrete shives & fibre for plaster shives & fibre for finishing plaster hemp wool in rolls or panel hemp mat for flooring

OCCUPY THE EPA

Across the Country...



- Connecticut and New Hampshire – passed laws that establish studies of potential industrial hemp production in the state.

Economic forecast - Marijuana

- Legal marijuana grew 74% last year 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?
- Global market – more than 25,000 hemp products
- Higher rate of return per acre than any other crop except Tobacco. (Congressional Research Service Report for Congress 2013)

Cole Memo (8/29/2013)

- **DOJ identified 8 federal enforcement priorities**
 - preventing the distribution to minors;
 - preventing revenue from going to criminal enterprises, gangs, and cartels;
 - preventing the diversion to other states;
 - preventing state-authorized activity from being used as a cover for the trafficking of other drugs or illegal activity;

Cole Memo (8/29/2013)

- **DOJ identified 8 federal enforcement priorities**
 - preventing violence and the use of firearms;
 - preventing drugged driving and the exacerbation of other adverse public health consequences;
 - preventing the growing of marijuana on public lands; and
 - preventing possession or use on federal property.

Cole Memo (8/29/2013)

- DOJ's guidance relies upon expectation that state governments “implement strong and effective regulatory and enforcement systems,” with “robust controls and procedures on paper,” and “effective in practice.” “If state enforcement efforts are not sufficiently robust to protect against [8 enforcement priorities] the federal government may seek to challenge the regulatory structure.”

NOTE - Guidance only, individual prosecutors have discretion to deviate from federal enforcement priorities.

Changes?

- New President, 2016
- Republican controlled Congress, 2015
- New U.S. Attorney General Loretta Lynch
- New U.S. Deputy Attorney General
- Nebraska and Oklahoma's suit against Colorado alleging federal preemption

Casinos – Financial Institution

- **FinCEN's guidance applies to all financial institutions covered under FinCEN regulations, including casinos.”**
- Jim Dowling, a former White House advisor on money laundering issues and now a regulatory consultant to casinos, told gaming executives they are obligated to follow the same marijuana guidelines as banks. **“Casinos can’t accept any money from them, or they have to comply with the new government guidance,”** Dowling said.

Nathan Halverson, *Feds Warn Casinos to Turn Away Gamblers With Medical Marijuana Ties*, KQED News, June 12, 2014, available at <http://ww2.kqed.org/news/06/12/2014/-medical-marijuana-banks-casinos-federal-regulation>

- How can Tribes with a casino participate in the Cannabis industry?

Washington

- 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.
Passed April 24, 2015

Oregon

- July 1, 2015 – personal possession and use is permitted
- Liquor Control Commission is tasked with implementation.
- License applications will be accepted starting January, 2016

Alaska

- Alaska has historically allowed possession in small quantities
- Decriminalization effective Feb 24, 2015
 - 1 oz outside the home by person 21 years or older
 - Trade in marijuana - ok
 - Possession of up to 6 plants - ok
- Regulations must be implemented within 9 months

Federal legislation

- Regulate Marijuana Like Alcohol Act, introduced by Rep. Jared Polis (D-Colorado) would completely removed marijuana from the federal government's list of controlled substances and subject it to the same federal regulations currently governing alcohol.
 - States are not required to legalize
 - Creates federal regulatory scheme for states who do legalize

Federal legislation

- Marijuana Tax Revenue Act, introduced by Rep. Earl Blumenauer (D-Oregon). Blumenauer's bill would place a federal excise tax on federally-regulated marijuana.
 - States are not required to legalize
 - Creates federal regulatory scheme for states who do legalize
- 2 similar bills were rejected last session.

Federal legislation

- 1 Senate bill introduced
- The Compassionate Access, Research Expansion and Respect States Act (Sens. Paul, Booker, Gillibrand)
 - Reschedule marijuana from Schedule I to Schedule II
 - Move to Schedule II would mean federal regulatory recognition that marijuana has medicinal value but also high abuse potential.
 - Prohibit federal government from cracking down on medical marijuana operations that are operating in compliance with state law.
 - Allows hemp (less than .3% THC)

Federal legislation

- The Compassionate Access, Research Expansion and Respect States Act (Sens. Paul, Booker, Gillibrand)
 - Allow financial institutions to provide financial services to state-legal cannabis businesses.
 - Allows VA to provide information on medicinal marijuana to Veterans
 - First such bill in the Senate as opposed to 15 previously in the House.
 - **Merkley & Wyden co-sponsors
- House Companion Bill – Sponsors Rep. Cohen (D-TN) and Young (R-AK) - bipartisan

Veteran's Affairs Directive 2011-004

- “While patients participating in State marijuana programs must not be denied VHA services...”
- “It is VHA policy to prohibit VA providers from completed forms seeking recommendations or opinions regarding a Veteran’s participation in a State marijuana program.”



Obama Administration

- Removed requirement for Public Health Service Review for non-federally funded marijuana research
 - Requirement was ONLY for marijuana – not any other substance on the Schedule 1 (heroin etc)
 - Will allow increase in research on all aspects of cannabis use – medicinal, recreational and hemp.



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.
- Gaming and marijuana collision – Nevada's stance
- Banking issues – will a bank accept the money?



What does this mean for Indian Country?

- Companies and investors are often reluctant to do business on reservations ... because getting contracts enforced under tribal law can be iffy. Indian nations can be small and issues don't come up that often, so commercial codes aren't well-developed and precedents are lacking And Indian defendants have a home court advantage.
- “We're a long way from having a reliable business climate,” says Bill Yellowtail, a former Crow official and a former Montana state senator. “Businesses coming to the reservation ask, ‘What am I getting into?’ The tribal courts are not reliable dispute forums.”

Forbes, “Why are Indian Reservations So Poor? A Look At the Bottom 1%”, 2011

(<http://www.forbes.com/sites/johnkoppisch/2011/12/13/why-are-indian-reservations-so-poor-a-look-at-the-bottom-1/>).

...But, Marijuana In Indian Country?



Current Tribal Marijuana Activity

- Suquamish Tribe and Squaxin Island Tribe sign Marijuana Compacts under HB 2000.
- Flandreau Santee Sioux announce marijuana resort.
 - State AG has asked them to re-think.
- Passamaquoddy Tribe inks deal for marijuana operation.
- Other tribes exploring legalization.
-but
- Alturas Rancheria, Pit River Rancheria marijuana raided by federal and state law enforcement
- Pinoleville Rancheria marijuana raids by State law enforcement.

Legal Options*

Doing nothing should NOT be an option.

1. Prohibit
2. Decriminalize
3. Authorize recreational only
4. Authorize medical only
5. Authorize recreational & medical
6. Participate in state licensed industry

* Each option requires development of robust tribal regulatory system to implement, license and provide enforcement

Decision Time

- Key Question – *If the tribe decides to legalize, how will it participate?*
- Governmental role –
 - License, regulate, enforce, tax
- Industry participant –
 - Produce, Process, Retail

** What is impact on federal funding if Tribe chooses to participate in Industry?

Decision Time

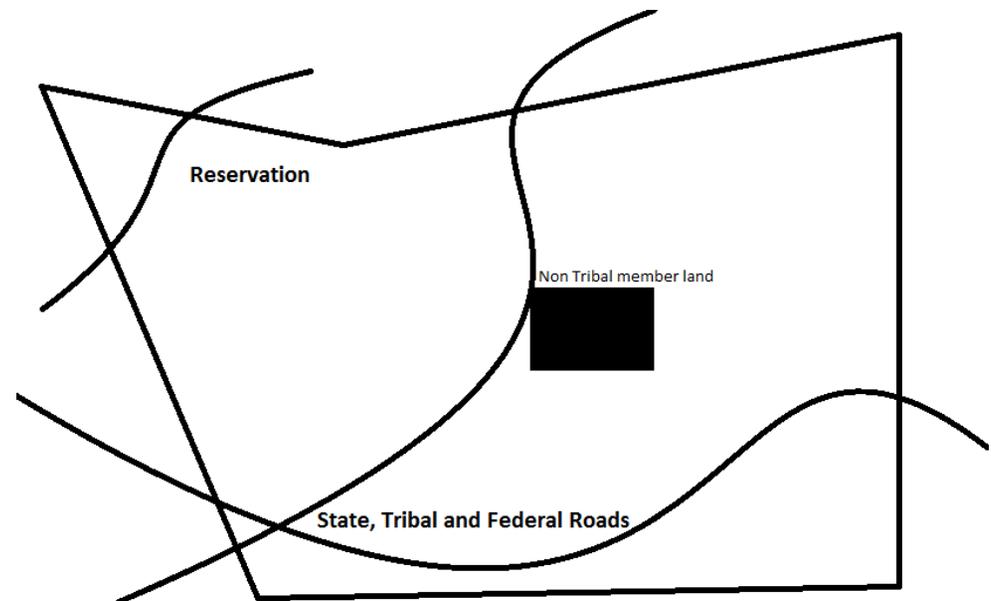
- What must Tribes consider when deciding whether to legalize, decriminalize or prohibit marijuana in Indian Country?
 - Community Issues —
 - Historical substance abuse on reservations.
 - Community concerns for or against
 - Employment, including federal program employees
 - Employment opportunity?
 - Tribal member entrepreneurship opportunity

Decision Time

- What must Tribes consider when deciding whether to legalize, decriminalize or prohibit marijuana in Indian Country?
 - Government Issues —
 - Affect on other Federal Programs: 638, HUD, IHS, USDA, ICW, H20
 - Status of legality in your state — external politics
 - Potential revenue source
 - Cost of implementation
 - Sales, Taxation, Licensing, Regulating & Enforcement

Other Considerations

- Price of admission: Additional resources required if the Tribe decides to legalize, prohibit or decriminalize marijuana.
- Jurisdictional issues: Public Law 280 state civil & criminal jurisdiction over Tribal members
- Other statutes giving state jurisdiction over tribal lands



Make a Decision & Adopt As Tribal Law

- Gather information before making a decision
- Consider your State's authorization or lack thereof
 - Jurisdiction & resources to implement
 - Political effects
- Memorialize the decision (prohibitive or permissive) in Tribal law
 - Some tribes may have to obtain federal approval of their ordinance by BIA.
- Review all other tribal ordinances to ensure consistency

Legalization Checklist

- Consultation with US District Attorney
- Formal non-prosecution agreement
- Formal agreements with surrounding law enforcement agencies, including Homeland Security if close to a border.
- Evaluation of jurisdictional issues
- Development of robust regulatory system “in practice”
 - Licensing
 - Regulation
 - Enforcement

Legalization Checklist

- MOU and/or Non-Prosecution Agreements with law enforcement agencies
 - Department of Justice
 - Homeland Security & Border Patrol
 - BLM/Park Rangers
 - State, County, City
 - BIA
- Consider PL-280, Restoration Acts, and other jurisdictional issues
- Consider federal challenge for BIA

Back to weed... A case study



- What does the cannabis industry see as advantages?
 - 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.
 - Sovereignty as a tool to access financial services
 - NOTE – Sovereign immunity viewed favorably under this scenario
 - Reasonable regulation
 - Tribes know how to regulate and how to work with feds
 - Foreign trade zones?

Questions?

Lael Echo-Hawk

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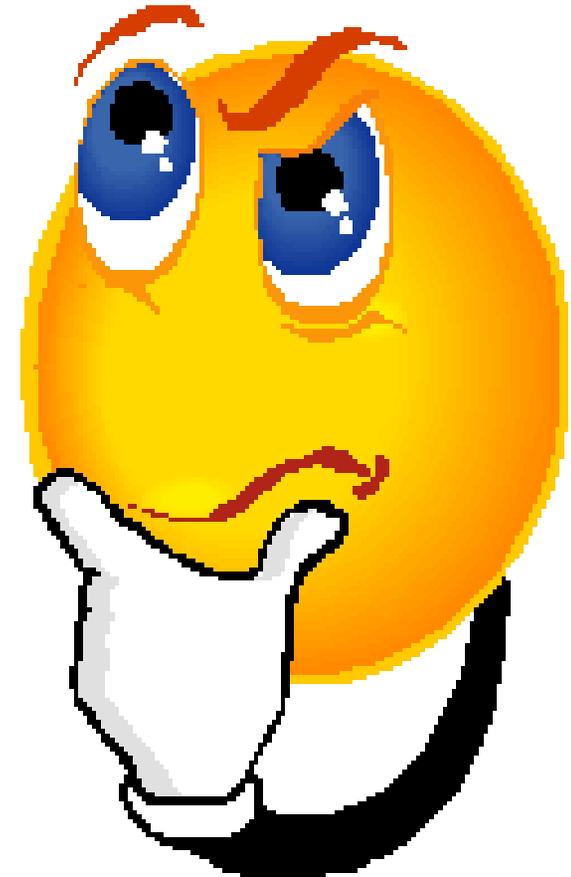
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January 31, 2011

**ACCESS TO CLINICAL PROGRAMS FOR VETERANS
PARTICIPATING IN STATE-APPROVED MARIJUANA PROGRAMS**

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy regarding access to clinical programs for patients participating in a State-approved marijuana program.

2. BACKGROUND

a. Department of Veterans Affairs (VA) providers must comply with all Federal laws, including the Controlled Substances Act. Marijuana is classified as a Schedule I drug under the Controlled Substances Act.

b. Veterans who receive their care from VA and who have a desire to participate in one of several State marijuana programs might ask their VA physicians to complete State authorization forms.

c. State laws authorizing the use of Schedule I drugs, such as marijuana, even when characterized as medicine, are contrary to Federal law. The Controlled Substances Act (Title 21 United States Code (U.S.C.) 801 et al.) designates Schedule I drugs as having no currently-accepted medical use and there are criminal penalties associated with production, distribution, and possession of these drugs. State law has no standing on Federal properties.

d. VHA policy does not administratively prohibit Veterans who participate in State marijuana programs from also participating in VHA substance abuse programs, pain control programs, or other clinical programs where the use of marijuana may be considered inconsistent with treatment goals. While patients participating in State marijuana programs must not be denied VHA services, the decisions to modify treatment plans in those situations need to be made by individual providers in partnership with their patients. VHA endorses a step-care model for the treatment of patients with chronic pain: any prescription(s) for chronic pain needs be managed under the auspices of such programs described in current VHA policy regarding Pain Management.

3. POLICY: It is VHA policy to prohibit VA providers from completing forms seeking recommendations or opinions regarding a Veteran's participation in a State marijuana program.

4. ACTION

a. **Deputy Under Secretary for Health for Operations and Management (10N).** The Deputy Under Secretary for Health for Operations and Management is responsible for ensuring that medical facility Directors are aware of the prohibition of completing forms for participation in State marijuana programs.

b. **Chief Officer Patient Care Services.** The Chief Officer Patient Care Services is responsible for providing clinical guidance to VA providers regarding factors to be considered

VHA DIRECTIVE 2011-004
January 31, 2011

when determining how substance abuse, pain control, or other treatment plans could be impacted by a Veteran's participation in State marijuana programs.

c. **Medical Facility Director.** Each medical facility Director is responsible for ensuring facility clinical staff are aware:

(1) Of the prohibition of completing forms for participation in State marijuana programs.

(2) If a Veteran presents an authorization for marijuana to a VA provider or pharmacist, VA will not provide marijuana nor will it pay for it to be provided by a non-VA entity. **NOTE:** *Possession of marijuana, even for authorized medical reasons, by Veterans while on VA property is in violation of VA regulation 1.218(a)(7) and places them at risk for prosecution under the Controlled Substances Act.*

(3) That if a patient reports participation in a State marijuana program to a member of the clinical staff, that information is entered into the "non-VA medication section" of the patient's electronic medical record following established medical facility procedures for recording non-VA medication use.

5. REFERENCES

a. Office of General Counsel (OCG) Opinion on State Medical Marijuana Registration Forms - VAOPGCADV 9-2008.

b. Title 21 U.S.C. 801 et al, the Controlled Substances Act.

6. FOLLOW-UP RESPONSIBILITY: Pharmacy Benefits Management Services (119) is responsible for the content of this Directive. Questions may be directed to (202) 461-7326.

7. RECISSIONS: VHA Directive 2010-035 is rescinded. This VHA Directive expires January 31, 2016.

Robert A. Petzel M.D.
 Under Secretary for Health

DISTRIBUTION: E-mailed to the VHA Publication Distribution List 2/4/2011

INDIAN HEALTH SERVICE PORTLAND AREA



Regional Specialty Referral Center Update

Mr. Richard Truitt, PE, Director
Office of Environmental Health and Engineering
October 2015



Regional Specialty Referral Center



❖ Overview

- ❖ The Portland Area Master Healthcare Plan:
 - ❖ Proposes a Network of Three Regional Specialty Referral Centers (RSRC's)
 - ❖ Illustrates the RSRC's Will Expand Access to Care
 - ❖ RSRC's will Conserve PRC Funds for Higher Levels of Care
 - ❖ Examples of Specialty Care Include Dermatology, Cardiology, General Surgery, and Tele-Medicine
- ❖ IHS Currently Does Not Provide a Mechanism to Construct and Provide Staff for an RSRC.
- ❖ The Portland Area Solution: Develop a Pilot Project to Demonstrate the Viability of RSRC's.



Regional Specialty Referral Center – Pilot Project



❖ Current Approach

- ❖ Develop a Proposed Project that Demonstrates Readiness for Implementation.
 - ❖ Location
 - ❖ POR/PJD/Business Plan
 - ❖ Strong Tribal Support.
- ❖ The PAFAC is Meeting Regularly and Developing Recommendations to Strengthen the Pilot Project Proposal.



Regional Specialty Referral Center

❖ **Positive Developments**

- ❖ Two Tribes Have Expressed Strong Interest in Hosting the Pilot Project
 - ❖ Chehalis
 - ❖ Puyallup
- ❖ PAFAC Members Visited Both Locations on May 14.
- ❖ Both Tribes Agree With Four Core Operating Principles.
 - ❖ Any Federal Resources Allocated Will Not be Available for Individual Tribes to Contract.
 - ❖ The Network Will be Federally Operated Initially.
 - ❖ A Qualified Tribal Organization Broadly Representing Portland Area Tribes May Contract Operation of the Network.
 - ❖ Third Party Revenue Will be Used to Improve and Expand Access to Specialty Care Across the Entire Portland Area



Regional Specialty Referral Center

❖ **Positive Developments**

- ❖ The Area Director Made \$110,000 Available to Support Planning and Project Development.
- ❖ These Funds are Being Utilized to Update the Interim PAFAC Report to consider:
 - ❖ Affordable Care Act Impacts
 - ❖ Comparison of the Chehalis and Puyallup Sites.
- ❖ The PAFAC will meet October 29 with the Healthcare Consultant OEHE has under Contract to update the Report. This will Assist the PAFAC in their work to Recommend a location for the first of three regional facilities.



Regional Specialty Referral Center

❖ **Positive Developments**

- ❖ After the IHS Director 's Listening Session Held in Issaquah on July 23, Principal Deputy Director Mc Swain provided \$150,000 to further Project Development.
- ❖ Upon completion of the Interim PAFAC Report Update and Site Selection, these additional Funds combined with remaining Area funds will be utilized to develop the PJD, POR, and Business Plan for the proposed facility.



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.



Legislative & Policy Update

NW Portland Area Indian Health Board
 Quarterly Board Meeting
 Hosted by Confederated Tribes of the Umatilla

October 23, 2015

1



Report Overview

1. Appropriations Update & Continuing Resolution
2. Contract Support Cost Updates
3. Indian Health Legislation in 114th Congress
4. 100% FMAP & TTAG Updates
5. HRSA 340(b) Regulation



FY 2016 Continuing Resolution

- 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
- Senate provides \$17 million increase for H&C accounts while House provides \$78 million
- Senate provides \$61 million for Facilities accounts, while House provides \$6 million
- Congress passed CR through 12/11/2015 for twelve regular appropriation bills
- CR funds @ 2015 levels; less a .2018% across the board decrease



FY 2017 Budget Request

- Discussion at TSGAC Meeting with IHS Deputy Director
- Positive developments for the FY 2017 budget
- Full funding for current services and contract support costs may be possible
- HHS Secretary Burwell took “took our proposals to heart”
- Emphasis on behavioral health and suicide prevention



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)



Legislative Issues in 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



Contract Support Cost Update

- IHS Continues to revisit CSC negotiated amounts using a cost incurred approach more than a year or more later
 - BIA does not follow the same method – why does IHS?
 - IHS advises that it must verify that CSC is being paid on the correct amount and cost-incurred (audit) is the only way to do this
- IHS Past Year's Claims – Agency want to settle by end of this year
- Revised CSC Policies: BIA has completed a revised policy; IHS should have a draft available soon for review
 - Fixed Rates
 - OMB should bring IHS and BIA CSC Workgroups together to align the issues and resulting policies



Contract Support Cost Update

- CSC Appropriations in FY 2016 and potential sequester
 - Congress and Administration have established a policy to fully fund CSC requirements
 - In event of FY 2016 year long CR; or sequester if CSC is not adequate IHS will likely reprogram funds
 - FY 2016 CR is approximately \$55 million short of fully funding CSC requirements
 - A potential 2% sequester and across the board cut will result in not enough CSC funds
 - Administration could request an anomaly for additional funding in the appropriation
- Mandatory CSC proposal



IHS Dear Tribal Leader letters

- DTLL on IHS implementation of a new Integrated Data Collection System Data Mart (IDCS DM)
- Intended to improve GPRA/GPRAMA national clinical measures
- RPMS has decreased as tribes opt to utilize commercial health information systems and the IDCS-DM is intended to address this
- An opt-out feature will be available to tribal programs that do not want their data included in GPRA and GPRAMA reporting
- Tribal consultation closes on October 31, 2015
- Session during QBM with IHS Deputy Director and OIT



CMS 100% FMAP Policy Change

- AK & SD Medicaid Expansion proposals to CMS
- AK 100% FMAP request for emergency and non-emergency medical transportation and services provided through CHS/PRC referrals
- SD requests 100% FMAP for telehealth services, specialty services provided through collaborative arrangements, and services provided by community health representatives
- CMS has conducted Tribal consultation and expected to issue a decision soon
- NPAIHB has submitted recommendations
 - 100% FMAP for CHS referrals or
 - 100% FMAP for services under contract with I/T/U
 - Without link to I/T there is not incentive for States to work w/Tribes



CMS-Tribal Technical Advisory Group Issues

- Summary of Benefit Documents for zero and limited cost sharing variations
- Referrals for cost-sharing and proper payments
- Marketplace Call Center Tribal Scripts
- Network Adequacy for I/T/Us – contract issues
- Simplify Family Plan Provisions for Indians
- Enrollment data for Indians
- Transition from Marketplace Coverage to Medicaid coverage (AK) – Could effect Idaho
 - New Medicaid eligibles can not cancel Marketplace coverage
 - NACs and CCIIO have invested much time in this process
 - Results in enrollee not having coverage for some time which has resulted in bills to individual s
 - Complicates Indian cost-sharing for QHP & Medicaid



HRSA 340B Proposed Guidance

- HRSA has proposed 340B Drug Pricing Program Omnibus Guidance, August 28, 2015, makes significant changes regarding individuals eligible for 340B drug pricing
- Guidance redefines the required relationship between a provider and a patient & will effect Tribal access 340B drug pricing:
 1. require that the relationship between a patient and a provider be evaluated on a prescription-by-prescription basis; and
 2. that the prescription be issued at a tribal facility.
- Will make PRx issued by providers serving tribal health program patients outside of tribal clinic facilities ineligible for 340B pricing
- NPAIHB Comments clarify standards that should be applicable to Tribal health programs to "permit covered entities" and not focus on facilities ; and defining patient eligibility under the ISDEAA



Discussion?



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MEMORANDUM

September 22, 2015

TO: NATIONAL INDIAN HEALTH BOARD

FROM: Geoff Strommer *Geoff Strommer* (by TAE)
 HOBBS, STRAUS, DEAN & WALKER, LLP

Re: *Health Care Litigation Update*

I. Introduction

Lawsuits challenging the Affordable Care Act (ACA) and its implementation have continued to make their way through the courts despite the Supreme Court's decisions upholding the law. This past summer, the Supreme Court upheld the availability of premium tax credits on federally facilitated exchanges, avoiding a construction of the ACA that would have crippled its implementation. *King v. Burwell*, 135 S. Ct. 2480 (2015). Challenges to the employer mandate continue, including disputing its application to tribal governments, as well as suits involving contraceptive coverage, administrative delays in implementation of the law, and the Origination and Takings Clauses of the Constitution. Part II of this memorandum provides an update on litigation challenging the Affordable Care Act and its implementation under various theories.

^A central part of the ACA is the authorization of Medicaid expansion. In both Alaska and Arizona state legislatures have sought to block governors' plans to expand Medicaid. Part III discusses the cases in both states.

Additionally, litigation specific to Indian health providers has continued, including contract support cost litigation, cases against IHS regarding the funding amounts under Indian Self-Determination and Education Assistance Act (ISDEAA) contracts, contract disputes with third parties, and funding for leases for Village Built Clinics in Alaska. Part IV of this memorandum provides an overview of recent and pending cases that are specific to Indian health providers.

II. Challenges to the Affordable Care Act

The Supreme Court Upholds the Individual Mandate and Premium Tax Credits

The United States Supreme Court has twice rejected challenges that would have crippled the Affordable Care Act. In 2012, the Supreme Court upheld the Affordable

Care Act's individual mandate in *National Federation of Independent Businesses v. Sebelius*, 132 S. Ct. 2566 (2012) [hereinafter "*NFIB v. Sebelius*"]. The ACA's individual mandate requires individuals to have health insurance that meets certain minimum standards or pay a "shared responsibility payment." The Court ruled that this shared responsibility payment was in fact a tax penalty and upheld the ACA's individual mandate as a valid exercise of Congress's tax power. This ruling was critical to the ACA's survival because the tax penalty ensures that individuals may not merely wait until they are sick to purchase health insurance. Having healthy individuals pay into insurance plans is critical to those plans' abilities to pay the cost of health care coverage for sick individuals.

In *NFIB*, however, the Court also held that the ACA's expansion of Medicaid was unconstitutional. The Court found that Medicaid expansion exceeded Congress's spending power by threatening to terminate existing Medicaid funding if states chose not to expand their Medicaid programs. The case, therefore, made Medicaid expansion optional for states.

The Supreme Court decided its most recent ACA case in June 2015 when it decided *King v. Burwell*. 135 S. Ct. 2480 (2015). The Court held that premium tax credits are available on federally facilitated health insurance exchanges as well as state-based exchanges. To ensure that low-income individuals can afford to comply with the ACA's individual mandate, the law provides for premium assistance in the form of tax credits. The ACA allows states to implement their own exchanges, but if they choose not to, then the federal government operates a federally facilitated exchange in that state. The Internal Revenue Service (IRS) has made premium tax credits available to individuals who purchased insurance on either a federally facilitated or state-based exchange.

In *King*, the Court rejected the argument that the plain language of the ACA provided tax credits for persons enrolled in health coverage "through an Exchange established by the State under [section] 1311" of the ACA. 26 U.S.C. § 36B(b)(2)(A). The majority held that in light of the structure and purpose of the ACA, this phrase was intended to include insurance purchased through federally facilitated exchanges when states declined to create their own health insurance exchanges. The Court's decision was important to ensuring the affordability of health insurance to low-income individuals.

Employer Mandate Litigation

The Supreme Court's decision in *King v. Burwell* has had a significant impact on cases that were pending in district court challenging the employer mandate, particularly as it applies to states. The ACA requires "applicable large employers," which are employers with 50 or more full-time employees, to offer employees and their dependents health coverage that meets certain minimum requirements. 26 U.S.C. § 4980H. Employers are assessed a penalty if they fail to provide such coverage and an employee or dependent then qualifies for a premium tax credit by purchasing insurance through an exchange.

The Oklahoma Attorney General as well as the State of Indiana and 29 Indiana school districts have challenged the employer mandate as it applies to states in *Oklahoma ex rel. Pruitt v. Burwell*, No. 6:11-cv-00030 (E.D. Okla. filed Jan. 21, 2011) and *Indiana v. IRS*, No. 1:13-cv-1612 (S.D. Ind. filed Oct. 8, 2013). Federally facilitated exchanges were operated in both states, which declined to create their own state-based exchanges. Both states made arguments similar to that in *King*, asserting that premium tax credits were not available in their states because the ACA did not permit them to be provided for insurance purchased on a federally facilitated exchange. The states reasoned, employers in their states could not be subject to tax penalties for failing to offer ACA-compliant health coverage because their employees could never go on a federally facilitated exchange and receive a tax credit, and therefore the employer mandate tax penalty could never be triggered. Both cases also argued that the ACA violates the Tenth Amendment to the extent that it applies the employer mandate to states and their political subdivisions.

In *Pruitt*, Oklahoma won at the district court level and the United States appealed to the Tenth Circuit Court of Appeals; that appeal was stayed pending the outcome of *King v. Burwell* in the U.S. Supreme Court. Following the outcome of *King*, the parties in *Pruitt* agreed that the district court judgment should be reversed, as *King* settled the issue of whether premium tax credits could be issued on federally facilitated exchanges. On July 28, 2015, the Tenth Circuit issued an order reversing the district court's decision. Procedural Termination, *Oklahoma ex rel. Pruitt v. Burwell*, No. 14-7080 (10th Cir. July 28, 2015). In *Indiana*, the plaintiffs have conceded that *King* disposed of their challenge to the IRS regulations allowing premium tax credits on federally facilitated exchanges. However, they continue to press their Tenth Amendment claims. Joint Notice Regarding Further Proceedings, *Indiana v. IRS*, No. 1:13-cv-1612 (S.D. Ind. July 21, 2015).

Another pending employer mandate case relates specifically to tribal governments. The Northern Arapaho Tribe filed suit in federal district court in the District of Wyoming, challenging IRS regulations extending the employer mandate to tribal governmental employers. *Northern Arapaho Tribe v. Burwell*, No. 14-cv-247 (D. Wyo. filed Dec. 8, 2014). Although the ACA does not specifically apply the employer mandate to tribal governments, the IRS regulations include governmental entities and define them to include tribal governmental employers. 26 C.F.R. §§ 54.4980H-1(a)(23), 301.6056-1(b)(7). The Northern Arapaho Tribe argued that the regulations were invalid because they contravene the language of the statute, which does not apply the employer mandate to tribes. The Tribe also argued that Congress never intended the employer mandate to apply to tribal governmental employers, as evidenced by the fact that Congress exempted individual Indians from the individual mandate. The Tribe further asserted that the employer mandate would make insurance more expensive for tribal member employees because an offer of insurance from an employer would make them ineligible for the tax credits and cost-sharing benefits that they would otherwise be entitled to when purchasing insurance through an exchange.

On July 2, 2015, the district court dismissed the Northern Arapaho Tribe's case. *Northern Arapaho Tribe*, no. 14-cv-247, 2015 WL 4639324 (D. Wyo.). Among other bases for dismissal, the court found that the ACA unambiguously expressed Congress's intent that the employer mandate apply to tribes. The court reasoned that if Congress wished to exempt tribes from the employer mandate, it needed to have done so explicitly. The Tribe appealed to the Tenth Circuit Court of Appeals on August 28, 2015.

Religious Challenges to Contraceptive Coverage

Other than *NFIB v. Sebelius* and *King v. Burwell*, the Supreme Court has only issued one other decision on the merits in an ACA case. In *Burwell v. Hobby Lobby Stores, Inc.*, the court addressed a religious freedom challenge to contraceptive coverage regulations, known as the "contraceptive mandate." 134 S. Ct. 2751 (2014). The ACA requires applicable large employers to offer insurance coverage that includes preventive care and screening for women at no cost. 42 U.S.C. §§ 300gg-13(a)(4). The Department of Health and Human Services (HHS) has interpreted this requirement to require that large employers provide contraceptive coverage without any cost sharing requirements. Coverage of Preventive Services Under the [ACA], 77 Fed. Reg. 8725 (Feb. 15, 2012). The regulations provide a religious accommodation under which non-profit religious organizations may certify their objection and avoid having to pay for such coverage for their employees. When a non-profit religious organization objects to contraceptive coverage, the insurance company rather than the employer must pay the cost of the coverage. However, no such exemptions were available for for-profit employers.

In June 2014, the Supreme Court in *Hobby Lobby* held that regulations requiring employers to provide free access to contraception violated the Religious Freedom Restoration Act (RFRA) when applied to closely held corporations whose owners had religious objections to such coverage. 134 S. Ct. 2751 (2014). Since *Hobby Lobby*, challenges to the contraceptive mandate have continued, and there have been a total of over 100 suits challenging the mandate since the ACA's passage.¹

On September 17, 2015, the Eighth Circuit Court of Appeals in St. Louis ruled that the ACA *does* violate the rights of religiously affiliated employers by requiring them to provide contraceptive coverage, despite the fact there is no charge for the coverage. *Sharpe Holdings, Inc. v. Burwell*, No. 14-1507 (8th Cir. Sep. 18, 2015) (slip op.). The Court ruled that requiring the employers to "self-certify" on a form that contraception was against their religious beliefs was itself a burden on the employers' free exercise rights under *Hobby Lobby*, stating that the court could not second guess the reasonableness of correctness of the employers' religious beliefs. *Id.* at 17. The decision departs from the holdings of other Circuit Courts of Appeals, thus creating a "circuit

¹ National Women's Law Center, *Status of the Lawsuits Challenging the Affordable Care Act's Birth Control Coverage Benefit* (Sep. 4, 2015), <http://www.nwlc.org/status-lawsuits-challenging-affordable-care-acts-birth-control-coverage-benefit>.

split,” and increasing the likelihood that the Supreme Court will take up one of these cases in the coming terms.

Challenges to the Obama Administration's Delays in ACA Implementation

Additional ACA challenges have included litigation contesting the Obama Administration's delays in implementing certain ACA provisions. In November 2013, the Administration announced that it would delay enforcement of the ACA's minimum standards for insurance coverage. This prevented the cancellation of insurance plans, allowing individuals to keep their current plans so long as states did not take action to bar the renewal of these plans. The State of West Virginia filed suit, and argued that in addition to violating the ACA, this "administrative fix" was an unlawful delegation of federal power to the states in violation of articles I and II of the Constitution and violated the Tenth Amendment by making states responsible for determining whether federal law should be enforced. *West Virginia ex rel. Morrissey v. Department of Health & Human Servs.*, No. 1:14-cv-01287 (D.D.C. filed July 29, 2014). On September 3, 2015, the court heard oral arguments on the Department of Health and Human Services' motion to dismiss for lack of jurisdiction.

Another challenge to the Administration's implementation of the ACA came from the United States House of Representatives. *United States House of Representatives v. Burwell*, No. 14-cv-01967 (D.D.C. filed November 21, 2014). First, the House of Representatives argued that the Administration spent billions of dollars that Congress had not appropriated in order to make direct payments to health insurance issuers to offset the expense of the cost-sharing reductions in the ACA. Although the ACA authorizes such payment, the House of Representatives argued that Congress never passed legislation appropriating funds for this purpose. Second, the House of Representatives argued that the Administration had effectively amended the ACA by delaying the implementation of the employer mandate and by issuing regulations that only imposed penalties when large employers failed to offer coverage to a certain percentage of employees and their dependents even though the ACA requires that all employees and their dependents be offered coverage.

On September 9, 2015, the court dismissed the House of Representatives' claims regarding implementation of the employer mandate but ruled that it had standing to pursue its appropriations-related claims. *U.S. House of Reps. v. Burwell*, No. 14-cv-1967, 2015 WL 5294762 (D.D.C. Sep. 9, 2015). The court reasoned that while the House did not have standing to require the Administration to comply with the ACA in its implementation of the employer mandate, it did have standing to pursue constitutional claims that the Administration usurped congressional power by expending non-appropriated funds, providing a concrete and particularized injury that was traceable to the federal defendants and remediable by the court. On September 15, the White House announced that it would appeal the ruling allowing the appropriations claims to proceed by seeking an interlocutory appeal to the D.C. Circuit Court of Appeals. The District Court will need to decide whether to grant the right of appeal—and stay the case while

that appeal proceeds—or reject it and proceed on the merits of the appropriations related claims.

Origination and Takings Clause Challenges

Circuit courts have twice denied challenges to the ACA based on the Constitution's Origination Clause. In *Sissel v. Department of Health and Human Services*, the plaintiff argued that the ACA's individual mandate violated the Constitution's Origination Clause. 760 F.3d 1 (D.C. Cir. 2014). The Origination Clause requires that bills for raising revenue originate in the House of Representatives, while the ACA originated in the Senate. The Court of Appeals for the District of Columbia rejected the challenge, reasoning that the ACA's primary purpose was not revenue generation but rather to increase health insurance coverage and decrease the costs of that coverage. On August 7, 2015, the court of appeals denied rehearing en banc, and the plaintiffs have since filed a petition for certiorari with the United States Supreme Court.

In *Hotze v. Burwell*, the plaintiffs also lodged an Origination Clause attack while additionally arguing that the ACA's employer mandate was an unconstitutional taking that violated the Fifth Amendment's Takings Clause. 784 F.3d 984 (5th Cir. 2015). The Fifth Circuit Court of Appeals dismissed the case for lack of standing and because it was barred by the Anti-Injunction Act, which prohibits suits to restrain the assessment or collection of a tax. The Fifth Circuit denied rehearing on August 17, 2015.

III. Challenges to Medicaid Expansion

On August 24, 2015, the Alaska Legislative Council filed suit in state court to challenge the Governor's decision to expand Medicaid. *Alaska Legislative Council v. Walker*, No. 3AN-15-09208CI (Alaska Super. Ct. filed Aug. 24, 2015). The Legislative Council argued that it alone, and not the Governor, had the authority to authorize additional groups of people to be eligible for Medicaid. Governor Walker has argued that although *NFIB v. Sebelius* struck down the federal government's ability to make current Medicaid funding contingent on expansion, the ACA nonetheless requires states to expand their Medicaid programs. On August 28, 2015, the court denied a temporary restraining order in the case, and the Alaska Supreme Court affirmed this denial of a temporary restraining order on August 31, 2015. Order, Sup. Ct. No. S-16059 (Alaska, Aug. 31, 2015) available at <http://courtreports.alaska.gov/webdocs/media/docs/ak-leg-council/order-s16059.pdf>.

In Arizona, lawmakers have also attempted to challenge Arizona's plan for funding Medicaid expansion. *Biggs v. Brewer*, No. CV 2013-011699 (Ariz. Super. Ct. (Maricopa) filed Sept. 12, 2013). The thirty-six legislators and three citizens who filed suit argued that passage of a "hospital assessment" that would fund Arizona's share of Medicaid expansion was a tax and therefore required a two-thirds vote under state law rather than the simple majority with which it was passed. On August 26, 2015, the trial court granted the defendants' motions for summary judgment. Under Advisement Ruling,

Biggs v. Brewer, No. CV 2013-011699 (Ariz. Super. Ct. (Maricopa), Aug. 26, 2015) available at https://goldwater-media.s3.amazonaws.com/cms_page_media/2015/9/2/m6981949.pdf. The court found that the hospital assessment was not a tax under state law and did not require a two-thirds majority. The Goldwater Institute, which has been instrumental in litigating the case, has indicated that the decision will be appealed to the Arizona Court of Appeals.

IV. Indian Health Care Litigation

There are a number of important recent or pending cases specifically involving Indian health care issues.

Contract Support Cost Litigation

On June 30, 2015, the United States Supreme Court granted the Menominee Indian Tribe of Wisconsin's petition for a writ of certiorari in a contract support cost case that our firm is litigating. *Menominee Indian Tribe of Wis. v. United States*, No. 14-510 (U.S. Supreme Court). The Tribe filed contract support cost claims in September 2005 for underpayments under the Indian Self-Determination and Education Assistance Act (ISDEAA) in the years 1995 through 2004. The Indian Health Service (IHS) denied the claims as untimely, saying they exceeded the Contract Dispute Act's six-year statute of limitations. The Tribe, however, argued that under Supreme Court precedent, its claims should have been equitably tolled by pending class action claims. The Tribe filed its opening brief before the Court on September 2, 2015, which is accessible at http://www.americanbar.org/content/dam/aba/publications/supreme_court_preview/briefs_2015_2016/14-510_pet.pdf.

ISDEAA Contract Funding Cases

Our firm also represented the Pyramid Lake Paiute Tribe in its suit against the Department of Health and Human Services (HHS) after the IHS terminated the Tribe's Emergency Medical Services (EMS) program. *Pyramid Lake Paiute Tribe v. Burwell*, No. 1:13-01771 (D.D.C. filed Nov. 8, 2013). The IHS had operated the program since 1993, but after the Tribe submitted its proposal to contract the program under the ISDEAA, the IHS terminated the program. IHS then declined the contract proposal, stating that the Tribe was proposing more funds than were available because the program had been terminated. On October 7, 2014, the district court ruled for the Tribe on its key funding arguments but did not order the IHS to enter the contract at the proposed funding level. *Pyramid Lake Paiute Tribe*, 70 F. Supp. 3d 534 (D.D.C. 2014). The Tribe and the IHS subsequently reached a settlement agreement, and HHS filed an unopposed motion to dismiss the case on August 10, 2015.

Another recent case involving contract funding under the ISDEAA was brought by the Seneca Nation of Indians against HHS in August 2014. *Seneca Nation of Indians v. Department of Health & Human Servs*, No. 1:14-cv-01493 (D.D.C. filed Aug. 29,

2014). The Tribe is contesting the IHS' attempt to cut \$3,774,392 from its annual funding base for fiscal years 2013-2015. Previously, the Tribe's annual funding was increased by this amount after the Tribe realized there had been a substantial undercount of its active user population. The Tribe then proposed an amendment to its FY 2010 and FY 2011 funding agreements to increase base funding by \$3,774,392. Because the IHS did not issue a response within 90 days, as required by statute, the funding agreement was deemed approved, and the Tribe won a court case awarding the Tribe the increased amount. *See Seneca Nation of Indians v. Department of Health and Human Services*, 945 F.Supp.2d 135 (D.D.C. 2013).

While the Tribe was litigating the issue of the FY 2010 and FY 2011 amounts, it also requested an increase of \$3,774,392 for FY 2012, but this increase was denied by IHS. The Tribe filed a claim with the Interior Board of Indian Appeals (IBIA) over the FY 2012 amount. *See Seneca Nation of Indians v. Nashville Area Chief Contracting Officer* (Docket No. IBIA 12-041). After the FY 2010 and FY 2011 litigation was resolved, IHS again rejected funding agreements that included the additional \$3,774,392. for FY 2013, FY 2014, and FY 2015.

In August 2014, the Tribe filed suit in federal district court in the District of Columbia challenging the 2013–2015 denials and arguing that under the ISDEAA the IHS may not reduce the Tribe's annual funding level. The IBIA then stayed its proceeding pending resolution of the Tribe's suit over the 2013–15 amounts. However, HHS moved to dismiss the district court case in June 2015, arguing that it cannot be resolved prior to resolution of the stayed IBIA case. HHS asserts that the Tribe's arguments regarding the 2013–2015 amounts are contingent upon resolution of the funding level for the FY 2012 contract. The motion to dismiss is still pending.

Third-Party Contract Dispute Cases

In April 2014, the Grand Traverse Band of Ottawa and Chippewa Indians sued Blue Cross and Blue Shield of Michigan (BCBSM) for violations of a contract under which BCBSM administers the Tribe's self-insured employee benefits plan. *Grand Traverse Band of Ottawa & Chippewa Indians v. Blue Cross & Blue Shield of Mich.*, No. 5:14-cv-11349 (E.D. Mich. filed April 1, 2014). The Tribe alleged that BCBSM has been paying more than it should have under the contract for Contract Health Services (CHS). The Tribe asserted that BCBSM should not have been paying more than Medicare-like Rates for CHS-eligible claims based on regulations that went into effect in July 2007 and, at a minimum, BCBSM was contractually obligated to apply an 8 percent discount to its rates to reflect the Medicare-like Rate. The Tribe also alleged that BCBSM was collecting an administrative fee from the money it used to pay claims in violation of the contract. The parties settled the issue of administrative fees while continuing to litigate the applicability of Medicare-like Rates. On July 17, 2015, BCBSM filed a third party complaint against Munson Medical Center, arguing that it breached its contract with BCBSM by failing to provide necessary information or charge rates. BCBSM argues that

Munson Medical Center is responsible to the extent that BCBSM is found liable to the Tribe. Both cases continue in the Eastern District of Michigan.

The Alaska Native Tribal Health Consortium (ANTHC) sued Premera Blue Cross (Premera) in 2012 for failure to pay the higher of ANTHC's reasonable billed charges or the highest amount Premera would pay to a non-governmental entity under section 206 of the Indian Health Care Improvement Act. *Alaska Native Tribal Health Consortium v. Premera Blue Cross*, No. 3:12-cv-0065 (D. Alaska filed Mar. 27, 2012). In September 2014, ANTHC moved for summary judgment, arguing that its billed charges should be deemed reasonable. Premera filed a cross motion for summary judgment, arguing that ANTHC's billed charges were not reasonable or, in the alternative, that Premera had paid ANTHC in accordance with the Alaska Usual and Customary Rate which is usually higher than ANTHC's billed charges. In July 2015, the court denied the motions for summary judgment, finding that questions remained over whether Premera had paid substantially less than ANTHC's billed charges. The parties are expected to have a settlement conference during the week of October 19–23, 2015.

Village Built Clinic Litigation

The Maniilaq Association (Maniilaq) is currently in litigation regarding IHS' denial of a lease for its Kivalina, Alaska Village Built Lease proposal. *Maniilaq Ass'n v. Burwell*, No. 1:15-cv-00152 (D.D.C. filed Jan. 30, 2015). Our firm represents Maniilaq in this matter. Maniilaq asserts that the lease is mandatory under section 105(I) of the ISDEAA. IHS, however, has contended that it is free to cap funding at the historical Village Built Clinic (VBC) lease amount received by Maniilaq rather than pay the amount determined under the compensation options and criteria in the section 105(I) regulations.

The case is an outgrowth of prior litigation regarding IHS' obligation to enter into and fully fund leases for VBCs. Previously, Maniilaq requested IHS enter into a mandatory lease for its VBC in Ambler, Alaska. IHS failed to respond within 45 days, as required by statute. IHS's eventual response stated that it did not enter into leases with ISDEAA contractors for VBC facilities; a lease under section 105(I) cannot be incorporated into an ISDEAA funding agreement; Maniilaq must apply for a lease through the IHS Lease Priority System; and that IHS would not be required to provide monetary compensation for such lease. Maniilaq sued IHS, and in November 2014, the court held that the offer containing the lease was deemed accepted by operation of law when IHS failed to respond within 45 days and that the lease may be incorporated into an ISDEAA funding agreement. *Maniilaq Association v. Burwell*, 72 F.Supp.3d 227 (D.D.C. 2014).

In the present litigation, Maniilaq's motion for summary judgment is pending before the court. Maniilaq has asked the court to resolve the issue of lease compensation. Oral argument on Maniilaq's motion has not yet been scheduled.

V. Conclusion

Challenges to the ACA and efforts to block Medicaid expansion have continued. These suits are likely to taper off somewhat as courts resolve various issues regarding implementation of the ACA. We will keep a close eye on these cases as they progress as well as continuing to track cases that involve issues specific to Indian health providers.

If you have any questions about the information discussed above, you may reach me at gstrommer@hobbsstrauss.com or (503) 242-1745.



The Deputy Attorney General

Washington, D.C. 20530

August 29, 2013

MEMORANDUM FOR ALL UNITED STATES ATTORNEYS

FROM: James M. Cole 
Deputy Attorney General

SUBJECT: Guidance Regarding Marijuana Enforcement

In October 2009 and June 2011, the Department issued guidance to federal prosecutors concerning marijuana enforcement under the Controlled Substances Act (CSA). This memorandum updates that guidance in light of state ballot initiatives that legalize under state law the possession of small amounts of marijuana and provide for the regulation of marijuana production, processing, and sale. The guidance set forth herein applies to all federal enforcement activity, including civil enforcement and criminal investigations and prosecutions, concerning marijuana in all states.

As the Department noted in its previous guidance, Congress has determined that marijuana is a dangerous drug and that the illegal distribution and sale of marijuana is a serious crime that provides a significant source of revenue to large-scale criminal enterprises, gangs, and cartels. The Department of Justice is committed to enforcement of the CSA consistent with those determinations. The Department is also committed to using its limited investigative and prosecutorial resources to address the most significant threats in the most effective, consistent, and rational way. In furtherance of those objectives, as several states enacted laws relating to the use of marijuana for medical purposes, the Department in recent years has focused its efforts on certain enforcement priorities that are particularly important to the federal government:

- Preventing the distribution of marijuana to minors;
- Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels;
- Preventing the diversion of marijuana from states where it is legal under state law in some form to other states;
- Preventing state-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity;

- Preventing violence and the use of firearms in the cultivation and distribution of marijuana;
- Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
- Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
- Preventing marijuana possession or use on federal property.

These priorities will continue to guide the Department's enforcement of the CSA against marijuana-related conduct. Thus, this memorandum serves as guidance to Department attorneys and law enforcement to focus their enforcement resources and efforts, including prosecution, on persons or organizations whose conduct interferes with any one or more of these priorities, regardless of state law.¹

Outside of these enforcement priorities, the federal government has traditionally relied on states and local law enforcement agencies to address marijuana activity through enforcement of their own narcotics laws. For example, the Department of Justice has not historically devoted resources to prosecuting individuals whose conduct is limited to possession of small amounts of marijuana for personal use on private property. Instead, the Department has left such lower-level or localized activity to state and local authorities and has stepped in to enforce the CSA only when the use, possession, cultivation, or distribution of marijuana has threatened to cause one of the harms identified above.

The enactment of state laws that endeavor to authorize marijuana production, distribution, and possession by establishing a regulatory scheme for these purposes affects this traditional joint federal-state approach to narcotics enforcement. The Department's guidance in this memorandum rests on its expectation that states and local governments that have enacted laws authorizing marijuana-related conduct will implement strong and effective regulatory and enforcement systems that will address the threat those state laws could pose to public safety, public health, and other law enforcement interests. A system adequate to that task must not only contain robust controls and procedures on paper; it must also be effective in practice. Jurisdictions that have implemented systems that provide for regulation of marijuana activity

¹ These enforcement priorities are listed in general terms; each encompasses a variety of conduct that may merit civil or criminal enforcement of the CSA. By way of example only, the Department's interest in preventing the distribution of marijuana to minors would call for enforcement not just when an individual or entity sells or transfers marijuana to a minor, but also when marijuana trafficking takes place near an area associated with minors; when marijuana or marijuana-infused products are marketed in a manner to appeal to minors; or when marijuana is being diverted, directly or indirectly, and purposefully or otherwise, to minors.

must provide the necessary resources and demonstrate the willingness to enforce their laws and regulations in a manner that ensures they do not undermine federal enforcement priorities.

In jurisdictions that have enacted laws legalizing marijuana in some form and that have also implemented strong and effective regulatory and enforcement systems to control the cultivation, distribution, sale, and possession of marijuana, conduct in compliance with those laws and regulations is less likely to threaten the federal priorities set forth above. Indeed, a robust system may affirmatively address those priorities by, for example, implementing effective measures to prevent diversion of marijuana outside of the regulated system and to other states, prohibiting access to marijuana by minors, and replacing an illicit marijuana trade that funds criminal enterprises with a tightly regulated market in which revenues are tracked and accounted for. In those circumstances, consistent with the traditional allocation of federal-state efforts in this area, enforcement of state law by state and local law enforcement and regulatory bodies should remain the primary means of addressing marijuana-related activity. If state enforcement efforts are not sufficiently robust to protect against the harms set forth above, the federal government may seek to challenge the regulatory structure itself in addition to continuing to bring individual enforcement actions, including criminal prosecutions, focused on those harms.

The Department's previous memoranda specifically addressed the exercise of prosecutorial discretion in states with laws authorizing marijuana cultivation and distribution for medical use. In those contexts, the Department advised that it likely was not an efficient use of federal resources to focus enforcement efforts on seriously ill individuals, or on their individual caregivers. In doing so, the previous guidance drew a distinction between the seriously ill and their caregivers, on the one hand, and large-scale, for-profit commercial enterprises, on the other, and advised that the latter continued to be appropriate targets for federal enforcement and prosecution. In drawing this distinction, the Department relied on the common-sense judgment that the size of a marijuana operation was a reasonable proxy for assessing whether marijuana trafficking implicates the federal enforcement priorities set forth above.

As explained above, however, both the existence of a strong and effective state regulatory system, and an operation's compliance with such a system, may allay the threat that an operation's size poses to federal enforcement interests. Accordingly, in exercising prosecutorial discretion, prosecutors should not consider the size or commercial nature of a marijuana operation alone as a proxy for assessing whether marijuana trafficking implicates the Department's enforcement priorities listed above. Rather, prosecutors should continue to review marijuana cases on a case-by-case basis and weigh all available information and evidence, including, but not limited to, whether the operation is demonstrably in compliance with a strong and effective state regulatory system. A marijuana operation's large scale or for-profit nature may be a relevant consideration for assessing the extent to which it undermines a particular federal enforcement priority. The primary question in all cases – and in all jurisdictions – should be whether the conduct at issue implicates one or more of the enforcement priorities listed above.

Memorandum for All United States Attorneys
Subject: Guidance Regarding Marijuana Enforcement

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As with the Department's previous statements on this subject, this memorandum is intended solely as a guide to the exercise of investigative and prosecutorial discretion. This memorandum does not alter in any way the Department's authority to enforce federal law, including federal laws relating to marijuana, regardless of state law. Neither the guidance herein nor any state or local law provides a legal defense to a violation of federal law, including any civil or criminal violation of the CSA. Even in jurisdictions with strong and effective regulatory systems, evidence that particular conduct threatens federal priorities will subject that person or entity to federal enforcement action, based on the circumstances. This memorandum is not intended to, does not, and may not be relied upon to create any rights, substantive or procedural, enforceable at law by any party in any matter civil or criminal. It applies prospectively to the exercise of prosecutorial discretion in future cases and does not provide defendants or subjects of enforcement action with a basis for reconsideration of any pending civil action or criminal prosecution. Finally, nothing herein precludes investigation or prosecution, even in the absence of any one of the factors listed above, in particular circumstances where investigation and prosecution otherwise serves an important federal interest.

cc: Mythili Raman
Acting Assistant Attorney General, Criminal Division

Loretta E. Lynch
United States Attorney
Eastern District of New York
Chair, Attorney General's Advisory Committee

Michele M. Leonhart
Administrator
Drug Enforcement Administration

H. Marshall Jarrett
Director
Executive Office for United States Attorneys

Ronald T. Hosko
Assistant Director
Criminal Investigative Division
Federal Bureau of Investigation



SEP 23 2015

Dear Tribal Leader:

I am writing to inform you of a major change to annual performance reporting for the Indian Health Service (IHS). Each year, the IHS reports its performance results (also known as budget measures) in the annual President's budget request to Congress. Budget measures include required reporting of IHS's Government Performance and Results Act (GPRA) and Government Performance and Results Modernization Act (GPRAMA) clinical performance results.

In fiscal year (FY) 2016, the IHS plans to begin preparations to implement the Integrated Data Collection System Data Mart (IDCS DM), a new reporting mechanism within the National Data Warehouse (NDW). The IDCS DM provides a mechanism for Tribes and Urban health programs that do not use the IHS's Resource and Patient Management System (RPMS) to participate in GPRA and GPRAMA reporting. I am requesting your input on Tribal health program needs and interests associated with this new reporting mechanism.

Historically, a majority of Tribal health programs have used the RPMS as their health information system, with GPRA and GPRAMA performance data for these Tribal programs included with IHS data in reporting. Agency clinical GPRA and GPRAMA submissions in support of the IHS budget have never included data from Tribal health programs that do not use RPMS. With increasing numbers of Tribal health programs electing to purchase commercial health information systems, Tribal participation has decreased.

Many Tribes that use commercial health information systems have expressed a desire to continue participating in national GPRA and GPRAMA reporting in support of the IHS budget. The IDCS DM provides a mechanism for non-RPMS Tribal health programs to submit export files that meet IHS Office of Information Technology (OIT) standards for reporting to the National Patient Information Reporting System (please see the OIT Web site for more information: https://www.ihs.gov/NDW/index.cfm?module=dsp_dqw_hl7interface). An "opt-out" feature in the IDCS DM will be available for Tribal programs that do not want their data included in GPRA and GPRAMA reporting. Under IDCS DM, GPRA and GPRAMA results can be calculated from data exported to the NDW, regardless of the electronic health information system used locally.

The major performance reporting changes include:

- Updated Data Source – Agency clinical performance reporting has used the RPMS Clinical Reporting System (CRS) since 2005. The IHS will begin reporting IDCS DM results in FY 2018.
- User Population Estimates – The IDCS DM will standardize the use of User Population Estimates as the denominator for the clinical GPRA and GPRAMA measures.

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- Reporting Year – The GPRA and GPRAMA reporting year (July 1 – June 30), will change to match the User Population Estimates reporting year (October 1 – September 30). The GPRA and GPRAMA year change consolidates local efforts to simultaneously submit one final export to meet the same User Population and GPRA and GPRAMA deadlines.
- Enables Full IHS, Tribal, and Urban Indian Health Program (I/T/U) Participation – The I/T/U population may be better represented in performance data because Urban and non-RPMS user data can now be reported with national results.

I have asked Area Directors to identify an upcoming Area meeting or schedule a conference call to consult with Tribes on the IDCS DM implementation by October 31. I am requesting your input and feedback to gauge Tribal interest in IDCS DM participation in the following areas: 1) ways to make the system easy to use; 2) ways to communicate system updates; and 3) ways to identify potential barriers and challenges (e.g., costs, if any).

Thank you for your partnership as we work to improve the collection and reporting of the Agency's national performance results. I encourage you to share this letter with your health care administrators, GPRA coordinator, health information technology staff, and others, as appropriate.

Please submit your written comments by **October 31, 2015**. You can submit your input by e-mail to consultation@ihs.gov or by postal mail to: Mr. Robert McSwain, Deputy Director, IHS, 801 Thompson Avenue, Suite 440, Rockville, Maryland, 20852.

If you have any questions about the consultation process or the IDCS DM implementation, please contact the IHS Office of Public Health Support by telephone at (301) 443-0222, or send an e-mail to HQ_OPHSidcs@ihs.gov.

Sincerely,

/Robert G. McSwain/

Robert G. McSwain
Deputy Director

Enclosure: IHS Integrated Data Collection System Data Mart Fact Sheet

Indian Health Service

Integrated Data Collection System Data Mart (IDCS DM) Fact Sheet

The Integrated Data Collection System Data Mart (IDCS DM) is a new national performance data mart built within the Indian Health Service (IHS) National Data Warehouse (NDW).

The IDCS DM is built to enhance IHS's current system of reporting national clinical measure results as required by the Government Performance and Results Act (GPRA) and the GPRA Modernization Act (GPRAMA).

This fact sheet describes what the system is, the impact to IHS, Tribal and Urban (I/T/U) programs, its purpose, benefits, limitations and implementation plans.

What is the IDCS DM?

The IDCS DM is a centralized performance data mart that produces secure, on-demand web-based reports at the service unit, Area and national levels. This new data mart enhances the current Clinical Reporting System (CRS).

Why is IHS building IDCS DM?

Many Tribes and Urban programs using commercial health systems have expressed a desire to continue participating in national GPRA/GPRAMA reporting in support of the IHS budget.

IHS currently reports clinical GPRA/GPRAMA measure results using the CRS National GPRA/GPRAMA Report in Resource and Patient Management System (RPMS). Currently, only RPMS users can participate in IHS's national performance reporting.

The IDCS DM provides a mechanism for non-RPMS Tribal and Urban health programs to include their data for national reporting for budget purposes.

When will IDCS DM be deployed?

The system will be built and tested during 2015-2016. IHS will begin reporting clinical results from IDCS DM for Fiscal Year (FY) 2018. Results will be reported as required by GPRA/GPRAMA in the Agency's Annual Congressional Justification and other reports. Due to the timing of the federal budget process, the FY 2020 Congressional Justification is the earliest point in time IHS will report FY 2018 results.

How does the IDCS DM impact current reporting for I/T/U programs?

- All clinical measures will be reprogrammed because of the new data source, new reporting year, and denominator change to the User Population (as referenced in Table 1).
- Measure results will still be calculated electronically.
- If Tribal programs do not want their data included in national results, there will be an "opt out" feature to skip over their data.

The purpose of the IDCS DM is to enhance the CRS in the following ways:

- Enables full I/T/U participation - Uses any patient registration and clinical data export files (RPMS, non-RPMS and fiscal intermediary) submitted to the NDW to calculate national performance results.
- Streamlines Reporting - Results will be based on the annual User Population Estimates, I/T/U sites will only need to submit one National Patient Information Registration System (NPIRS) export for the User Population Estimates and national clinical results.
- On-demand Results – All data exported to the NDW can be used to generate secure, on-demand, web-based GPRA results using data that are as current as the last weekly data refresh of files uploaded in the NDW.
- Enhances data access – Centralized programming and on-demand web based reports efficiently provide performance results on a more frequent and ad hoc basis making results available for decision making or other purposes.

Is IHS consulting and conferring with Tribes and Urban programs on IDCS DM?

IHS will consult with Tribes and confer with Urban programs during 2015 to gauge participation interest, ways to make the system easy to use, identify ways to communicate system updates, and identify barriers and challenges (e.g., costs, if any).

Table 1. Comparison of the Resource and Patient Management System's (RPMS) Clinical Reporting System (CRS) and the Integrated Data Collection System Data Mart (IDCS DM)

	RPMS CRS		IDCS DM
Data Source	Measure logic searches local RPMS servers for performance results	➔	Uses all data exported to the NDW for performance calculations (RPMS, non-RPMS, Fiscal Intermediary)
Denominator Population	CRS defined Active Clinical Population	➔	IHS User Population
Focus	National performance results include RPMS data only	➔	National performance results represent I/T/U data submitted to the NDW
Logic	RPMS patches containing CRS logic updates installed on local RPMS servers	➔	Programmed centrally, measure logic can be changed quickly within IDCS DM
Report Frequency	Q2, Q3, Q4 for national aggregation from the local site ->Area Office -> National	➔	Run each quarter for national GPRA results, OR users run on-demand reports as needed
Reporting Year	July 1 – June 30	➔	Fiscal Year – October 1 – September 30
Reports	Locally run on RPMS server	➔	On-demand web based Service Unit, Area and National level reports
Results	Based on patient registration and clinical data housed in the local RPMS server	➔	Calculations are based on the patient no matter where the care was received

What are the benefits of the IDCS DM?

The IDCS DM offers a more cost-effective method to produce national performance results potentially reducing the burden on local I/T/U programs that provide the underlying data to the NDW. National, Area and Service Unit level results are reported in percentages and no personal identifiers are included in the results.

IDCS DM data will be updated (refreshed) on a weekly basis. Currently, locally run CRS reports must undergo two aggregation processes before national performance results are available. This process adds almost two months to end of quarter aggregated performance results.

IDCS DM can utilize all data submitted to the NDW by local facilities and service units to produce GPRA/GPRAMA results that represent I/T/U programs. As a result, the Agency's performance results reported in the annual Congressional Justification may be more representative of the I/T/U population.

What are the IDCS DM limitations?

- Measure performance will decline – The User Population denominator is larger than the CRS Active Clinical denominator.
- Data is limited to the export – IDCS DM uses the exported data to the NDW which is a sub-set of all the data that exists in a local RPMS server. CRS reports can access all data housed in the local RPMS server to run reports.

Does IDCS DM replace the CRS?

IDCS DM enhances the CRS -- it does not replace it. IDCS DM expands on the capabilities built from CRS. The CRS will continue to be available for local quality improvement efforts. Changes to the clinical measures programmed in CRS will be mirrored in IDCS DM programming.

What is the IHS implementation plan?

IHS will begin testing the system in 2015 through early 2016. I/T/U programs will be invited to participate.



CMS Tribal Issues Chart

ONGOING ISSUES

TOPIC	ONGOING ISSUE	STATUS	NEXT STEPS
TOPIC 3: Electronic verification of Indian status	Issue 2: TTAG recommends that CMS utilize the IHS Active User Database for electronic verification of eligibility for the tribal exemptions.	Because ECN numbers do not differentiate between tribal membership and ITU eligible status, can the IHS Active User Database now be used to verify exemption eligibility and issue ECNs through the Marketplace?	Ongoing. Under review by CMS.
TOPIC 5: QHP Network Adequacy *This issue is under review by the newly formed CCIIO Workgroup.	Issue 1: Per the 2015 Issuer Letter (released in March 2014), QHPs are required to offer contracts to Indian health care providers, consistent with the model QHP addendum and similar to requirements in Medicare Part D contracts. Although CCIIO has consistently reported that all QHPs have attested to offering contracts to ITUs, TTAG is requesting that CMS document that QHPs are offering contracts to ITUs and requests a list of ITUs that have been offered contracts.	The IHS Tribal Self Governance Advisory Group (TSGAC) and TTAG sent a joint letter to CMS requesting verification of whether QHPs offered contracts to specific ITUs in certain geographic areas. CMS responded to the letter and explained it was not possible for CMS to survey all the QHPs.	We received the TSGAC study, and it is currently under review by CMS.
TOPIC 6: Issuers not providing clear information regarding AI/AN zero cost sharing or limited cost sharing information	Issue 1: TTAG sent a letter to CCIIO on May 29, 2014 outlining concerns about information Issuers are distributing regarding AI/AN cost sharing reductions and the letter makes a series of recommendations. In addition, TTAG submitted comments to the Summary of Benefits and Coverage and Uniform Glossary proposed rule (CMS-9938-P) regarding this issue.	The Summary of Benefits and Coverage and Uniform Glossary proposed rule (CMS-9938) addresses this issue. CMS reviewed the TTAG comments and the final rule was released in June 2015.	Ongoing. The CCIIO workgroup is going to follow up on this issue.
TOPIC 8: Indian specific training and Indian desk at the call center	Tribes are concerned that the training materials do not contain complete information on AI/AN provisions and that the call center staff are not able to answer AI/AN specific questions.	With input from the TTAG, the navigator training materials have been revised. In addition, the call center staff received additional training on AIAN provisions. The call center is working to develop a process, such as using second tier managers, to answer AI/AN	Ongoing. CMS DTA will continue to develop fact sheets and outreach materials for navigators and other outreach workers as needed and with input from

CMS Tribal Issues Chart

TOPIC	ONGOING ISSUE	STATUS	NEXT STEPS
*This issue is under review by the newly formed CCIIO Workgroup.		specific questions. DTA provided an O&E update at the November TTAG face-to-face.	TTAG. CMCS is exploring options to enhance Indian specific training and resources.
TOPIC 9: Data metrics for AI/AN enrollment in the Marketplace and Medicaid	Tribes have asked for specific information on the numbers of AI/ANs who have enrolled in the Marketplace, who have selected a QHP with zero cost sharing or limited cost sharing variations.	OEAD reported in February 2015 that 24,000 AI/ANs enrolled in Zero Cost Sharing plan variations and 4,000 AI/ANs enrolled in Limited Cost sharing plan variations. This report did not include data from State Based Marketplaces. The Marketplace Data Team attended a joint ACA Policy-Data subcommittee meeting to discuss requests for specific data.	Ongoing. The Marketplace Data Team responded to the TTAG request for data and the CCIIO workgroup is currently reviewing the data.
TOPIC 11: Special Enrollment Period (SEP) for AI/ANs	Issue 2: Family members who do not meet the definition of Indian under the ACA can enroll outside of the open enrollment period in FFM states if one family member on the application is eligible for the SEP. However, TTAG reported that SBM states (Minnesota, in particular) do not believe they have the authority to allow non-Indian family members to utilize the SEP when applying on the same application as AI/AN family members because that policy is inconsistent with the regulations.	Current policy allowing mixed AI/AN families applying on one application to utilize the SEP only applies to FFM states at this time. The FAQ on healthcare.gov/tribal qualifies that "If your state runs its own Marketplace, visit your state's website to apply for a Special Enrollment Period. It may handle SEPs for American Indians and Alaska Natives differently."	Ongoing. CMS is following up on this issue.
TOPIC 17: Special Rules for Indians – Cost sharing reductions for Indians below 100% FPL in non-expansion states	There are conflicting interpretations of the statutory provisions in section 1402 of the ACA (the Special Rules for Indians) and the regulation requiring that cost sharing is only available for those who qualify for an APTC. APTCs are only available for people between 100% and 400% FPL. As a result, American Indians below 100% who do not qualify for Medicaid (mostly in non-expansion states) that should by statute	CCIIO clarified its policy to explain that individuals with incomes below 100% qualify for limited cost sharing plans.	Ongoing. Working on new outreach materials to reflect this policy update.

CMS Tribal Issues Chart

TOPIC	ONGOING ISSUE	STATUS	NEXT STEPS
	qualify for zero cost sharing (below 300%) are being charged full cost sharing because they do not qualify for APTCs.		
TOPIC 18: Medicaid Estate Recovery	Issue 2: The Medicaid Estate Recovery exception for AI/ANs excludes any land or property on trust land, including former reservations. In California, because of the unique status of California Indian land, it's unclear whether tribal land falls within the exception and is therefore exempt from Medicaid Estate Recovery.	DTA has met with CRIHB and is reviewing information received from them on June 12.	Ongoing.
TOPIC 19: Out of state enrollment in Medicaid (Across State Borders)	TTAG requested CMCS to examine whether students attending out of state Indian boarding schools could be treated as residents of the state where the boarding school is located for purposes of Medicaid.	DTA and the TTAG Across State Borders subcommittee has met with the CMCS staff. TTAG submitted recommendations to CMS.	Ongoing. TTAG recommendations being considered as CMS develops guidance.
TOPIC 23: TTAG Charter	TTAG charter needs to be updated.	On the January TTAG conference call, a request was made for volunteers to serve on a work group to provide recommendations on updates to the charter.	Forming a work group and planning to meet at the November or February face-to-face TTAG meeting.
TOPIC 24: Family plan cost sharing reductions (CSR)	Under the current rules, everyone in a family plan gets the same cost sharing as the person with the least generous cost sharing reduction. Meaning, mixed families (families with both tribal members and non-Indians) lose their Indian cost sharing reduction unless they enroll in two separate family plans, one for people who are enrolled members of tribes and one for the other people in the family. However, because each family plan has an out-of-pocket (OOP) limit, families have two OOP limits to satisfy. This would apply to families with one or more members enrolled in a limited cost sharing plan.	TTAG included this issue in their recommendations in their comments to the 2016 Payment Notice proposed rule.	Ongoing. The final rule was released on February 27, 2015 and addresses most tribal comments submitted by TTAG. The SME from CCIIO spoke at the ACA Policy Subcommittee on March 26, 2015 and explained that, at this time, there is no exception for any family with mixed eligibility for

CMS Tribal Issues Chart

TOPIC	ONGOING ISSUE	STATUS	NEXT STEPS
	When the rule was proposed initially, Tribes submitted comments asking for this policy to limit the total OOP per family. The response from CMS was essentially that they couldn't handle that level of complexity at that time, but that they would revisit this with Tribes in the following year. Now, Tribes want to revisit this issue.		cost sharing reductions, including mixed Indian families (some members of the family eligible for zero or limited cost sharing and others that are not).
TOPIC 25: PQRS meaningful use requirements for ITUs	PQRS meaningful use requirements implement strict penalties for ITUs that fail to adequately report. Tribes are concerned that the requirements are difficult to meet and resulting penalties are burdensome.	CMS CCSQ attended the November TTAG Face-to-Face to discuss the PQRS meaningful use requirements.	Ongoing. CCSQ is working with IHS to develop reporting requirements.
TOPIC 26: QHP Referrals	Tribal members in limited cost sharing plans do not pay any cost sharing when receiving care through an ITU or from other providers when receiving EHBs that have been referred from an ITU. However, to avoid paying cost sharing when receiving EHBs from providers other than ITUs, tribal members need to present a referral from an ITU.	In response to concerns raised by Tribes, Tribal Leaders, and issuers, CMS consulted on the information that is needed in these referrals so AI/ANs will not be charged cost sharing when they seek EHBs from their enrolled QHP through referrals under PRC. CMS consulted on the scope of information that should be included in the referral and asked for comments on the possibility of "blanket" or "comprehensive" referrals versus episodic referrals. CMS held an All Tribes Call on August 19 and consulted on September 21 at NIHB.	Ongoing. CMS is considering comments received during consultation.
TOPIC 27: 100% FMAP for services provided through an IHS/Tribal facility	Currently, if an AI/AN Medicaid beneficiary receives services through an IHS or Tribally operated health facility, CMS matches the amount paid for those services at 100%. This is referred to as 100% FMAP. However, if the AI/AN Medicaid beneficiary receives Medicaid covered services from a non-IHS/Tribal provider, such as through a Purchased or Referred Care referral, CMS matches at the State's regular	Because any response to SD and AK proposals would have national implications for Indian health providers across the country. CMS has been consulting on its current policy and possible changes to it. CMS met individually with SD and AK Tribal leaders, and held national All Tribes' Calls and a face-to-face consultation at NIHB on Sept. 21 st .	Ongoing. CMS is still in the process of evaluating its policy and considering comments received during consultation.

CMS Tribal Issues Chart

TOPIC	<i><u>ONGOING ISSUE</u></i>	STATUS	NEXT STEPS
	FMAP rate. South Dakota and Alaska submitted proposals asking CMS to expand the 100% FMAP to certain services.		

CMS Tribal Issues Chart

PARKING LOT ISSUES:

Issues that are not complete, but are pending non-CMS action, will be “parked” here until action can be taken

TOPIC	<u>ONGOING ISSUE</u>	STATUS	NEXT STEPS
TOPIC 1: ACA Definition of Indian	Align ACA definition of Indian, (which is a member of a federally recognized tribe) with the Medicaid definition of Indian, (which includes members and persons of Indian descent) and is consistent with eligibility criteria for Indians who are eligible for services from IHS.	<p>The definition of Indian in the ACA is a statutory definition and will require a legislative fix.</p> <p>The Medicaid definition was developed for purposes of implementing Section 5006 of ARRA (Protections for Indians under Medicaid). The term “Indian” was not defined by statute and thus, CMS could define Indian consistent with IHS eligibility criteria.</p> <p>Senate Bill 1575, to align the ACA definition with the Medicaid and IHS definitions, was introduced last term, but never got out of committee.</p>	There is currently no action for CMS to take until legislation is reintroduced.
TOPIC 3: Electronic verification of Indian status	Issue 1: AI/ANs have to verify Indian status in order to qualify for certain provisions, such as SEP and cost sharing reductions. Tribes and IHS have requested that CMS incorporate the IHS active user data into the national data hub so that Indian status can be verified electronically.	In 2014, the IHS Active User Database will not be incorporated into the national data hub at this time.	Until the definition of Indian is reconciled with the definition used by IHS in the Active User Database, this request will be pending.

CMS Tribal Issues Chart

COMPLETED ISSUES

TOPIC	COMPLETED ISSUE	STATUS	NEXT STEPS
TOPIC 2: Tribal Exemption from Shared Responsibility Payment	<p>Members of federally recognized tribes and individuals who are not tribal members but are eligible for services from an Indian health care provider (ITU) can file an exemption from the shared responsibility payment in two ways: 1) apply to the Marketplace for an exemption through the mail; or, 2) file for the exemption when completing a federal tax return.</p> <p>Issue 1: Tribes have requested that the process for obtaining a tribal exemption be the same for both tribal members and individuals eligible for services from ITUs via a federal income tax return.</p> <p>Issue 2: For tribal members who have received an exemption based on tribal membership, CCIIO should incorporate into the application a process for tribal members to use their exemption number or exemption letters to verify Indian status for SEP and cost sharing reductions.</p> <p>Issue 3: Because tribal members continue to experience issues when filing exemption applications, tribes have requested that CCIIO review pending exemption applications to resolve these issues.</p>	<p>On September 18, 2014, the Secretary announced at the Secretary's Tribal Advisory Committee that individuals eligible to receive services from an ITU provider would also be able to claim an exemption from the shared responsibility payment through the tax filing process starting with the 2014 tax year.</p> <p>CMS reviewed the issue and determined that a tribal member exemption number and letter cannot be used to verify Indian status instead of uploading and submitting the same tribal documents that were used to verify Indian status for the tribal member exemption.</p> <p>CMS and ANTHC worked together to resolve the outstanding exemption applications in Alaska.</p>	<p>Completed. DTA is working on outreach materials to explain the change and new process for the Indian Exemption.</p> <p>Completed. ECN numbers cannot differentiate between tribal membership and ITU eligibles and therefore cannot be used to verify Indian status for cost sharing reductions and special enrollment periods at this time.</p> <p>Completed.</p>

CMS Tribal Issues Chart

TOPIC	<u>COMPLETED</u> ISSUE	STATUS	NEXT STEPS
	<p>Issue 4: Tribes want to assist CMS in revising the exemption application for 2015.</p> <p>Issue 5: TTAG requested funding for ITUs to assist with completing exemption applications.</p> <p>Issue 6: Clarification is needed on how mixed AI/AN households file exemptions when household members have different exemptions (meaning, tribal membership exemptions <i>and</i> ITU eligible exemptions).</p> <p>Issue 7: Because the exemptions are for federal income tax purposes, the Exemption Processing Center, a CMS contractor, is contacting some exemption applicants to verify the identity and exemption status of all individuals listed on the application. For example, the contractor has been contacting Indian applicants to clarify whether non-Indian spouses or children are also applying for the exemption or are just included on the application because they are part of the applicant's tax household.</p> <p>Issue 8: How many tribal member or ITU exemptions has the CCIIO contractor processed so far?</p>	<p>CMS DTA advised TTAG to send in a letter with their comments in the event the exemption application is revised.</p> <p>There is no separate funding available to support ITU staff assisting with exemption applications.</p> <p>Based on the Secretary's September 2014 policy (allowing members and ITU eligibles to apply on their tax returns, creating a single Indian exemption), this should no longer be an issue.</p> <p>Under review by CMS. Assistors and Navigators have reported that when applicants indicate that the spouses or dependents are, "non-Indian" or "not applying for an exemption," the contractor has <i>not</i> been contacting the applicant for clarification.</p> <p>At the March 2015 STAC meeting, CCIIO reported 237,000 tribal applications received and 214,000 processed.</p>	<p>Completed. Tribal exemption application was updated October 2014 to reflect TTAG suggestions.</p> <p>Completed. No funding available.</p> <p>Completed.</p> <p>Completed. CMS developed FAQs to address exemption issues, that are available on our DTA website (http://go.cms.gov/AIAN) and on a new exemption page at www.healthcare.gov/tribal. These links were sent to our listserv week of March 23rd.</p> <p>Completed.</p>

CMS Tribal Issues Chart

TOPIC	COMPLETED ISSUE	STATUS	NEXT STEPS
<p>TOPIC 4: Uploading tribal documents</p>	<p>AI/ANs continue to have problems uploading tribal docs online to verify Indian status. Because this continues to be an on-going problem, Tribes have requested that CMS determine if it is a software compatibility issue and if so, identify a list of software needed to allow tribal documents to be uploaded and post it on healthcare.gov website.</p>	<p>CCIIO explained that applicants should submit in one of the following file types: pdf, jpg, jpeg, gif, tiff, bmp, png. If applicant still experiences problems, the files may be too large. In that case, try converting the files to pdf versions or mail copies of their docs with their application numbers.</p>	<p>Completed. DTA drafted an FAQ for the Marketplace and DTA O&E websites.</p>
<p>TOPIC 5: QHP Network Adequacy</p> <p>*This issue is under review by the newly formed CCIIO Workgroup.</p>	<p>Issue 2: TTAG would like CCIIO to incorporate guidance from the 2015 issuer letter into formal regulations. TTAG submitted comments to the Proposed Rule CMS-9944-P “Notice of Benefits and Payment Parameters for 2016” on December 22, 2014.</p> <p>Issue 4: At the November 2014 TTAG meeting, Oneida Nation (WI) reported that certain QHPs in Wisconsin refuse to offer contracts.</p>	<p>The problem is that QHPs are only required to attest that they’ve offered contracts to ITUs; they are <i>not</i> required to demonstrate or verify. The data that TTAG is requesting is not readily available and CMS does not have the staff resources to complete the request. However, CCIIO has repeatedly told TTAG to report any problems ITUs have entering into contracts with QHPs and they will have their oversight division follow up on a case-by-case basis.</p> <p>Gene Freund joined the ACA Policy Subcommittee call on 12/11/14 to discuss the proposed rule. CMS is currently reviewing TTAG’s formal comments to the proposed rule, 2016 Payment Notice.</p> <p>Based on this report, CCIIO contacted the QHP that had refused to contract. The QHP is a closed panel HMO and is therefore not required to contract with ITUs because it is an alternative health plan. Notwithstanding, Oneida Nation has a right of recovery under the Indian Health Care Improvement Act (S. 206).</p>	<p>Completed. The final rule was released on February 27, 2015 and addresses most tribal comments submitted by TTAG.</p> <p>Completed. CMS, IHS, and Oneida Nation had a call. Oneida Nation will send section 206 IHS guidance to the QHP.</p>

CMS Tribal Issues Chart

TOPIC	COMPLETED ISSUE	STATUS	NEXT STEPS
<p>TOPIC 6: Issuers not providing clear information regarding AI/AN zero cost sharing or limited cost sharing information</p>	<p>Issue 2: TTAG recommends that CCIIO requires QHPs to issue cards indicating zero or limited cost sharing on the card.</p>	<p>The state department of insurance would have to regulate this. It is beyond the scope of what CMS can regulate.</p>	<p>Completed.</p>
<p>TOPIC 7: Tribal Sponsorship. Under current regulations, Marketplaces may permit Indian tribes, tribal organizations, and urban Indian organizations to pay QHP premiums for qualified individuals, subject to terms and conditions set by the Marketplace.</p>	<p>Issue 1: Tribes have requested that QHPs be required to develop Tribal sponsorship programs.</p> <p>Issue 2: For those tribes who have established a tribal sponsorship program, Issuers are having a hard time processing payments and there is limit on the number of credit card transactions per day.</p>	<p>CMS cannot require QHPs to develop sponsorship programs. The decision for tribes, tribal organizations, and urban organizations to pay premiums is tribal specific and these entities need to do a cost benefit analysis to determine whether it is financially beneficial to pay premiums on behalf of their tribal members.</p> <p>Tribes need to review their agreement with the issuers regarding the number of transactions that can be processed per day. Tribes can then negotiate with the issuer to modify the payment terms.</p>	<p>Completed. On August 26, 2014, CMS DTA held a webinar on Tribal Sponsorship programs and have tribal programs who have successfully implemented a tribal sponsorship program to present on best practices. Over 150 attended.</p> <p>Completed. This is an issue between the tribes and the issuer. CMS has no authority in this area.</p>
<p>TOPIC 10: Referral and Payment Guidance and Cost Sharing Reductions</p>	<p>Tribes developed guidance on when referrals are needed to avoid cost sharing for services received at ITUs and at non-ITU providers. Tribes are concerned with a FAQ that was issued without tribal consultation that indicates cost sharing reductions are not available for AI/ANs who enroll in closed panel QHPS and receive services from an out of network provider.</p>	<p>Held All Tribes Call on Closed Panel FAQs on June 25, 2014.</p>	<p>Completed. CCIIO reviewed comments from the All Tribes Call and is not able to change the policy. The issue of whether an ITU has the right of recovery for services provided under 206 to an AI/AN beneficiary enrolled is an IHS determination.</p>

CMS Tribal Issues Chart

TOPIC	COMPLETED ISSUE	STATUS	NEXT STEPS
TOPIC 11: Special Enrollment Period for AI/ANS	Issue 1: Permit family members who do not meet the definition of Indian under the ACA can enroll outside of the open enrollment period, in FFM states. (Ongoing issue addressing SEPs in SBM states located in ONGOING ISSUES CHART above, Topic 11, Issue 2)	FAQ was developed and posted on healthcare.gov/tribal that explains for those families that apply through the Federal-facilitated Marketplace, if one family member on the application is eligible for the Special Enrollment Period (SEP), all family members who apply on the same Marketplace application would be eligible for the SEP if otherwise eligible to enroll in a QHP, in FFM states.	Completed.
TOPIC 12: Clarification is needed as to how to report Tribal income on the Marketplace and Medicaid applications.	Appendix B of the Family Application explains that certain tribal income is not counted for Medicaid and CHIP eligibility determinations. Tribes are confused by the questions in Appendix B and think that we are asking them to report income that should be exempt.	If the tribal income is not taxable by IRS, then the income should not be reported on the Marketplace application and Appendix B. The only income that is reported on Appendix B is taxable tribal income that could be excluded for Medicaid and CHIP purposes.	Completed. CMS DTA will post an FAQ on healthcare.gov/tribal and develop a fact sheet for outreach purposes.
TOPIC 13: Children Dental Stand Alone Plans	It is the tribal position that zero and limited cost sharing reductions apply to Children Dental Stand Alone Plans.	Per statute, cost sharing reductions do not apply to Stand Alone dental plans, including pediatric dental care.	Completed. DTA drafted an FAQ for the healthcare.gov/tribal website.
TOPIC 14: Designated authorized representative in on-line application vs call center vs paper.	There is no place to designate an authorized representative on the on-line application. A Call Center representative has stated that the authorization via telephone is good only for 14 days. Due to problems experienced by AI/ANS, Tribes have requested that the authorization be longer than 14 days.	CCIIO reviewed this issue and determined that authorization for a designated authorized representative will be good for 365 days.	Completed. DTA drafted an FAQ for the healthcare.gov/tribal website.
TOPIC 15: Notice for annual eligibility redeterminations for	The proposed redetermination notices do not include information about Indian provisions or protections. The TTAG would like CCIIO to issue a separate redetermination or renewal notice just to AI/ANS on	CMS held an All Tribes Call on July 21, 2014 and asked for comments on what information should be included in a redetermination notice	Completed. CMS reviewed the TTAG comments and suggested language. CMS determined that a separate

CMS Tribal Issues Chart

TOPIC	<u>COMPLETED</u> ISSUE	STATUS	NEXT STEPS
exchanges and health insurance issuer guidance regulation (CMS-9941-P)	the Marketplace.	TTAG recommended that CMS issue a Dear Tribal Leader letter notifying tribes that the redetermination letters would be going out to Marketplace consumers.	redetermination letter for AI/ANs was not possible. However, the redetermination for all Marketplace consumers included a sentence explaining that AI/ANs can change plans monthly. Because the redetermination letters referenced the tribal special enrollment period, it was determined a DTLL was not necessary.
TOPIC 16: Former Foster Care Children.	Section 1902 of the Social Security Act allows former foster care children to enroll in Medicaid. Section 2004 of the ACA extended the age of enrollment to 26. CMS guidance (FAQ) includes tribes so former foster care children under the responsibility of a tribe can also enroll in Medicaid under the same requirements as those under the responsibility of the state. The issue is that Arizona Medicaid (AHCCCS) disagrees with CMS's inclusion of tribes in this guidance.	CMS met with AHCCCS to discuss the issue. AHCCCS held a tribal consultation on 10/16. CMS discussed issue with AHCCCS and AHCCCS agreed that they would cover AI/AN former foster care children, but will need to develop process with tribal foster care programs.	Completed.
TOPIC 18: Medicaid Estate Recovery	Medicaid Estate Recovery allows states to recover payments from some Medicaid beneficiaries. Estate Recovery applies to Medicaid beneficiaries over the age of 55 and is only an option when Medicaid pays for Long Term Supports and Services, more commonly known as Long Term Care. Long Term		

CMS Tribal Issues Chart

TOPIC	COMPLETED ISSUE	STATUS	NEXT STEPS
	<p>Care.</p> <p>Issue 1: It has been reported that AI/AN consumers are not applying for Medicaid for fear of having their homes or property taken through Medicaid Estate Recovery. AI/AN consumers need general guidance on Medicaid Estate Recovery.</p>	<p>CMS developed general guidance explaining the overall Medicaid Estate Recovery rule and the exception for AI/ANs. At the November 2014 TTAG meeting, CMS provided a copy of the guidance for TTAG review and input.</p>	<p>Completed. CMS finalized and posted a fact sheet on our website, held a webinar, and participated in an all-state SOTA call on Medicaid Estate Recovery.</p>
<p>Topic 20: Improve Medicaid reimbursements to tribal residential treatment centers (IMD)</p>	<p>TTAG and STAC raised issue on how tribal residential treatment facilities and Youth Regional Treatment Centers (YRTC) can receive Medicaid reimbursements, including Medicaid reimbursement of out of state patients</p>	<p>CMCS is exploring how the Institutions for Mental Diseases (IMD) exclusion applies to YRTCs.</p>	<p>Completed. CMS held a webinar with SAMHSA to explain the IMD exclusion, how it is applied to Tribal programs, and how Tribal programs can qualify as Psychiatric Residential Treatment Facilities (PRTF).</p>
<p>TOPIC 21: Tribal Collections request from OMB</p>	<p>OMB requested data from IHS and CMS as the amount of Medicare and Medicaid collections generated by tribally operated facilities.</p>	<p>The TTAG requested that before OMB requests IHS and CMS to provide this information, that tribal consultation is held.</p>	<p>Completed. IHS responded to OMB and relayed tribal concerns. No tribal collections information will be required at this time.</p>
<p>TOPIC 22: Reporting Tribal income (MAGI)</p>	<p>There are certain income exclusions for AI/ANs when determining income eligibility for CMS programs. AI/AN beneficiaries are having difficulty understanding what income to include on their applications for the Marketplace or Medicaid/CHIP.</p>	<p>DTA has completed a fact sheet on Indian trust income and MAGI. It is available on our website. We will be holding a webinar on MAGI. CMS also held a webinar and participated in an all-state SOTA call on MAGI.</p>	<p>Completed.</p>



OCT 05 2015

Indian Health Service
Rockville, MD 20852

Ms. Lynn Malerba
Chief, Mohegan Tribe
Tribal Self-Governance Advisory Committee
c/o Self-Governance
1133 20th Street NW, Suite 220
Washington, DC 20036-3462

Dear Chief Malerba:

Thank you for your letter providing recommendations regarding quality reporting measures and the request for an analysis.

In your letter, you provide an overview of efforts by the Tribal Self-Governance Advisory Committee's (TSGAC) to work with the Centers for Medicare & Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG) to have discussions with CMS about using Government Performance and Results Act (GPRA) measures instead of the clinical quality management approaches. We understand the TSGAC believes the Indian Health Service (IHS) and Tribes should be aligning quality assurance with the Medicare and Medicaid approaches, particularly since there might be economic consequences with regard to revenue from these important payment sources for services. You also asked the IHS to conduct a comparative analysis of GPRA (modified GPRA Modernization Act, GPRAMA) and clinical quality management approaches. For the purposes of establishing a common goal, the analysis was to possibly include: 1) timelines for each; 2) type of data collection; and 3) costs of data collection.

I am writing to inform you that the IHS is working to assess the impact of GPRA/GPRAMA and CMS's clinical quality management approaches. We understand TSGAC concerns on the potential reporting and cost burden associated with various requirements for GPRA/GPRAMA and clinical quality measures. We will continue to work with you, CMS, and HHS to identify appropriate solutions to reduce duplicative efforts.

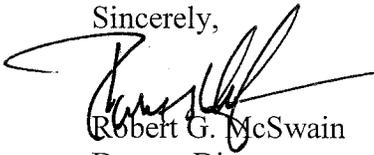
As we continue to work towards identifying methods to reduce duplication and improve the overall reporting process, I want to take this opportunity to update you on a major change to annual reporting of GPRA/GPRAMA clinical performance results. Beginning in FY 2016, the IHS is preparing to implement the Integrated Data Collection System Data Mart (IDCS DM), a new reporting mechanism within the National Data Warehouse. The IDCS DM provides a mechanism for Tribes and Urban Indian health programs that do not use the IHS's Resource and Patient Management System (RPMS) to participate in GPRA/GPRAMA reporting. The IHS is requesting Tribal consultation on this topic with feedback submission by October 31, 2015. The Dear Tribal Leader Letter and Fact Sheet dated September 23, 2015, is available on the IHS Web site at <https://www.ihs.gov/newsroom/triballeaderletters/>.

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As requested, the IHS is working on preparing a formal analysis and submitting a written report. However, the analysis and report will be unavailable for review during the TSGAC quarterly meeting on October 6, 2015. As soon as a response is available, we will submit for TSGAC review and discussion.

I appreciate your partnership as we work to improve and align quality reporting efforts across the Indian health care system. I look forward to continued dialogue on this important topic.

Sincerely,



Robert G. McSwain
Deputy Director

National Indian Health Board



Submitted electronically via: Notice.comments@irs.counsel.treas.gov

October 1, 2015

CC:PA:LPD:PR (Notice 2015-52)
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station, Room 5203
Washington, DC 20044

RE: Notice 2015-52 on Section 4980I — Excise Tax on High Cost Employer-Sponsored Health Coverage

I. INTRODUCTION.

I write to the Internal Revenue Service (IRS) on behalf of the National Indian Health Board (NIHB)¹ in response to IRS Notice 2015-52 (Notice 2015-52). In Notice 2015-52, the IRS solicits comments on potential regulatory approaches for implementing Section 4980I of the Tax Code,² which establishes an excise tax on certain employer-sponsored health benefits under which coverage providers must pay a tax on employee plans that exceed certain statutory cost thresholds (the excise tax).³

NIHB previously submitted comments on the excise tax in response to Notice 2015-16, the IRS's February 26, 2015 solicitation of input on various aspects of the tax's implementation.⁴

¹ Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

² See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9001, 124 Stat. 119, 793 (2010), codified as amended at 26 U.S.C. § 4980I. Unless otherwise noted, references to "Sections" of statutes within this comment refer to sections of the Tax Code in chapter 26 of the United States Code.

³ The thresholds are \$10,200 for self-only coverage and \$27,500 for non-self-only coverage, subject to certain adjustments specified in the statute. 26 U.S.C. § 4980I(b)(3)(C).

⁴ These comments are included as an attachment to this current response.

In these previous comments, NIHB noted that benefits provided by Tribes and Tribal organizations are excluded from from the scope of the excise tax:

- In the context of government-provided benefits, the excise tax only applies to “coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.”⁵ Because this government plan provision does not list or even mention plans administered by an Indian Tribe or Tribal organization, despite specifically addressing state and federal government plans,⁶ well-recognized rules of statutory interpretation require that Tribal plans be considered exempt from the excise tax.⁷
- In the event that the IRS construes Section 4980I as applying to Tribal employers who administer their own plans,⁸ the statute taxes excess benefit provided to employees covered “under any group health plan made available to the employee by an employer which is excludable from the employee’s gross income under section 106 [of the Tax Code], or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).”⁹ Because coverage for Tribal member employees is not excluded from income pursuant to Section 106, but rather by virtue of Section 139D, it is not included

⁵ 26 U.S.C. § 4980I(d)(1)(E).

⁶ The IRS has recognized that the government-specific clause must be read as an integrated whole with the introductory language in 26 U.S.C. § 4980I(d)(1)(A), noting that the fact that the government clause only mentions “civilian” governmental plans implicitly means that Congress intended that military governmental plans are not subject to the excise tax. Notice 2015-16 at 8. This interpretation, and the government plan clause generally, would not make sense if Congress had intended that the excise tax apply to any government plans other than those specified in paragraph (d)(1)(E). *See, e.g., FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (courts must “interpret the statute ‘as a symmetrical and coherent regulatory scheme,’ and ‘fit, if possible, all parts into a [] harmonious whole’”) (citation omitted).

⁷ For example, statutes relating to Indians must be “construed liberally in favor” of Tribes. *Montana v. Blackfeet Tribe of Indians*, 471 U.S. 759, 766 (1985). In addition, statutes of general applicability that interfere with rights of self-governance, such as the relationship between Tribal governments and on-reservation Tribal businesses and their employees, require “a clear and plain congressional intent” that they apply to Tribes before they will be so interpreted. *See, e.g., E.E.O.C. v. Fond du Lac Heavy Equip. & Const. Co., Inc.*, 986 F.2d 246, 249 (8th Cir. 1993) (Age Discrimination in Employment Act did not apply to employment discrimination action involving member of Indian Tribe, Tribe as employer, and reservation employment); *accord Snyder v. Navajo Nation*, 382 F.3d 892, 896 (9th Cir. 2004) (Fair Labor Standards Act did not apply to dispute between Navajo and non-Navajo Tribal police officers and Navajo Nation over “work [done] on the reservation to serve the interests of the tribe and reservation governance”).

⁸ Tribal employers who purchase group health insurance for their employees would not be liable for the tax, as liability for the tax is limited to “coverage providers,” which in those cases would be the health insurance issuer rather than the employer itself. 26 U.S.C. § 4980I(c). Any reference to Tribal employers in this comment is therefore limited to those employers administering self-funded plans.

⁹ 26 U.S.C. § 4980I(d)(1)(A).

in the scope of taxable benefits for purposes of Section 4980I and should accordingly be exempt from the excise tax.

NIHB hereby incorporates by reference its previous comments on the excise tax, and reiterates its request that the IRS expressly recognize that plans offered by Tribes and Tribal organizations are exempt from the tax pursuant to the plain language of Section 4980I.

To the extent that the IRS ultimately construes Section 4980I as applying to Tribal employers, notwithstanding the statutory provisions noted above, NIHB offers the following comments regarding a matter of particular concern on which the IRS solicits input. Specifically, we believe that Notice 2015-52's proposed excise tax payment/reimbursement methodology, under which the "administrator" of a self-insured plan (if determined to be an entity other than the employer itself for purposes of Section 4980I) would pay the tax on the employer's behalf and then bill the employer for the cost after grossing up the amount of the entity's non-deductible excise tax to account for income tax on the reimbursement, is impermissible as a matter of statutory interpretation and very problematic as a matter of tax policy. We elaborate below.

II. DISCUSSION.

Section 4980I(c)(1) states that the "coverage provider" is liable for paying the excise tax. In the context of self-insured plans, the coverage provider is "the person that administers the plan benefits."¹⁰ According to Notice 2015-52, because the latter phrase is undefined in the Code or related statutes:¹¹

[T]he excise tax will be paid . . . by the "person that administers the plan benefits" (which may, in some instances, be the employer) in the case of self-insured coverage. It is expected that, if a person other than the employer is the coverage provider liable for the excise tax, that person may pass through all or part of the amount of the excise tax to the employer in some instances. If the coverage provider does pass through the excise tax and receives reimbursement for the tax (the excise tax reimbursement), the excise tax reimbursement will be additional taxable income to the coverage provider. Because § 4980I(f)(10) provides that the excise tax is not deductible, the coverage provider will experience an increase in taxable income (that is not offset by a deduction) by reason of the receipt of the excise tax reimbursement. As a result, it is anticipated that the amount the coverage provider passes through to the employer may include not only the excise tax reimbursement, but also an amount to account for the additional income tax the coverage provider will incur (the income tax reimbursement).¹²

¹⁰ 26 U.S.C. § 4980I(c)(2)(C).

¹¹ *But see infra* for a discussion of why this interpretation is not accurate.

¹² Notice 2015-52 at 7.

In the context of self-insured plans, the IRS accordingly proposes that (1) the employer will calculate its excise tax liability; (2) pass that information to “the person that administers the plan benefits,” which the IRS believes may be the employer, a third party administrator (TPA), or some other entity as determined on a case-by-case basis; (3) that third party (if not the employer) will pay the excise tax; (4) the third party will then bill the cost onto the employer; (5) the employer will reimburse the third party the amount of the Section 4980I excise tax; and (6) in addition, the third party (either as part of the excise tax pass-through or as a separate process) will bill the employer an additional sum to reflect the third party’s increase in taxable income in the form of the excise tax reimbursement that it receives from the employer and the grossed up amount of the income tax reimbursement itself. We do not believe that this convoluted scenario is permissible as a matter of reasonable statutory interpretation and the clear statutory intent.

First, the IRS’s interpretation would impose an effective tax rate on an employer that exceeds the rate specified in Section 4980I. In the event that an employer provides excess benefits, Section 4980I(a) imposes an excise tax “*equal to 40 percent of the excess benefit.*”¹³ But by authorizing a TPA to pay the excise tax and bill the employer, and to additionally bill a grossed up income tax amount to cover the TPA’s own income tax liability with respect to the reimbursement payment, the employer’s liability for tax does not *equal* forty percent of the excess benefit; it *exceeds* it. For example, in the event of an employer’s \$2,500 excess benefit, and assuming an effective income tax rate on the TPA of twenty percent, the TPA would pay the excise tax of \$1,000, and then bill the employer for that amount, plus the \$250 the TPA will owe in income tax on the reimbursement of the non-deductible excise tax and related reimbursement of the income tax itself. That would mean that a Tribe, or any other tax-exempt entity operating a self-insured plan through a taxable TPA, would actually pay \$1,250 of tax on an excess benefit of \$2,500, or an effective tax rate of fifty percent.¹⁴

In addition, the application of this proposed methodology leads to a vicious cycle of increasing excise tax liability for the employer. In determining the cost of applicable coverage subject to the excise tax, Section 4980I(d)(2)(A) provides that “any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account.” While the drafters acknowledge in the Notice that the computation of the excess benefit under the employer’s plan will not include the excise tax reimbursement, the Notice indicates that reimbursement of the TPA’s income tax most likely will be added to the cost of coverage subject to the Section 4980I tax.¹⁵

¹³ 26 U.S.C. § 4980I(a) (emphasis added).

¹⁴ See Notice 2015-52 at 8-9 (explaining tax calculation formula under the scenario envisioned by the drafters of the Notice).

¹⁵ Notice 2015-52 at 7-8. However, this interpretation is at odds with the plain language of Section 4980I(d)(2)(A) noting that any portion of cost of coverage “which is attributable to the tax imposed under this section shall not be taken into account.” The income tax should be considered to be “attributable to the tax imposed under” Section 4980I and subsequently excluded; if not, the IRS is essentially admitting that it has created the income tax payments sua sponte, without statutory authorization, and in violation of the statutory forty percent excise tax responsibility.

In practice, this means that should any ultimate implementing regulations treat the TPA as the person administering the plan benefits, and implicate the proposed pay-and-reimburse model, employers will be stuck in a cycle through their reimbursement of the TPA's income tax expenses will subsequently increase the employer's own cost of coverage. Unless the employer amends its plan, this increase in coverage cost will subsequently increase the employer's excise tax liability and its TPA income tax reimbursement obligation. This itself will once again increase the deemed cost of coverage and further gross up the employer's excise tax liability, thus triggering the entire cycle in perpetuity.

This has the potential to drastically compound an employer's effective liability under the statute *without any increase of benefits under its plan*. For instance, one Tribe has calculated that it would be liable for approximately \$250,000 in penalties on an excess benefit of \$625,000. Applying the IRS's "income tax liability" formula would result in an additional \$62,500 owed to a TPA with a marginal income tax rate of 20%, which would then increase the Tribe's cost of coverage to \$712,500 and its excise tax payment to \$275,000: a \$25,000 increase in liability. In imposing the Section 4980I excise tax as being "equal" to forty percent of the excess benefit, Congress simply did not leave room for an interpretation under which the end-result is an effective tax rate will almost always exceed this stated statutory amount if a TPA is responsible for administration of the plan under the terms established by the employer.

Second, and as noted above, the IRS states that this payment and reimbursement process is necessary because "Section 4980I does not define the term 'person that administers the plan benefits'" who is liable to pay the tax.¹⁶ But this is not accurate: Section 4980I(f)(6) defines the "person that administers the benefits" as the "plan sponsor if the plan sponsor administers benefits under the plan," while Section 4980I(f)(7) then defines "plan sponsor" through the incorporation of section 3(16)(B) of the Employee Retirement Income Security Act of 1974. This provision states in relevant part that the plan sponsor in this context is "the employer in the case of an employee benefit plan established or maintained by a single employer."¹⁷

We believe that the most natural reading of these provisions as a whole is that the employer should be considered the person that "administers benefits" under the plan, in that the employer has the ultimate administrative authority to set the plan terms, pick the TPA and usually make final benefit decisions. If that were the case, the employer itself would calculate and pay the tax, without having to involve third parties. That seems a much more logical application of the tax than the complex TPA reimbursement scenario Notice 2015-52 suggests, particularly with respect to any Tribe or other tax-exempt employer.¹⁸

¹⁶ Notice 2015-52 at 7.

¹⁷ 26 U.S.C. § 4980I(f)(7) (incorporating by reference 29 U.S.C. § 1002(16)(B)(i)).

¹⁸ In addition, the Indian canons of construction demand that the agency avoid such an anti-Tribal interpretation of an unclear statute. *See, e.g., Montana, supra.*

Third, as a matter of practical implementation and tax policy, requiring that employers coordinate tax payments with a TPA invites a host of administrative difficulties that would not exist if employers simply paid the tax themselves.¹⁹ For example, Section 4980I(e) penalizes the “coverage provider” for failure to properly calculate and pay the tax, which, per the Notice, would mean the TPA. But how will the TPA ensure that the employer has properly calculated the tax amount, which it would then send to the TPA for payment? What recourse would the TPA have if the employer failed to calculate the tax amount accurately and in a timely manner? Would the TPA face a compliance penalty for failure to remit the correct amount of tax based on calculations for which it was not responsible? This would seem to suggest that TPAs would have to oversee or otherwise “check the work” of the employer in order to insulate themselves from liability; would the TPA be authorized to pass through the costs of these added burdens to the employer? Would such pass throughs increase the employer’s cost of coverage?²⁰

These are just some of the many difficulties and potentially lawsuit-inducing adversarial situations that could arise under Notice 2015-52’s pay and reimburse model. As a practical matter, Congress cannot have intended to subject both employers and TPAs to the cost of undertaking such a complex and expensive system, particularly as compared to the relatively straightforward option of simply having the plan sponsor (the employer, in the case of a self-insured plan) calculate and pay the excise tax on its own. Absent any clear statutory direction for doing so, the IRS should not unnecessarily complicate an already complicated calculation.

III. CONCLUSION.

Section 4980I has the potential to seriously affect Tribes’ ability to structure employee benefit packages in accordance with Tribal-specific needs. Because the statute excludes Tribes from the list of covered governmental entities, and by its terms does not apply to health benefits provided by a Tribe or Tribal organization to a member of an Indian Tribe, the NIHB does not believe that Tribal employers who administer their own plans should be subject to the excise tax. Should the IRS disagree on this point, however, we believe that the Notice 2015-52’s proposed pay and reimburse model will impermissibly inflate Tribes’ excise and income tax based liabilities far beyond the statutory rate specified in Section 4980I. The IRS should abandon this payment model both as a matter of law and tax policy in favor of allowing employers to calculate and pay the tax themselves on any excess benefits they may provide.

¹⁹ The IRS acknowledges this point when it requests comments on a number of difficult issues related to the implementation of this process, such as the manner in which the employer can reimburse the TPA for the income tax-specific portion of the transaction, the discussed issue of whether the income tax payment goes towards cost of coverage, the formula used when calculating the income tax, and other issues. *See* Notice 2015-52 at 7-9.

²⁰ In addition to these tax compliance issues, there would be a number of new contractual issues that would arise out of the employer–TPA relationship once this new tax goes into effect, such as the need to verify the TPA’s marginal income tax rate on which a portion of the claimed reimbursement is based. While those matters are separate from the tax compliance issues themselves, they would result from an unnecessary and questionable interpretation of tax law.

RE: Notice 2015-52 on Section 4980I

October 1, 2015

Thank you for the opportunity to engage with the IRS on this matter. NIHB stands ready to work with the IRS on any necessary follow up issues and looks forward to a continued open dialogue on the excise tax.

Sincerely,



Lester Secatero, Chair
National Indian Health Board

Attachment:

1. Comment on Notice 2015-16 on Section 4980I – Excise Tax on High Cost Employer-Sponsored Coverage, Submitted on May 15, 2015.

National Indian Health Board



May 15, 2015

CC:PA:LPD:PR (Notice 2015-16)
Internal Revenue Service
Room 5203
Ben Franklin Station, P.O. Box 7604
Washington, D.C. 20044

RE: Notice 2015-16 on Section 4980I — Excise Tax on High Cost Employer-Sponsored Health Coverage

I. INTRODUCTION.

I write to the Internal Revenue Service (IRS) on behalf of the National Indian Health Board (NIHB)¹ in response to IRS Notice 2015-16 (the Notice), in which the IRS solicited comments on potential regulatory approaches for implementing Section 4980I of the Tax Code.² Section 4980I establishes an excise tax on certain employer-sponsored health benefits under which coverage providers, including health insurance issuers and employers who administer self-funded plans, must pay a tax on employee plans that exceed certain statutory cost thresholds.³ Thank you for the opportunity to comment on the Notice.

We believe that the plain language of Section 4980I exempts Indian Tribal employers who administer self-funded plans from the excise tax altogether.⁴ This interpretation is further

¹ Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

² See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9001, 124 Stat. 119, 793 (2010), codified as amended at 26 U.S.C. § 4980I. Unless otherwise noted, references to “Sections” of statutes within this comment refer to sections of the Tax Code in chapter 26 of the United States Code.

³ The thresholds are \$10,200 for self-only coverage and \$27,500 for non-self-only coverage, subject to certain adjustments specified in the statute. 26 U.S.C. § 4980I(b)(3)(C).

⁴ Tribal employers who purchase group health insurance for their employees would not be liable for the tax, as liability for the tax is limited to “coverage providers,” which in those cases would be the health insurance issuer rather than the employer itself. 26 U.S.C. § 4980I(c). Any reference to Tribal employers in this comment is therefore limited to those employers administering self-funded plans.

supported as a matter of policy, as applying the excise tax to Tribal employers can significantly burden their ability to provide adequate health benefits to Tribal members and to recruit and retain employees. We therefore urge the IRS to recognize the statutorily mandated Tribal exemption in any eventual implementing regulations.

To the extent that the IRS ultimately construes Section 4980I as applying to Tribal employers, notwithstanding the statutory provisions discussed below, the NIHB believes that the regulations must recognize the unique nature of Tribal benefits and maximize employer flexibility when structuring their plans. This would include distinguishing between Tribal member employees and non-Tribal member employees, excluding various benefit types from the scope of the tax, allowing employers to narrowly tailor their grouped employees when calculating plan value, and clarifying the applicability of the controlled group rules to Tribal entities. We elaborate on all of these points below.

II. DISCUSSION.

a. Longstanding rules of statutory interpretation indicate that Section 4980I excludes Indian Tribal employers from the excise tax.

Section 9001 of the Patient Protection and Affordable Care Act (ACA), which established Tax Code section 4980I, applied the excise tax to excess benefits provided under “applicable employer-sponsored coverage,” as defined in subsection 4980I(d)(1). That subsection includes a provision specific to governmental employers, which states that “applicable employer-sponsored coverage” includes “coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.”⁵ This government plan provision does not mention anything about plans administered by an Indian Tribe or Tribal organization, despite specifically addressing state governments and the federal government.⁶

Under well-recognized rules of statutory interpretation, Congress’s exclusion of Tribal governments from Section 4980I must be considered deliberate. First, statutes of general applicability that interfere with rights of self-governance, such as the relationship between Tribal governments and on-reservation Tribal businesses and their employees, require “a clear and plain congressional intent” that they apply to Tribes before they will be so

⁵ 26 U.S.C. § 4980I(d)(1)(E).

⁶ The IRS has recognized that the government-specific clause must be read as an integrated whole with the introductory language in 26 U.S.C. § 4980I(d)(1)(A), noting that the fact that the government clause only mentions “civilian” governmental plans implicitly means that Congress intended that military governmental plans are not subject to the excise tax. Notice at 8. This interpretation, and the government clause generally, would not make sense if Congress had intended that the excise tax apply to any government plans other than those specified in paragraph (d)(1)(E). See, e.g., *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (courts must “interpret the statute ‘as a symmetrical and coherent regulatory scheme,’ and ‘fit, if possible, all parts into a [] harmonious whole’”) (citation omitted).

interpreted.⁷ Although Congress repeatedly referenced Indian Tribes in the ACA,⁸ and specifically discussed governmental entities in Section 4980I, it did not include Tribes at all in the statutory provision concerning the coverage of the excise tax. This indicates that the Section 4980I does not apply of its own force to Tribal employers who administer their own plans.⁹

Second, there are numerous provisions in the Tax Code that explicitly mention Tribal governmental entities,¹⁰ include Tribally-sponsored benefits within the definition of “governmental plans” in various contexts,¹¹ or specifically note when Tribal governmental entities are to be treated identically to State governments for the purposes of a given rule.¹² These provisions almost all cite the definition of “Indian tribal government” set out in Section 7701 of the Tax Code, a provision which the ACA repeatedly referenced and amended.¹³ So, even though Congress applied numerous provisions in the ACA to Indian

⁷ *E.E.O.C. v. Fond du Lac Heavy Equip. & Const. Co., Inc.*, 986 F.2d 246, 249 (8th Cir. 1993) (Age Discrimination in Employment Act did not apply to employment discrimination action involving member of Indian Tribe, Tribe as employer, and reservation employment); *accord Snyder v. Navajo Nation*, 382 F.3d 892, 896 (9th Cir. 2004) (Fair Labor Standards Act did not apply to dispute between Navajo and non-Navajo Tribal police officers and Navajo Nation over “work [done] on the reservation to serve the interests of the tribe and reservation governance”).

⁸ *See, e.g.*, Section 1402(d)(2) (referring to health services provided by an Indian Tribe); Section 2901(b) (referring to health programs operated by Indian Tribes); Section 2951(h)(2) (referring to Tribes carrying out early childhood home visitation programs); Section 2953(c)(2)(A) (discussing Tribal eligibility to operate personal responsibility education programs); Section 3503 (discussing Tribal eligibility for quality improvement and technical assistance grant awards).

⁹ To whatever extent that there is uncertainty on this front, the Indian canons of statutory construction require that statutes relating to Indians be “construed liberally in favor” of Tribes. *Montana v. Blackfeet Tribe of Indians*, 471 U.S. 759, 766 (1985).

¹⁰ *See, e.g.*, 26 U.S.C. § 54F(d)(4) (including “Indian tribal governments (as defined in [Tax Code] section 7701(a)(40))” as qualified bond issuers for certain projects); 26 U.S.C. § 401(k)(4)(B)(iii) (“An employer which is an Indian tribal government (as defined in [Tax Code] section 7701(a)(40)), a subdivision of an Indian tribal government (determined in accordance with section 7871(d)), an agency or instrumentality of an Indian tribal government or subdivision thereof, or a corporation chartered under Federal, State, or tribal law which is owned in whole or in part by any of the foregoing may include a qualified cash or deferred arrangement as part of a plan maintained by the employer.”).

¹¹ *See, e.g.*, 26 U.S.C. § 414(d) (“The term ‘governmental plan’ includes a plan which is established and maintained by an Indian tribal government (as defined in [Tax Code] section 7701(a)(40)), a subdivision of an Indian tribal government (determined in accordance with section 7871(d)), or an agency or instrumentality of either. . .”).

¹² *See, e.g.*, 26 U.S.C. § 168(h)(2)(A)(i), (iv) (defining “tax-exempt entities” as including both “the United States, any State or political subdivision thereof, any possession of the United States, or any agency or instrumentality of any of the foregoing,” and “any Indian tribal government described in section 7701(a)(40),” and then explicitly noting that “any Indian tribal government . . . shall be treated in the same manner as a State”).

¹³ *See* ACA Section 9010(d)(2) (incorporating definitions from Section 7701); Section 1409(a) of the Health Care and Education Reconciliation Act of 2010 (adding new subsection (o) to Section 7701).

Tribes, clearly knows how to include Tribal governments or health plans within the scope of a particular Tax Code provision,¹⁴ and in the ACA explicitly amended the Tax Code section that includes a commonly-cited definition of “Tribal government,”¹⁵ it did not mention Tribes in Section 4980I’s discussion of governmental entities. “[W]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposeful in the disparate inclusion or exclusion.”¹⁶ Section 4980I must be construed to exclude Tribal plans from the excise tax.

b. Policy considerations support the statutory exclusion of Tribal employers who administer their own plans from the excise tax.

Congress has recognized both that “[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government’s historical and unique legal relationship with, and resulting responsibility to, the American Indian people” and that it is a “major national goal . . . to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States.”¹⁷ Applying the excise tax to Tribal employers that administer their own plans, in addition to running counter to Section 4980I’s statutory language, also undercuts Congress’s national policy towards Indian health.

Many areas with a high concentration of Tribal entities also have some of the steepest insurance prices in the United States. For example, the United Benefits Advisors’ 2014 Health Insurance Cost Survey determined that the average cost of insurance in Alaska was \$12,584.00 per employee, far exceeding the \$10,200 excise tax threshold.¹⁸ At least one

¹⁴ See, e.g., *City of Milwaukee v. Illinois & Michigan*, 451 U.S. 304, 329 n.22 (1981) (“The dissent refers to our reading as ‘extremely strained,’ but the dissent, in relying on § 505(e) as evidence of Congress’ intent to preserve the federal common-law nuisance remedy, must read ‘nothing in this section’ to mean ‘nothing in this Act.’ We prefer to read the statute as written. Congress knows how to say ‘nothing in this Act’ when it means to see, e. g., Pub.L. 96–510, § 114(a), 94 Stat. 2795.”); accord *Arcia v. Fla. Sec’y of State*, 772 F.3d 1335, 1348 (11th Cir. 2014) (“[W]here Congress knows how to say something but chooses not to, its silence is controlling.”) (citations omitted).

¹⁵ See, e.g., Indian Self-Determination and Education Assistance Act, Pub. L. No. 93-638, § 105, 88 Stat. 2203, 2208-09 (1975) (codified as amended at 42 U.S.C. § 215(d), 42 U.S.C. § 2004b) (federal law required to explicitly include Indian Tribes within the scope of statutory benefits previously limited to state and local governments).

¹⁶ *Dean v. United States*, 556 U.S. 568, 573 (2009).

¹⁷ 25 U.S.C. § 1601(1)-(2). We note that the federal government’s budgeting and expenditures do not come close to meeting the requirements of the trust responsibility: IHS is only funded at approximately 56% of need, and a recent contract support cost shortfall was estimated at \$90 million. NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP’S RECOMMENDATIONS ON THE INDIAN HEALTH SERVICE FISCAL YEAR 2015 BUDGET 3, 6 (2013).

¹⁸ Peter Freska, United Benefits Advisors, *The State of Healthcare Insurance – The Top Five Highest and Lowest Costs of Health Insurance* (May 7, 2015),

Tribal employer in Alaska has examined its own benefits packages and determined that current costs are \$11,880.84 per employee for self-only coverage (\$1,680.84 over the statutory threshold) and \$36,236.64 for family coverage (\$8,736.64 over the statutory threshold). These costs do not mean that the Tribe is encouraging irresponsible overuse of health care by offering “Cadillac” plans to their employees. Rather, the high expenses are driven by the necessity of employee recruitment in rural areas and the market forces associated with providing coverage in remote portions of Alaska, factors over which Tribal employers have little control.

Rather than fulfilling the government’s trust responsibility towards Indian health, applying the excise tax to Tribal employers would force the employers into one of the following scenarios:

- **Option 1:** Pay the tax. Tribes must then divert their limited and finite funding away from necessary services such as law enforcement, health care, and other governmental requirements in order to “pay” the IRS. This circuitous process will essentially result in the Tribe receiving federal funding to provide member services and then paying it back to the United States in the form of the excise tax. The Tribe might then be forced to increase employee contribution amounts or cost-sharing in its self-funded plan to make up a portion of the difference.¹⁹
- **Option 2:** Replace its existing plan, which has been carefully tailored according to the needs of the Tribal workforce and the realities of market pressures, with lower-cost insurance. The replacement coverage may be less comprehensive, include fewer in-network providers, or have higher costs for the individual employee. This will result in dissatisfaction and potentially lower health outcomes for the employee and difficulties for the Tribe in employee recruitment and retention.
- **Option 3:** Eliminate employer-sponsored coverage altogether. The Tribe will then become potentially liable for the ACA’s employer mandate penalty, which would again force the Tribe to divert funding back to the federal government. The Tribe will also be placed at a significant disadvantage from a human resources standpoint.

None of these options respect either the trust responsibility or the fact that Tribal design of employee benefits packages is itself an exercise in sovereignty. The NIHB believes that

<http://rss.ubabenefits.com/tabid/2835/Default.aspx?art=prOFd2v2yq4%3D&mfid=ybBRLsooTzo%3D> (calculating the average total amount that an employer can expect to pay to provide insurance for a given employee in a given state or profession, across plan variations and coverage types).

¹⁹ Such an increase could potentially eliminate the Tribal plan’s grandfathered status under the ACA, if applicable. See 45 C.F.R. § 147.140(g)(1).

these policy considerations strongly support the statutory exclusion of Tribes from the excise tax, and we request that the IRS acknowledge that fact in any ultimate regulations.

c. Even if it does not construe the statute as entirely excluding Tribal plans, the IRS should exclude coverage provided to Tribal member employees from the definition of “applicable employer-sponsored coverage.”

In the event that the IRS construes Section 4980I as applying to Tribal employers who administer their own plans,²⁰ we note that the tax applies to the excess benefit provided to any employee covered under any “applicable employer-sponsored coverage.” The term “applicable employer-sponsored coverage” means coverage “under any group health plan made available to the employee by an employer which is excludable from the employee’s gross income under section 106 [of the Tax Code], or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).”²¹ With certain exceptions, Section 106 generally excludes the value of “employer-provided coverage under an accident or health plan” from an employee’s gross income.²²

Coverage for Tribal member employees, however, is not excluded from income pursuant to Section 106, but rather by virtue of Section 139D, which excludes from an individual’s gross income the value of:

- Any health service or benefit provided or purchased, directly or indirectly, by IHS through a grant to or a contract or compact with a Tribe or Tribal organization, or through a third-party program funded by IHS;
- Medical care provided, purchased, or reimbursed by a Tribe or Tribal organization for, or to, a Tribal member (including the member’s spouse or dependent);
- Coverage under accident or health insurance (or an arrangement or plan having the effect of accident or health insurance) provided by a Tribe or Tribal organization for a Tribal member (including the member’s spouse or dependent); and
- Any other medical care provided by a Tribe or Tribal organization that supplements, replaces, or substitutes for a program or service relating to medical care provided by the federal government to Tribes or Tribal members.²³

²⁰ For the remainder of this comment, we will assume *arguendo* that the excise tax rules will apply to Tribal employers who administer their own plans. Tribal employers who purchase coverage for their employees from a plan issuer would not be liable for the tax.

²¹ 26 U.S.C. § 4980I(d)(1)(A).

²² 26 U.S.C. § 106(a).

²³ 26 U.S.C. § 139D(b). This Tax Code provision was implemented pursuant to Section 9021 of the ACA.

Because coverage for Tribal member employees is excludable under Section 139D rather than section 106, it is not included in the definition of “applicable employer sponsored coverage” for purposes of Section 4980I. This is an important distinction, as Tribes may provide members with health insurance as an extension of or in association with an employee plan (whether as a group plan, through premium sponsorship in an ACA Marketplace, etc.). While these benefits might at first glance seem to “mimic” a Section 106 plan to which the excise tax would apply, the coverage would instead be exempt under Section 139D and remain outside the scope of the tax. Any proposed rule issued by the IRS should clarify this fact as a definitional matter in order to ensure that the tax is not levied against benefits provided by a Tribal employer to a Tribal member employee.²⁴ We request that the IRS consult with the NIHB and the Tribal Technical Advisory Group (TTAG)²⁵ concerning specific approaches and language for reconciling any overlap between Section 4980I and Section 139D, and to generally address the application of the excise tax to Tribes.

d. The NIHB supports the IRS’s proposed benefit exclusions from the definition of “applicable employer-sponsored coverage.”

The Notice seeks comment on whether or not the IRS should exclude the following benefits when calculating the value of an employee’s total compensation package: (1) certain types of on-site medical coverage; (2) Employee Assistance Program (EAP) benefits;²⁶ and (3) self-insured dental and vision coverage.²⁷ The NIHB supports the exclusion of all three sets of benefits from the tax.

With regard to on-site medical services, the IRS states that it already plans on excluding such services from the excise tax so long as they (1) are provided at a facility that is located on the premises of an employer or employee organization; (2) consist primarily of first aid that is provided during the employer’s working hours for treatment of a health condition, illness, or injury that occurs during those working hours; (3) are available only to current employees,

²⁴ In addition, we believe that the regulations should recognize that applying the excise tax to Tribal member plans will frustrate one of the key goals in enacting Section 139D, as Tribes will be less likely to provide such tax-exempt benefits to their members (employee or otherwise) if they are concerned that doing so could subject the Tribal fisc to liability under Section 4980I.

²⁵ The TTAG advises CMS and other federal agencies on Indian health policy issues involving Medicare, Medicaid, the Children’s Health Insurance Program, and any other health care program funded (in whole or in part) by CMS. In particular, the TTAG focuses on providing policy advice regarding improving the availability of health care services to AI/ANs under federal health care programs.

²⁶ Generally, EAPs offer free and confidential assessments, counseling, referrals, and follow-up services to employees who have personal and/or work-related issues affecting mental and emotional well-being, such as alcohol and other substance abuse, stress, grief, family problems, marital distress, workplace issues, and psychological disorders.

²⁷ Fully-insured dental and vision coverage are statutorily excluded from the calculation. 26 U.S.C. § 4980I(d)(1)(B)(ii).

and not retirees or dependents; and (4) are provided with no charge to the employee.²⁸ The IRS is seeking comment on whether it should also exclude more complex benefits from the tax.²⁹

As an initial matter, we note that Section 139D exempts medical care provided by a Tribe to its members and their spouses and dependents from taxable income. It would be incongruous, to say the least, to implement Section 4980I in a manner that would count the value of such services towards an employee's total compensation package. This is particularly true given that Section 139D, which was enacted to implement federal trust responsibility, is designed to confirm that when a Tribe provides IHS-funded health service to their members, spouses and dependents under the ISDEAA, the value of such services is not considered income to the receiving individual. Section 4980I should not be interpreted in a manner that would nonetheless penalize a Tribe for providing ISDEAA-mandated health care to its members simply because those members are employees covered under a self-funded plan.

In addition, we believe that the IRS should exempt from the excise tax any medical services provided to any employee by an I/T/U program for workplace-related health issues, and should expand the exemption even to services provided at the nearest appropriate Tribal health program (whether or not on-site). First, with regard to the on-site requirement, employees in urban areas may have fairly easy access to urgent care centers, hospitals, or other health facilities should they not want to obtain services at an on-site clinic. By comparison, the remote location of many Tribal businesses means that the local Indian health program, regardless of where it is specifically situated, might be the only geographically viable option for treating work-related injury or illness or for providing other necessary care during the workday. Requiring that the facility be located on-site ignores this reality and might automatically exclude Tribal employers that (rightfully) rely on an Indian health facility to treat employee conditions. The IRS should accordingly extend the workplace exception to care provided to employees at the nearest appropriate facility, even if it is technically not on the employer's campus.³⁰

Second, and as discussed above, Section 139D encourages Indian health programs to provide health services to Tribal members by excluding the value of such services from the individual's gross income. If the cost of this care is then counted towards the excise tax, Tribes (especially those with large populations of employee-members) may be forced to reconsider the scope of certain services they can afford to provide to their member-employees as a tax-exempt workplace benefit. This will run counter to congressional intent by "punishing" the Tribe for seeking to provide quality care and benefits to its employees. Again, we believe that the IRS should consult with the NIHB and the TTAG concerning the

²⁸ Notice at 8-9.

²⁹ *Id.* at 9.

³⁰ In the alternative, the IRS could designate any facility located within the boundaries of a current or former Indian reservation or Alaska Native Village, or otherwise located on Tribal trust land, as being "on-site" for any associated Tribal employer.

potential scope of an Indian-specific exclusion with regard to the treatment of workplace health issues.

We similarly believe that EAP benefits should not count towards the excise tax. AI/ANs suffer from a disproportionate level of substance abuse,³¹ violence against women,³² and suicide,³³ and have one of the highest rates of unemployment of any ethnic group.³⁴ These are precisely the types of issues that EAPs seek to address, with benefits extending to the individual employee, his or her family, the Tribal workplace, and the community at large.³⁵ Tribal employers can also tailor their EAPs to provide culturally-appropriate services, which may be an employee's only opportunity to receive such benefits and the difference between whether or not an employee ultimately seeks EAP assistance. Subjecting EAP benefits to the excise tax will discourage Tribal employers from continuing to offer such programs and will disproportionately disadvantage AI/AN communities.³⁶

Finally, we support the IRS's proposal to exclude self-insured dental and vision plans from the excise tax.³⁷ This will assist the ability of Tribal employers to provide quality coverage to their employees without incurring additional costs under Section 4980I.

e. The NIHB supports flexible disaggregation rules.

In most cases, the IRS will determine the value of a health care plan for the purposes of the excise tax by evaluating the average plan cost among all "similarly situated beneficiaries."³⁸ While Section 4980I requires that employers group self-only coverage enrollees separately from non-self-only coverage when determining which beneficiaries are "similarly situated,"³⁹

³¹ U.S. SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, THE TEDS REPORT: AMERICAN INDIAN AND ALASKA NATIVE SUBSTANCE ABUSE TREATMENT ADMISSIONS ARE MORE LIKELY THAN OTHER ADMISSIONS TO REPORT ALCOHOL ABUSE 1 (NOV. 18, 2014).

³² NATIONAL CONGRESS OF AMERICAN INDIANS, NCAI POLICY RESEARCH CENTER, POLICY INSIGHTS BRIEF: STATISTICS ON VIOLENCE AGAINST NATIVE WOMEN 2-3 (FEB. 2013).

³³ SUICIDE PREVENTION RESOURCE CENTER, SUICIDE AMONG RACIAL/ETHNIC POPULATIONS IN THE U.S.: AMERICAN INDIANS/ALASKA NATIVES 1 (2013).

³⁴ Jens Manuel Krogstad, *One-in-four Native Americans and Alaska Natives are Living in Poverty*, PEW RESEARCH CENTER (June 13, 2014), <http://www.pewresearch.org/fact-tank/2014/06/13/1-in-4-native-americans-and-alaska-natives-are-living-in-poverty/>.

³⁵ While this is particularly notable in the Tribal context, this is also generally true among workplaces nationwide.

³⁶ In the alternative, if the IRS ultimately includes EAP benefits within the scope of the excise tax, the NIHB requests that such programs be exempt if offered by a Tribe or Tribal organization.

³⁷ Notice at 9-10.

³⁸ *Id.* at 4.

³⁹ 26 U.S.C. § 4980I(d)(2)(A).

the IRS has broad discretion to consider other methods of permissible employee groupings.⁴⁰ The IRS is accordingly considering whether to promulgate “permissive disaggregation” rules under which employers would be able to designate plan beneficiaries as “similarly situated” based on either “a broad standard (such as limiting permissive disaggregation to bona fide employment-related criteria, including, for example, nature of compensation, specified job categories, collective bargaining status, etc.) while prohibiting the use of any criterion related to an individual’s health),” or else a “more specific standard (such as a specified list of limited specific categories for which permissive disaggregation is allowed),” including current and former employees or bona fide geographic distinctions.⁴¹

The NIHB urges the IRS to adopt broad permissive disaggregation rules that maximize employer flexibility to group plan beneficiaries according to the unique needs of the employer’s workforce.⁴² Determining who is “similarly situated” with respect to the cost of health care will require a nuanced understanding of the nature of the employer’s business, the specific needs of the employee population, geographic considerations concerning cost of care, etc. Forcing employees into very general categories may artificially skew the actual cost of coverage to the disadvantage of employers.

This is particularly apparent in the case of Tribal government employers. Tribes employ individuals to perform a broad spectrum of commercial and governmental functions, and might simultaneously be insuring physicians, timber cutters, office employees, policemen, and sanitation workers, all of whom might have position-specific needs in a health plan. In addition, insurance plans in frequently-remote Tribal areas tend to be expensive, have high cost-sharing amounts, or be less comprehensive than plans available in urban settings.⁴³ Requiring a Tribal employer to institute a “one size fits all” approach would not work well in these circumstances, and the excise tax rules may be better and more rationally applied if Tribes (and other employers with diverse workforces) have the flexibility to treat disparate groups of employees as covered by different plans.

f. The NIHB supports a flexible application of the past cost methodology for calculating plan value.

An additional area in which the IRS seeks comment is the manner in which self-insured plans would calculate plan values to compare against the statutory threshold. The agency has

⁴⁰ Section 4980I merely requires that the IRS establish rules “similar” to those governing employee aggregation when determining COBRA premiums. 26 U.S.C. § 4980I(d)(2)(A) (referring to the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272 (1986)).

⁴¹ Notice at 14.

⁴² Congress has equally recognized the necessity for adjusting patient pools by including specific statutory considerations based on age and gender, retirement status, and plan costs for individuals engaged in high-risk professions. *See* 26 U.S.C. § 4980I(b)(3)(C)(iii), (f).

⁴³ *See, e.g.*, Letter from Monica J. Linden, Commissioner, Montana Department of Securities and Insurance, to Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services (Mar. 10, 2014) (recognizing practical difficulties for Tribal employers in finding and offering adequate employee coverage).

proposed three primary options: the actuarial method, under which the cost of applicable coverage for a given determination period would be calculated using “reasonable actuarial principles and practices,” the past cost method, under which the cost of coverage would be equal to the cost to the plan for similarly situated beneficiaries for the preceding determination period (adjusted for inflation), or the actual cost method, under which the cost of coverage would be equal to the actual costs paid by the plan to provide health coverage for the preceding determination period.⁴⁴

With the caveat that the NIHB supports whichever methodology that maximizes flexibility for Tribal employers, we believe that some version of the past cost methodology will ultimately prove preferable. Compliance with an actuarial methodology (currently an undefined term) may require Tribes to expend significant resources on accountants, benefits administrators, or similar expert services in order to comply with the specifics of the methodology. By comparison, a past cost methodology is more likely to correspond with existing Tribal budgeting practices and will result in less disruption to their business. We agree, though, with the IRS’s recognition that the specifics of determining plan costs under any such methodology are complex enough to warrant further attention at a later date,⁴⁵ and request that the IRS consult with the NIHB and the TTAG in the interim for a more in-depth examination of methods that would prove most conducive for Tribal employers.

We also wish to respond to the IRS’s request for comment as to whether various individual costs should or should not be included in the overall value of employee plans when using the past cost methodology.⁴⁶ Specifically, the IRS should not include overhead expenses, which it defines as “salary, rent, supplies, and utilities . . . being ratably allocated to the cost of administering the employer’s health plans” within the calculation.⁴⁷ We believe that this may disproportionately yield higher costs for Tribal employers, which frequently have increased overhead associated with attempts to retain employees and do business in remote locations (particularly in Alaska, which has far higher costs of living and conducting business than in most of the lower 48 states).⁴⁸ Limiting the calculation to direct costs would be a fairer and better-grounded approach from a Tribal perspective.

g. The IRS should acknowledge the good faith standard applicable to government entities when implementing controlled group rules.

Section 4980I states that for the purposes of calculating benefit plan costs, “[a]ll employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 [of the Tax

⁴⁴ Notice at 15-20.

⁴⁵ *Id.* at 20.

⁴⁶ *Id.* at 17.

⁴⁷ *Id.*

⁴⁸ This does not even consider the practical difficulty, if not impossibility, of determining what proportion of general employer overhead applies to health plan administration.

Code] shall be treated as a single employer.”⁴⁹ These provisions, known as the “controlled group rules,” are part of the Employee Retirement Income Security Act of 1974 (ERISA) and generally govern circumstances in which employees of commonly controlled corporations, trades, or businesses will be treated as employees of a single, common entity.

However, the IRS has explicitly reserved application of the controlled group rules to governmental employers and has stated that government entities may “apply a reasonable, good faith interpretation” of the rules in other ACA-related contexts, such as the employer mandate.⁵⁰ The NIHB requests that the IRS recognize either in subsequent Notices or regulations that a Tribe’s good faith interpretation of the controlled group rules applies for the purposes of both the employer mandate and the excise tax, and that satisfying the standard in one context will equally satisfy the standard in the other. If not, Tribes will be forced to treat its enterprises differently under related ACA compliance requirements, which will be costly, administratively burdensome, and increase the risk of accidental errors in calculating excise tax or employer mandate liability.

III. CONCLUSION.

Section 4980I has the potential to seriously affect Tribes’ ability to structure employee benefit packages in accordance with Tribal-specific needs. Because the statute excludes Tribes from the list of covered governmental entities, and in light of the numerous other places in which the Tax Code explicitly applies to Tribes, the NIHB does not believe that Tribal employers who administer their own plans should be subject to the excise tax (both as a matter of law and policy). Should the IRS disagree on this point, however, it should at least recognize the distinctions between member and non-member employees as required by Section 139D, and should implement regulations maximizing employer flexibility in plan design. The NIHB also requests Tribal consultation with the IRS in order to ensure that the excise tax regulations properly reflect these concerns.

Thank you for the opportunity to engage with the IRS on this matter. The NIHB stands ready to work with the IRS on any necessary follow up issues and looks forward to a continued open dialogue on the ACA excise tax.

Sincerely,



Lester Secatero, Chair
National Indian Health Board

⁴⁹ 26 U.S.C. § 4980I(f)(9).

⁵⁰ Information Reporting by Applicable Large Employers on Health Insurance Coverage Offered Under Employer-Sponsored Plans, 79 Fed. Reg. 13,231, 13,234 n.3 (Mar. 10, 2014). To our knowledge, the IRS has not provided any additional guidance on this point.

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education

P.O. Box 1734, McAlester, OK 74501

Telephone (918) 302-0252 ~ Facsimile (918) 423-7639 ~ Website: www.tribalselfgov.org*Sent Electronically to: Denise.Turk@ihs.gov*

August 4, 2015

Mr. Robert G. McSwain, Principal Deputy Director
Indian Health Service
U.S. Department of Health and Human Services
Suite 440, The Reyes Building
801 Thompson Avenue
Rockville, MD 20852-1627

RE: Quality Reporting Measures

Dear Principal Deputy Director McSwain:

On behalf of the Tribal Self-Governance Advisory Committee (TSGAC), I am writing to provide you with our recommendations regarding quality reporting measures and to request IHS to conduct an analysis. As you are aware, the trends for both Medicare and Medicaid are to require providers to utilize their electronic medical records as part of clinical quality management. TSGAC and the Tribal Technical Advisory Group (TTAG) for the Centers for Medicare and Medicaid Services (CMS) have had discussions with CMS about using GPRA measures instead of the clinical quality management approaches. However, it appears that those recommendations have not gained any traction in CMS or HHS.

The proposed Medicaid Managed Care regulations¹ intend to align the Medicare and Medicaid quality measures so that health care delivery systems do not duplicate their efforts. We believe that the IHS and Tribes should also be aligning their quality assurance with the Medicare and Medicaid approaches, particularly since there may be economic consequences with regard to revenue from these important sources of payment for services.

Therefore, we would like to request that IHS conduct an analysis and comparison of the GPRA and Clinical Quality Management approaches. This analysis could include the following information:

- a. Timelines for each (Are they the same or different?)
- b. Type of data collection (What types of data are being collected? Are they the same or different?)
- c. Cost of data collection (What is the cost, to include equipment and software and human resources, of GPRA data collection system wide? How does that compare to the estimated cost of collecting data under Clinical Quality Management approaches that are in regulation or proposed regulations? What is the cost of doing both, versus one or another?)

¹ Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability; Proposed Rules, 80 Fed. Reg. 31,097 (June 1, 2015) ("Proposed Rule").

Many Self-Governance Tribes have been actively involved in GPRA pilot projects over the past several years. It would be helpful to know how many Self-Governance Tribes are reporting GPRA data and how many are not.

The reason we are asking IHS to conduct this analysis and provide a written report is that we think it is important for the IHS and Tribes to work together on a common goal. That goal could be to exempt Indian health from GPRA reporting, or it could be to use GPRA instead of Medicare and Medicaid clinical quality measures. Alternatively, we may find that there is no duplication of effort and the costs of doing both are negligible. Before we can make a recommendation on this important topic, we need to be better informed about the consequences of each approach.

We would like to put this important topic on our agenda for the next TSGAC quarterly meeting on October 6, 2015 and request that you assign someone to conduct this analysis and present a report of the findings at that meeting.

Should you need additional information or have questions regarding this letter and request, please contact me at (860) 862-6192; or via email: lmalerba@moheganmail.com. Thank you.

Sincerely,



Chief Lynn Malerba, Mohegan Tribe
Chairwoman, TSGAC

cc: P. Benjamin Smith, Director, OTSG, IHS
TSGAC and Technical Workgroup



June 30, 2015

Secretary Sylvia Mathews Burwell
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Re: Secretary's Tribal Advisory Committee Follow up from December meeting

Dear Secretary Burwell,

On behalf of the Secretary's Tribal Advisory Committee (STAC), we would like to express our deep gratitude for the highly very productive meeting on June 2-3, 2015. Your commitment to top concerns of Indian Country is clear, and we look forward to working you and the whole Department of Health and Human Services (HHS) to accomplish some of the key goals of Indian Country, especially when it comes to health.

In order to advance this productive relationship, we would like to present this letter to reiterate some of the topics discussed at the meeting, and share additional topics that did not get addressed at the meeting due to time constraints. The following letter does not constitute a comprehensive list of Tribal priorities for HHS, but represent some of the critical issues for Indian Country.

Mental Health and Suicide Epidemic

The STAC would like to thank you and your staff for the serious attention you are giving the recent suicide epidemic in Indian Country. Although the root causes of this crisis are complex, we are encouraged by the efforts at HHS to try to address it. Tribal leaders reiterate their desire to work in partnership with the agency on this matter to address both the short-term crisis and long-term strategies. To summarize our conversation at the meeting, we have the following recommendations:

- Better coordination of care between primary care and behavioral health services
- Better integration of culture and traditional spiritual practices into health care services at the local level
- Additional funding for staffing resources in Indian Country for mental health professionals and additional training for staff in local areas to be able to identify problem areas (i.e. increased funding under the Tribal Behavioral Health Grants)
- Additional funding for nationwide research on historical trauma and Adverse Childhood Experiences in Indian country
- Extensive listening to Native youth on this crisis for causes and solutions. This should include those who have been directly affected by suicide in the community including survivors, parents, friends and other loved ones
- Engaging communities in efforts to destigmatize mental and behavioral health issues and treatment
- Creation of demonstration projects to address mental and behavioral health in Indian Country and increased support for existing grant programs that address youth suicide and mental health

- Deploying immediate assistance, in consultation with the affected communities and in a culturally sensitive manner, to communities currently addressing suicide epidemics.
- Addressing long-term issues such as the dire economic conditions in many communities
- Inclusion of tribal representation on inter-departmental working groups to address the issue

Implementation of the Affordable Care Act – Centers for Medicare and Medicaid Services

The STAC would like to present our top four priority issues related to the implementation of the Affordable Care Act below.

We are concerned that the cost-sharing protections that are specific to American Indians and Alaska Natives, and are detailed in CMS regulations, might be being implemented in a manner that is not consistent with the regulations. Specifically, as detailed in 45 CFR § 155.350(b) and as explained in the preamble to the final rule on this provision, American Indians and Alaska Natives (AI/ANs) who meet the definition of Indian under the Affordable Care Act and who are enrolled in Marketplace coverage are eligible for at least the “limited cost-sharing variation.” (Those with incomes determined to be between 100 percent and 300 percent of the federal poverty level and who are eligible for premium tax credits are eligible for the “zero cost-sharing variation.”) We would like to engage with CMS to review these provisions and confirm that the provisions are being implemented in a manner consistent with the regulations and with the underlying provisions in the Affordable Care Act.

- We request that CMS consult with Tribes on this issue and review 45 CFR § 155.350(b).

On a related note, during a webinar presented on May 19th, CMS presented information that there is a cap for limited cost-sharing for American Indian and Alaska Natives at 400% of the FPL. CMS has since acknowledged that they presented incorrect information and that there is no cap for limited cost-sharing for AI/ANs. Correct information is critical to ensure increased enrollment in Indian Country.

- We request that CMS thoroughly train all personnel on the AI/AN special provisions and protections if they are going to be presenting information on it so that they are consistent in their messaging to Indian Country.

As documented in a recent study by the Tribal Self-Governance Advisory Committee to the Indian Health Service, government established requirements in the Federally Facilitated Marketplace (FFM) have had a positive impact on the number of QHP contract offers to Indian Health Care Providers (IHCPs) in FFM states when compared to contract offers to IHCPs in non-FFM states. But, we are seeing that some Qualified Health Plan (QHP) issuers are not offering contracts to IHCPs in FFM states per the Center for Consumer Information and Insurance Oversight (CCIIO) requirements. In addition, some QHP Issuers in FFM states are not including the QHP (Indian) addendum when they do offer contracts to IHCPs. In non-FFM states, though, offers of contracts to IHCPs by QHP issuers is much less frequent, with or without the QHP Indian Addendum.

- We recommend that CCIIO investigate non-compliance by QHP Issuers in FFM states and require non-FFM states adopt policies to ensure QHP issuers in their state meet the federal network adequacy standards, and absent meeting the standards institute a back-up mechanism requiring the adoption of the requirements in the CCIIO 2015 and 2016 Issuer Letters.

Our fourth priority issue is that some QHPs are requiring IHCPs to provide a referral for cost-sharing protections for each item or service the AI/AN receives from non-IHCPs. This is not practical and is resulting in blocking access to needed health care for these AI/AN enrollees in Marketplace coverage.

- We would like a comprehensive or blanket referral for cost-sharing that would apply to all medically necessary services that the AI/AN receives from non-IHCPs.

Arizona Medicaid Expansion Waiver – Centers for Medicare and Medicaid Services

In March, Arizona passed SB 1092, which will require the Director of Arizona's Medicaid program, Arizona Health Care Cost Containment System (AHCCCS), to apply for an 1115 waiver to the Centers for Medicare and Medicaid Services (CMS) by March 30 of each year for permission to institute cost-sharing requirements, work requirements and lifetime limits for adults receiving AHCCCS benefits.

Some of the requirements of SB 1092 include the following:

1. Institute a work requirement for all able-bodied adults receiving AHCCCS services, excluding long term care, to become employed, actively seek employment, attend school or a job training program, or both at least 20 hours a week, and to verify compliance with this requirement and any change in family income.
2. AHCCCS will verify when a person is seeking employment and to confirm changes of family income and re-determine eligibility for services
3. AHCCCS can ban an eligible person for one year if the individual knowingly fails to report family income changes or makes a false statement regarding work related requirements
4. Place a five-year lifetime limit of benefits on able-bodied adults that begins on the effective date of the waiver or amendment to the current waiver, excluding any previous time a person received AHCCCS benefits.

These requirements will have lasting negative and devastating impacts on the American Indian population in Arizona. The Inter-Tribal Council of Arizona estimates that more than one-third of the approximately 100,000 Tribal members now enrolled in AHCCCS would be adversely affected. These requirements are beyond the capabilities of most American Indians in Arizona. For the most part, there are few job opportunities on Indian reservations in Arizona. There is only a hand-full of employment sources.

Imposing these requirements on the most impoverished areas in the State only compounds the hopelessness and lack of adequate health care that prevail. Medical services to citizens who are in dire need of preventative health care for diseases such as diabetes will terminate. Federal reimbursement will also no longer be available.

- We urge the Secretary to deny this waiver request as it will have a significant detrimental impact to American Indian population in Arizona.

Employee Contract Settlement – Indian Health Service

On May 22, Acting Director of the IHS Robert McSwain notified Tribes that the Indian Health Service had reached an agreement with employee unions. The settlement resolves claims by IHS employees for overtime compensation for work that they performed in or for federally-operated IHS hospitals, clinics, or facilities and for which they were not adequately paid. The total amount of the settlement totals \$80 million. Of that \$80 million, \$20 million will come FY 2015 funding that was originally designated for staffing at the Kayenta Health Center in Arizona. The remainder of the settlement (\$60 million) will come from past year's appropriations and third party collections. Tribes are concerned that there was not any notification to Tribes on this matter until the settlement was finalized and that the funds used to pay this settlement will negatively impact patient care and other IHS operations. Indian Country believes that a supplemental appropriations request from Congress would have been more appropriate to address this concern.

- Please provide additional details on how the settlement funds will be allocated at the service unit level with an explanation of what the funds would have been previously used for.

Special Diabetes Program for Indians – Indian Health Service

The Special Diabetes Program for Indians (SDPI) is a program with significantly demonstrated successes. Data clearly shows that these interventions are working to decrease diabetes and obesity amount our population. However, this program has not received an increase from Congress since 2002. Many new Tribes would like to receive this money, but cannot without cutting others. The HHS has requested funding for this program at only \$150 million/ 3 years. The Tribal request has consistently been \$200 million / 5 years. One way to achieving this increase would be to request it in the President's Budget.

- Why has HHS not asked for an increase to this highly successful and underfunded program?
- Can HHS commit to asking for increased funding for SDPI in FY 2017 (\$200 million for 5 years)?

Contract Support Costs – Indian Health Service

Tribes are in support of achieving mandatory appropriations for Contract Support Costs (CSC) at the IHS. We would like to reiterate our gratitude that you heard this request and submitted it in the President's FY 2016 Budget Request. Tribes have concerns about the proposed 2 percent set-aside for Administrative costs outlined in the proposal and the fact that it was only a proposed as a three-year option. Therefore, we encourage you to:

- Work with Congress to support permanent mandatory funding of CSC without the 2 percent Administrative set-aside.

Tribal Oral Health Profiles – Indian Health Service

American Indians and Alaska Natives suffer disproportionately from oral health afflictions more than other ethnic groups. AI/AN children ages 2-5 have six decayed teeth, while the same age group in the U.S. population has only one. Tribes continually list dental health as one of their top budget priorities,

but the statistics for oral health disease in our communities remain the same. More must be done. A good starting point, would be for Tribes to have more information about the status of dental health in their communities through the creation of an “oral health profile” at the Tribal level. This profile should include tribal specific data of dental service needs in Tribal Communities; dental provider rates and shortages (number of dentists, dental hygienists, dental assistants and their ethnicity); available dental facilities (dental operatories and their utilization) and turnover rates for providers over a 10 year period. It would also be useful to know the Purchased/Referred Care backlog for dental care services over the past ten years, (ie., deferred services for any dental care services.) For example, according to the FY 2016 President’s Budget Request: “Approximately 90 percent of the dental services provided fall into the basic dental services by category.” It would be very helpful for Tribal government officials to know exactly what their specific community service needs are as they work to staff dental facilities in their communities. Some Tribes have completed this assessment out of their own funds, but many do not have that capacity. We request that IHS provide this for Tribes.

- Can IHS Dept. of Oral Health create these "oral health profile" reports with input from area offices and services units?
- Can the IHS present a report on the use of Electronic Health Records in Federal Direct Service Units? Is there collective information on each of the billable dental codes for each Area and nationally? Can the Dental Support Centers provide similar information for the Self-Determination and Self-Governance Tribes?
- Could the IHS or HRSA develop an oral health workforce plan that identifies what it would take to fully staff each Tribal Community with a complete team of dentists, dental therapists, hygienists and dental assistants? This plan might propose a 5 to 10 year strategy for doubling the workforce and describing what is happening in each Area to encourage American Indians and Alaska Natives to consider becoming a part of the oral health workforce.

Hepatitis C in Indian Country – Indian Health Service:

Hepatitis C Virus (HCV) affects an estimated 150 million persons worldwide, and about 5 million in the United States. National data suggest that there are many tens of thousands of HCV patients in Indian Country, with a high proportion of them undiagnosed. We appreciate the statement of HHS in the response to STAC’s December 2014 letter. The response implies that all of the HCV treatments are accessible and affordable at all IHS facilities. However, experience has demonstrated that simply inclusion on a formulary does guarantee access.

- Given the epidemic proportion of the increasing diagnosis rates, and the high curability of the disease, STAC is asking IHS to create a program with a specific funding allocation to deal with this and potentially end this disease in Indian Country.
- We request the Indian Health Service to provide STAC with data on many people within IHS service population have been diagnosed with HCV and how any are currently receiving treatment through IHS?
- The Committee recognizes IHS’ contributions and participation in the formulation of the HHS action plan, and would like to see a report on IHS’ progress achieving the goals and action items for which they are named as a participating agency. The Committee would also like to know

IHS' plan to develop more specific policies that relate to operationalizing the action items named in the HHS action plan (including guidance, policies or procedures for clinics and hospitals to follow).

- The agency's response to the December 2014 letter indicated that "All HCV treatment products are available for purchase through the IHS National Core Formulary (NCF)." The STAC would like to know if these options meeting patients' needs. The Committee would like some assurance that patients know of their HCV status, know their care management plan, and know when they can expect treatment.

Medical Marijuana Policy

Tribal governments are grappling with the question of how to best regulate marijuana in our communities. The answer will be different at every Tribe. For example, many Tribal elders take prescription medications with terrible side effects, and medical marijuana could offer a good alternative for some of these patients. The widespread increase in medical marijuana use calls into question the position taken in the Controlled Substances Act (CSA) that marijuana has "no currently accepted medical use." Yet, despite the fact that medical marijuana is legal in more than 35 states, IHS "recommended" in a 2011 letter 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."

Many tribes are seriously considering participating in a grow or dispensary enterprise as an actor or regulator. The Department of Justice has been unhelpful in understanding the boundaries of federal prosecutorial discretion. This is not a hypothetical concern. On May 8, 2015 Washington State Governor Jay Inslee signed into law HB 2000 , Marijuana — State Agreements with Indian Tribes, which authorizes the Governor to enter into agreements with federally recognized Indian tribes regarding any marijuana-related issue that involves both state and tribal interests or otherwise has an impact on tribal-state relations. The law exempts tribes from state sales, excise, and use taxes with respect to tribal commercial activities involving marijuana, but only where such exemption is covered by a tribal-state agreement. The law authorizes licensed marijuana retailers to purchase and receive marijuana and processed marijuana products from a federally recognized Indian tribe as permitted by a tribal-state agreement. And the law authorizes state licensed marijuana producers and processors to sell and distribute marijuana and processed marijuana products to a federally recognized Indian tribe as permitted by a tribal-state agreement.

Tribes must understand the consequences to federal funding that may be tied to CSA limitation and to federal agency policy. A viable and profitable economic venture must be balanced with an understanding of affects to federal Indian program funding. Further, a number of medicinal uses of cannabis are proven efficacious for a select number of afflictions. The use of medicinal prescriptions for tribal members at tribal IHS funded clinics needs to be analyzed in the context of the CSA and IHS policy.

As Tribes exercise their sovereignty on this issue, we seek HHS' open communication and transparency.

- Please share any policies of HHS that may affect a tribe that legalizes marijuana.

- Please share whether HHS has consulted with the Department of Justice regarding its enforcement priorities regarding marijuana in Indian Country.
- Please share where HHS or any of its agencies have withheld any funding to State governments based on their legalization of recreational or medical marijuana.
- Please share whether HHS is prepared at this time to engage in government-to-government consultations with individual tribes that intend to legalize marijuana.
- Would a tribe's HHS program funds be jeopardized should the tribe, or a subdivision or subsidiary of the tribe, operate a marijuana grow or dispensary enterprise on its tribal lands?
- Would a tribe's HHS program funds be forfeited or at risk in any way should the tribe regulate a third-party operated marijuana grow or dispensary enterprise on its tribal lands?
- Would a tribal organization / consortium HHS program funds be forfeited or at risk in any way should a member tribe of the organization / consortium operate or regulate a marijuana grow or dispensary enterprise on the tribal lands whereupon the tribal organization / consortium programs are operated?
- Has HHS or any directorate within HHS issued a policy statement or guidance about implications of a tribe's operation or regulation of a marijuana grow or dispensary enterprise on tribal lands? If not, is there a plan to release such guidance?
- Is any HHS regulation involved in the human consumption of marijuana products, including medicinal, smoking, inhalant or edible products? And if so, under what statute and regulations?
- Does "Federal property" in the CSA refer to any HHS funded facility or real property?

Implementation and Expansion of P.L. 102-477

Since 1992, the 477 program has allowed tribes and tribal organizations to consolidate programmatic employment related funding from the Departments of Interior, Health and Human Services and Labor, while streamlining program approval, accounting and reporting mechanisms, thus offering a model for Administrative Flexibility. The law empowers tribes and tribal organizations with the ability to increase efficiency, decrease administrative burden, increase self-determination and ensure superior results than their counterparts at the state and county level, all while maintaining program guidelines. Streamlined funding for 477 Plans through transfers under the provisions of the Indian Self-Determination and Education Assistance Act ("ISDEAA") has been an essential element of the success of the 477 Program. HHS programs, including TANF, Child Care and Native Employment Works are important components of this successful program. The STAC respectfully urges the Secretary to use your administrative powers to take steps that will fulfill the promise of this important tool for AI/AN success in moving people from welfare to work, such as:

- Remove new guidance requiring one or two years of managing a program and three previous clean audits (already required by the 477 Initiative) before inclusion into a tribe's 477 Plan.
- Assure in writing that funds will continue to be transferred through ISDEAA contracts and compacts.
- Return to reporting mechanisms that worked so well prior to 2009, and permanently rescind the 2009 Compliance Circular.
- Include other eligible programs into 477, such as LIHEAP, Community Services Block Grant, Tribal Vocational Rehabilitation, and Head Start.
- Support enactment of H.R. 329, and S.1443 bills that will amend the Indian Employment, Training and Related Services Demonstration Act of 1992 to facilitate the ability of Indian tribes to integrate

the employment, training, and related services from diverse Federal sources, and for other purposes.

Self-Governance Title VI proposal

We appreciate the Department's engagement on the expansion of Self-Governance within HHS. Multiple studies on this topic have found that this is feasible. Expanding Self-Governance translates to greater flexibility and efficiency with federal resources for Tribes to provide critical social services within agencies such as the Administration on Aging, Administration on Children and Families, Substance Abuse and Mental Health Administration, and Health Resources and Services Administration. The Self Governance Tribal Federal Workgroup (SGTFW) provided evidence in the success of the governance concept and made great strides in identifying a way forward in this federal-tribal partnership and process. We believe re-establishing a workgroup on this most important subject is in accord with this concept and approach. Tribes firmly believe that a pilot initiative would constructively advance the federal-tribal partnership.

- We reiterate our for a request that a renewed Tribal Federal workgroup to continue the work left undone (Pilot Title VI of ISDEA) at the cessation of the Self Governance Tribal Federal Workgroup (SGTFW) two years ago.

Head Start – Administration for Children and Families

Head Start programs provide vital services to Tribal communities, despite the fact that only 16 percent of age-eligible Indian child population is enrolled in Head Start. Only about 188 Tribes have access to the program, and few of those programs actually have sufficient funding to implement the necessary program improvements that would result in better outcomes for our young people. The Indian Head Start programs are required to comply with approximately 1,900 program standards, which often places a significant burden on already tight program resources.

Culture and language play a critical role in Indian Head Start programs, yet Native elders are not certified teachers. Programs currently must hire additional, certified staff merely to accompany the very elders who are in fact most highly qualified to educate Native children on cultural and linguistic matters. Indian Head Start is deeply committed to providing excellent programs. However, there needs to be further dialogue about developing reliable measurements of program quality in culturally diverse environments. The Classroom Assessment Scoring System (CLASS) lacks valid research on American Indian and Alaska Native children and was designed as a professional development tool rather than a monitoring tool. Triennial reviewers using CLASS have not proved to be culturally sensitive, placing programs in jeopardy based on the Designation Renewal System's (DRS) criteria. The use of CLASS to automatically trigger placing the lowest-scoring 10% in DRS regardless of their CLASS score is problematic.

- Lightening this regulatory burden, in accordance with recommendations in development from the National Health Start Directors Association, would free up vital staff and resources, particularly as many of these regulations impose unfunded mandates that require Indian Head Start programs to divert already scarce program resources.
- Head Start programs need additional Quality Improvement funds. Indian Head Start programs are deeply committed to providing high-quality services to Native children and their families. These programs, therefore, desperately need adequate Quality Improvement funds for staff training and

development, staff retention, improved classroom facilities, increased services, and other program needs.

- Tribes should, therefore, be able to develop their own locally designed certification programs in order to certify teachers for their Indian Head Start programs. Head Start programs should be able to revise performance standards themselves. Tribes should be able to develop their own performance standards under Head Start similar to how Tribes can develop their own performance standard under the No Child Left Behind Act at Department of Education. Additionally, Indian Head Start programs should be able to locally develop their own, culturally appropriate curriculum based on the language and knowledge of the communities they serve.
- Tribal programs should not be placed in DRS until after a year of consultation and re-evaluation, allowing Indian Head Start programs to improve and strengthen their services. NIHSDA would welcome the opportunity to work with Federal partners to develop better, more accurate assessment tools.

Temporary Assistance for Needy Families (TANF) – Administration for Children and Families

The goal of the TANF program should be to reduce poverty, not welfare rolls. We have many families that are approaching 60 months or have reached 60 months who are still dependent on welfare assistance to overcome various barriers not due to their lack of effort but due to a lack of opportunity and insufficient program resources. In fact, a 2014 Government Accountability Office (GAO) noted that “Action is Needed to Better Promote Employment-Focused Approaches.”

- The work participation rate metric is flawed and inappropriately used, and should be replaced with metrics developed by tribes.
- TANF performance evaluation should be revised to scrap the current emphasis on using error rates for eligibility determinations.
 - New benchmarks and performance incentives should be developed that acknowledge the full range of services needed to make welfare reform effective
- Increase the number of years allowable for TANF services, especially in Tribal communities.
- What is the status of the HHS response to the GAO recommendation that HHS issue guidance to clarify how the career pathways approach can be used by TANF agencies and identify potential changes to address the lack of incentives in the TANF program?

Effective Implementation of the Indian Child Welfare Act – Administration for Children and Families

The Indian Child Welfare Act (ICWA) was enacted by Congress in 1978 in response to alarming numbers of American Indian and Alaska Native (AI/AN) children being removed from their families by public and private child welfare agencies, most often being placed in non-Indian homes far from their tribal communities. Today, AI/AN children still face serious obstacles to receiving the full protections provided under the law. AI/AN children are disproportionately represented nationally at 2.0 times their population rate and among individual state foster care systems as much as 10 times their population rate.¹ While no single federal agency is provided full responsibility to monitor and ensure compliance with ICWA, the Administration for Children and Families (ACF) has oversight over much of state child welfare practice,

¹ Summers, A., Woods, S., & Donovan, J. (2013). Technical assistance bulletin: Disproportionality rates for children of color in foster care. National Council of Juvenile and Family Court Judges: Reno, NV.

including data collection, ensuring appropriate outcomes, and assisting states to improve their practice and policies to be in compliance with federal law. ACF has a critical role in helping collect important data, promoting effective tribal/state collaborations, increasing state capacity to comply with ICWA, and reversing the inequities and disparate treatment that can occur when ICWA is not followed. In order to assist the Administration and HHS in the implementation of ICWA and protection of AI/AN children and families we note the following priorities of STAC and thank HHS for their pursuit of these. The Department of Health & Human Services (DHHS) has authority to administer Title IV-B and Title IV-E, and through those, state compliance.

- Enhance data collection by ACF on issues pertaining to effective implementation of ICWA, including collection of data elements related to key ICWA requirements in individual ICWA cases and greater oversight of the Title IV-B requirement for states to consult with tribes on measures to comply with ICWA. We are pleased that ACF will be releasing their study in August 2015 on state activities to meet Title IV-B planning requirements to consult with tribes on ICWA implementation. We are also encouraged by ACF's work to consult with tribes on the development of ICWA related data measures for inclusion in the Adoption and Foster Care Automated Reporting System (AFCARS). ACF clarified that the Notice of Public Rulemaking Supplemental that will contain these proposed ICWA data elements will be published this summer.
- Administrative procedures and policy changes should be made that require action and follow-up by ACF in states where there is knowledge of ICWA non-compliance. When ACF becomes aware of ICWA non-compliance, they should work with the selected states and tribes within those states to develop clear action steps to address non-compliance and follow-up should be continuous until compliance has been met. This item has been highlighted in discussions between STAC leaders and HHS staff, but no plan for how this will be addressed has come forward. STAC leaders know that there are states that would be interested in receiving this type of assistance and examples where state non-compliance has been well-documented where assistance could be beneficial. We encourage HHS to reach out to tribes and STAC members to discuss how this priority might be addressed.
- Work with tribal governments and national Indian organizations with expertise in this area to develop improved technical assistance and training to help states effectively implement ICWA on an ongoing basis. ACF has been reaching out through the Tribal Capacity Center to address technical assistance and training needs, but there are additional opportunities to improve assistance to tribes that have not been explored. We would note the recent Region X listening session with tribes from the northwest states as another example. We encourage ACF to continue their efforts in other regions and look for opportunities to further involve national Indian organizations and tribes in these efforts.
- Consult with tribes on efforts between the Department of Justice (DOJ), Department of Interior (DOI), and DHHS regarding the Attorney General's ICWA initiative. The Attorney General's ICWA initiative acknowledges the need for greater federal collaboration on efforts to ensure compliance with ICWA and the disastrous effects that ICWA non-compliance has had on AI/AN children, families, and communities. We appreciate the updates on what HHS is doing with regards to ICWA compliance, but would like to hear more on how the work HHS is doing intertwines with the DOI and DOJ work, and other activities that are being discussed. We also appreciate having DOI and DOJ appear at STAC to provide updates as well.

Foster Care –Administration for Children and Families

Tribes are becoming more and more concerned as states begin to consider privatization of foster care. Our concerns relate to accountability of private foster care agencies whose only concern when a tribal child requires placement may be placement. Privatization of foster care ensures that this generation of tribal children in state foster care – and perhaps more – will be lost to private foster care agencies not knowledgeable or caring of how to apply the minimum Federal standards established by ICWA in 1979. Not being knowledgeable about ICWA is not an excuse, especially when current and future generations are at such substantial risk. HHS should collaborate with the Department of the Interior, Social Services, ICWA Programs, and states that are in the process of relinquishing their foster care responsibilities to private agencies.

- How will States ensure and DHHS monitor compliance with ICWA, especially as it relates to ICWA’s placement preferences, active efforts to reunify families, and meeting the minimum Federal standards established by ICWA in order to terminate Native parents’ rights?

Community Services Block Grant – Administration for Children and Families

The Community Services Block Grant (CSBG) program has a 5% indirect capped rate for the FY 2014 grant. Implementing the capped rate severely constrains this program and Tribes’ general funds that must pay for under-recoveries due to the capped rate. For example, Central Council’s CSBG program assists tribal citizens by promoting the creation of Alaska Native small businesses, by supporting existing Alaska Native small businesses as well as promoting the creation of culturally-relevant training in high-growth industries, by promoting employment in high-growth industries, by increasing tribal member accessibility to training and employment services, and by collaborating with regional organizations to understand regional economic development and create strategies for addressing obstacles and achieving goals for our tribal citizens and their communities.

- The indirect rate capped at such a low percentage makes our achieving tribal program goals a very difficult task that is a burden on Tribes’ general funds.

Data Collection – Administration for Children and Families

As Tribes develop their children and family program systems and access federal funds, there is an increased demand for accountability that can prove more burdensome and costly than effective. Historically, Tribes have not enjoyed access to sophisticated and comprehensive data management systems, and routinely operate several different data bases to collect tribal data based for each of many programs.

- Tribes need access to federal resources to develop and maintain data management systems that meet our needs to collect our own data, report our outcomes, and most importantly, in order to tell our own stories through data.

Other Key Issues For follow-up

In addition to the priorities listed above, the STAC continues to track priorities that were discussed with the HHS in previous meetings. We await a response on the following topics:

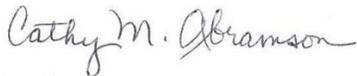
- Employer Mandate Under the ACA – Many Tribal governments are concerned that the requirement to provide health insurance for their IHS-eligible employees will be a significant cost burden, will make those employees ineligible for premium tax credits and Indian cost-sharing

exemptions, and will be a disincentive for individuals to sign up for the Insurance. HHS has noted that it is working with IRS on this issue. STAC respectfully requests an update on this effort.

- Advance Appropriations for the Indian Health Service – Tribes continue to work toward achieving Advance Appropriations for the Indian Health Service, and are seeking the support of the Administration. Advance Appropriations will allow IHS, Tribal and Urban Indian Health facilities the ability to coordinate care, plan, and provide overall better service to Tribes.
- Report on Tribal HHS Funding – STAC continues to request a report for grants received by Tribes and Tribal Organizations by HHS. While we understand that data collection can be challenging across agencies, it is critical for us to know how many Tribal entities are being funded for HHS so that we may understand where challenges lie in getting funding from HHS. We want the report to address how many applications there have been, and how many were funded.
- HIV Funding in Indian Country – Tribal communities continue to be concerned that CDC chose not to fund any Native-specific organizations when it comes to HIV Prevention efforts, despite the fact that HIV rates continue to rise in our communities. We understand that CDC has specific grant review criteria, but urge the agency to consider the government-to-government relationship that the federal government has with Tribes, not simply status as a minority group.
- ACF consultation: Tribes request that this be an annual event. Annual consultation events will assist in obtaining meaningful dialogue. By this, our overall program goals will be met and adequately funded.

In conclusion, we would like to reiterate our appreciation for your willingness to work with us and for your prioritization of issues in Indian Country. We look forward to continuing a strong relationship with you and to hearing your response to these requests.

Sincerely,



Cathy Abramson
Chairperson
Secretary's Tribal Advisory Committee

Submitted via E-mail: jeff.wu@cms.hhs.gov

September 30, 2015

Mr. Jeff Wu
Deputy Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Response to Request for Tribal Consultation on QHP Referrals for Limited Cost-Sharing Variation Plans

Dear Mr. Wu:

On behalf of the Tribal Technical Advisory Group (TTAG) to the Centers for Medicare and Medicaid Services (CMS), this letter is a response to your request for Tribal consultation on the issue of the minimum content of referrals for cost-sharing protections issued pursuant to ACA section 1402(d)(2).¹ The TTAG advises CMS on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program, and any other health care programs funded (in whole or in part) by CMS. In particular, the TTAG focuses on providing policy advice designed to improve the availability of health care services to American Indians and Alaska Natives under these federal health care programs, including through providers operating under the health programs of the Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations.

In response to the request for Tribal consultation on the minimum content of referrals issued by Indian health care providers (IHCPs)², TTAG recommends that CCIIO—

- Clarify with QHP issuers that the documentation requirements pertaining to the 03/L-CSV that are imposed by QHP issuers on IHCPs can be no more rigorous than those outlined in current or subsequent CCIIO guidance documents.

¹ The Indian-specific cost-sharing protections are comprised of (1) the ACA section 1402(d)(1) protections, sometimes referred to as the "02" or "zero cost-sharing variation" (02/Z-CSV), and (2) the section 1402(d)(2) protections, sometimes referred to as the "03" or "limited cost-sharing variation" (03/L-CSV). AI/ANs who meet the definition of Indian under the Affordable Care Act and are enrolled in Marketplace coverage qualify for at least one of the two Indian-specific cost-sharing variations. Under the limited CSV, a referral from an Indian health care provider (IHCP) is required for AI/AN enrollees to secure cost-sharing protections at non-IHCPs. Under the 02/Z-CSV, no such referral is needed to secure comprehensive cost-sharing protections at any provider

² Indian health care providers (IHCPs) include Indian Health Service, Indian Tribe, Tribal health organization, and urban Indian organization providers and are sometimes referred to as "I/T/Us."

- Refrain from issuing requirements on IHCP PRC programs (except for the recommended requirements below on minimum data elements to be contained in a referral for cost-sharing) that infringe on the ability and flexibility of IHCPs to continue to manage their PRC programs.
- Continue to permit IHCPs to issue a range of referral types and forms, such as a single item or service referral, a referral based on an episode of care, and a comprehensive referral.
- If determined necessary, issue revised guidance indicating the following minimum data elements to be contained in a referral for cost-sharing from an IHCP—
 - Identification of the patient for whom the referral is being issued;
 - Name of the IHCP issuing the referral;
 - Contact information for the IHCP; and
 - Date of the referral (which may be past the date services were received).

For some PRC referrals for cost-sharing, the information above will appear on the referral itself. For other referrals for cost-sharing, some of the information (such as the date of referral) is accessed by the QHP issuer contacting the IHCP at the telephone number or e-mail address included on the referral.

A. Background and History of Current Issue

On June 30, 2015, the Alaska Native Tribal Health Consortium (ANTHC or Consortium) sent a letter to the Center for Consumer Information and Insurance Oversight (CCIIO) of the Centers for Medicare and Medicaid Services (CMS) in the federal Department of Health and Human Services (HHS) requesting the intervention of CCIIO in order to ensure that American Indians and Alaska Natives (AI/ANs)³ in Alaska are not blocked from accessing the comprehensive Indian-specific cost-sharing protections provided to them under section 1402 of the Affordable Care Act. The Consortium explained that the policies and operational approaches being imposed by Moda Health were impeding access to needed health care services for AI/ANs enrolled through the Marketplace in plans operated by this issuer. These policies and approaches continue to threaten access to care for hundreds of Marketplace enrollees.

Specifically, the Consortium requested the following—

We seek the intervention of [CCIIO] to prevent Moda Health from imposing on tribal health organizations (THOs) in Alaska—and by this, imposing on Marketplace enrollees—referral requirements that go far

³ For purposes of this letter, references to Alaska Natives and American Indians are to persons meeting the definition of Indian under the Patient Protection and Affordable Care Act.

beyond the CCIIO guidance addressing this issue.⁴ Specifically, we are asking CCIIO to halt implementation of Moda Health's stated plan to reject, as of June 30, 2015, any THO-issued referrals for cost-sharing that do not include Moda Health-authored requirements.

We believe Moda Health was and continues to be in violation of 45 CFR §156.410(a). Subsection (a) of §156.410, "Cost-sharing reductions for enrollees," reads as follows—

(a) *General requirement.* A QHP issuer must ensure that an individual eligible for cost-sharing reductions, as demonstrated by assignment to a particular plan variation, pays only the cost-sharing required of an eligible individual for the applicable covered service under the plan variation. **The cost-sharing reduction for which an individual is eligible must be applied when the cost-sharing is collected.** (Emphasis added.)

Moda Health is failing to comply with the requirements of 45 CFR §156.410(a) in two ways. First, the QHP issuer is not applying the cost-sharing reductions to 03/L-CSV plan enrollees at the time an 03/L-CSV enrollee receives a service that is otherwise subject to cost-sharing, resulting in L-CSV plan enrollees being subject to a \$4,500 - \$5,250 deductible and \$4,650 – 13,200 in maximum out-of-pocket costs (depending on which Moda Health plan an enrollee is enrolled and whether under single or family coverage). As clearly indicated in the regulations at §156.410(a), an enrollee is "eligible" for the cost-sharing protections at the point of enrollment and assignment in an 03/L-CSV, not at some later date, such as when a referral is issued on behalf of the enrollee. Second, Moda Health is not honoring many of the referrals issued by Tribal Health Organizations (THOs)⁵ in Alaska and, as a result, is charging patients cost-sharing amounts that are to be eliminated under the 03/L-CSV protections.^{6 7}

In addition to not recognizing some THO referrals for cost-sharing, and in addition to attempting to impose a referral form on THOs that requires unnecessary and redundant information, in recent incidents Moda Health—after receiving a referral that contains the information initially demanded by Moda Health—contacted THOs for additional information beyond what was indicated previously by Moda Health as sufficient. Meeting the constantly changing demands of

⁴ From the CCIIO Q&A document titled "Cost-Sharing Reductions for Contract Health Services" and dated May 9, 2014. See Attachment A.

⁵ For example, two referrals were rejected by Moda Health early in 2015. Then, on March 30, 2015, Moda Health said they would not accept any additional comprehensive referrals. Since then, two additional comprehensive referrals were issued by THOs, and both were denied. Moda Health has not accepted a comprehensive referral since March 12th.

⁶ In this letter, the term THOs is used interchangeably with the term Indian Health Care Providers (IHCPs).

⁷ For instance, a Moda Health L-CSV bronze plan enrollee was recently subject to Moda Health applying a deductible in the amount of \$5,774.57 when the enrollee attempted to have a prescription filled.

this one QHP issuer—which are far beyond that required in CCIIO guidance—much less the potential demands of multiple QHP issuers, makes this process unworkable.

In addition, Moda Health appears to be in violation of 45 CFR §156.430(g). This section of the federal regulations reads—

(g) Prohibition on reduction in payments to Indian health providers. If an Indian is enrolled in a QHP in the individual market through an Exchange and is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, **or through referral under contract health services**, the QHP issuer may not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for the prohibitions on cost-sharing set forth in §156.410(b)(2) and (3). (Emphasis added.)

In not applying the cost-sharing protections at the time of application of cost-sharing amounts when an AI/AN enrollee receives services at a non-IHCP, Moda Health is effectively reducing the amounts paid to providers to whom the enrollee was referred by the amount of the imposed cost-sharing. This is resulting in denials of services to enrollees (if the enrollees fail to pay the cost-sharing amounts to the provider) or withdrawals of the request for services by enrollees for fear of being liable for the cost-sharing amounts.

The violation of these two provisions of federal regulations by Moda Health is impeding access to needed health care services for AI/AN plan enrollees.

In summary, Moda Health is violating federal regulations pertaining to the application of Indian-specific cost-sharing protections and by so doing is impeding access to needed health care services for AI/ANs enrolled in coverage through the Federally-Facilitated Marketplace. At the core of this issue (and the justification cited by Moda Health) is the imposition of Moda Health-generated requirements on THOs. These requirements infringe on the operation of the PRC programs operated by THOs in Alaska. Neither the failure to apply the statutory protections to AI/ANs fully nor the imposition of requirements on THO-operated PRC programs is acceptable. We ask CCIIO to direct Moda Health to refrain from imposing requirements on THOs that infringe on the operation of PRC programs by THOs, particularly as these requirements are not necessary for the implementation of the Indian-specific cost-sharing protections.

B. Request for Tribal Consultation on Content of Referrals for 03/L-CSV

In a July 9, 2015, notice, CMS issued a request for Tribal consultation “on the minimum information that must be included in a Purchased/Referred Care (PRC) referral made on behalf of American Indians and Alaska Natives enrolled in a Marketplace plan.”

We appreciate the opportunity to enter into Tribal consultation with CMS on this issue. We understand CCIIO must ensure that requests for payment made by QHP issuers for reimbursement for cost-sharing reductions advanced on behalf of AI/AN plan enrollees are documented and confirmed. It is in the interests of CCIIO, as well as AI/AN enrollees, that QHP issuers be reimbursed only when cost-sharing reductions were actually advanced on behalf of enrollees. Nonetheless, it is important to note that PRC programs are operated by IHCPs pursuant to policies established by the IHCPs. ACA section 1402 did not alter the authority of IHCPs to operate their PRC programs, and in implementing ACA section 1402, CCIIO and—in particular—QHPs should not infringe on IHCPs’ discretion in operating their PRC programs.

It is also important to state that, except for the instance mentioned above regarding one QHP operating in Alaska, IHCPs across the United States generally have not experienced problems with QHP issuers accepting the referrals issued by IHCPs for purposes of accessing the 03/L-CSV protections. We continue to believe that the document issued by CCIIO on May 9, 2014, provides sufficient guidance to QHP issuers on the documentation requirements a QHP issuer must meet to receive reimbursement for cost-sharing reductions advanced on behalf of plan enrollees.

Recommendations on Minimum Content of Referrals

If clarification on the minimum information to be included in an IHCP referral is deemed useful, using the May 9, 2014, guidance for reference, we provide recommendations below on the information to be provided by IHCPs. The remaining data elements identified in the May 9, 2014, guidance would be supplied by the QHP issuer.

It is useful to understand that PRC referrals issued by IHCPs take many forms. Some are paper form referrals similar in appearance to “prior authorization referrals.” Other referrals issued under PRC programs are in the form of cards, similar in appearance to health plan enrollment cards. Still other referrals under PRC programs are issued via e-mail correspondence. For some referrals under PRC programs, the information appears on the referral itself. For other referrals, some of the information (such as the date of referral) is accessed by the QHP issuer by contacting the IHCP at the telephone number or e-mail address included on the referral. And, as confirmed in the May 9, 2014 CCIIO guidance document, it is sometimes necessary for an IHCP to issue a referral after services have been received, providing a retroactive authorization.

Under our recommendations, an IHCP-issued referral would provide the following minimum information—

- Identification of the patient for whom the referral is being issued;
- Name of the IHCP issuing the referral;
- Contact information for the IHCP; and
- Date of the referral (which may be past the date services were received).

These four items are contained in the May 9, 2014, guidance from CMS/CCIIO to QHP issuers. Along with this information, IHCPs have the discretion to add additional information, such as whether the referral is for a particular set of items or services or for all essential health benefits. The remaining information identified in the May 9, 2014, guidance would be supplied by the QHP issuer. This information includes—

- The name and address of the provider(s) delivering the item(s) or service(s); and
- A description of the item(s) or service(s) furnished through referral, including the date(s) the item(s) or service(s) were provided.

As occurs under the 02/Z-CSV plans, under the 03/L-CSV plans, QHP issuers have the ability to access within their own records detailed information on the providers and services rendered, including provider name(s) and address(es), a listing and description of the item(s) and service(s) provided, and the date(s) the item(s) and service(s) were provided. None of this detailed information is secured from a PRC program when a QHP issuer seeks reimbursement for cost-sharing protections advanced under 02/Z-CSV. Likewise, none of this detailed information needs to be supplied by IHCPs for 03/L-CSV plan enrollees, as QHP issuers are already in possession of this information. For the IHCP to provide this information to the QHP issuer, the IHCP would either have to secure the Explanation of Benefits (EOBs) issued by the QHP issuer or gather the information from the records of plan enrollees.

Components of a PRC Program

A PRC program is comprised of two components. The first component is the function of referring Tribal members to outside providers for health care services. This is the “referred” component of the “Purchased and Referred Care” program. The second component is the function of authorizing payment for referred services when care is provided by outside providers. This is the “purchased” component of the “Purchased and Referred Care” program. Authorizations for payment made by a PRC program are constrained by the resources available to the PRC program. Referrals issued by PRC programs are not subject to the funding constraints of a PRC program and do not authorize payment for services from a PRC program.

Because IHCPs are obligated to operate their overall PRC programs within available funding, IHCPs oftentimes—but not always—impose a priority ranking when authorizing payments for medically necessary services. For instance, severely financially constrained PRC programs might solely authorize payment for “priority one” services, defined as health services addressing issues that threaten the life or a limb of a Tribal member. Other services that are typically

covered by QHPs, such as proven preventive services, are ranked as a lower priority and would not be authorized for payment.

Interaction of PRC Programs with 03/L-CSV Referrals

The primary goal of PRC programs is to facilitate access to health services, whether through issuing an authorization for payment (the “purchased” component of “Purchased and Referred Care”) when care has been or will be received at an outside provider and/or through issuing a referral to an outside provider without committing the referring IHCP’s PRC program to making a payment for the service (the “referred” component of “Purchased and Referred Care”).

Approaches employed by IHCPs in operating their PRC programs vary greatly. This is a result, in part, of IHCPs seeking to balance sometimes competing goals, such as minimizing barriers to accessing care at outside providers and coordinating all health care services received by IHS beneficiaries. Another goal that is considered by IHCPs is maximizing third-party revenues to the IHCPs in order to have adequate resources to expand health services capacity within the Indian health system. The approaches employed by IHCPs to balance the various goals results in IHCPs implementing greatly varying policies and procedures. For instance, one IHCP might issue a comprehensive referral to one beneficiary for all health services while issuing a referral for only one specific service for another beneficiary.

The range of approaches outlined here (as well as others) under IHCP-operated PRC programs fit comfortably with implementation of ACA section 1402(d)(2). This point is evident in the fact that IHCPs already have submitted a range of referral formats to QHP issuers and that AI/AN enrollees in the 03/L-CSV plans have secured comprehensive cost-sharing protections, with the exception of those enrolled in plans offered by one QHP issuer in Alaska.⁸

It is important to note that the law only states that a referral removes cost-sharing, it does not impose qualifications for what constitutes a referral. ACA § 1402(d)(2) reads—

“If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by [an IHCP] or through referral under contract health services—(A) no cost-sharing under the plan shall be imposed under the plan for such item or service ...”

The flexibility available to and applied by IHCPs is key to IHCPs’ continued ability to meet the health care needs of Tribal members and must not—and need not—be infringed upon in the implementation of the 03/L-CSV established under ACA section 1402(d)(2).⁹

⁸ It is important to note that many QHP issuers were initially unaware of the details of the 03/L-CSV and the 02/Z-CSV protections. IHCPs often engaged the QHP issuers to educate them on the Indian-specific provisions.

⁹ In regulations, at 45 CFR § 155.350(b), CMS refers to the section 1402(d)(2) Indian-specific cost-sharing protections as the “Special cost-sharing rule for Indians regardless of income.”

Addressing Comments Made by Federal Government Representatives During Tribal Consultation Sessions

Two teleconferences and one in-person meeting have been held as part of the Tribal consultation process. At these sessions, a number of questions were raised and comments made regarding broader issues involving implementation of the 03/L-CSV. We would like to address several of these issues, questions, and comments.

1. **Comment:** Congress established two variations of the Indian-specific cost-sharing protections. Implementation of the two variations must be sufficiently different to be true to the congressional intent.

Response: The difference between the 02/Z-CSV and the 03/L-CSV is that, under the 02/Z-CSV, “the issuer of the plan must eliminate all cost-sharing under the plan” without regard to whether the health care provider is an IHCP or not.¹⁰ Under the 03/L-CSV, “no cost-sharing under the plan shall be imposed under the plan for such item or service,” but a distinction is made between items and services provided by IHCPs and those provided by non-IHCPs. The comprehensive cost-sharing protections under 03/L-CSV apply at non-IHCPs only when the item or service is “furnished ... through referral under contract health services.”¹¹

The “through referral” requirement establishes a link between the availability of the comprehensive cost-sharing protections for an enrollee and the actions of the IHCP. This distinction is a significant one for IHCPs, as the IHCP is able to use the referral to influence the course of treatment for a beneficiary if the IHCP chooses to do so, for services provided by the IHCP and those provided by non-IHCPs. Although an IHCP is required to act by providing a referral if an AI/AN enrollee in a 03/L-CSV is to receive comprehensive cost-sharing protections at non-IHCPs, how an IHCP chooses to apply the PRC referral authority (*e.g.*, providing a service-specific referral, a comprehensive referral, or no referral at all) does not diminish the distinction between the two cost-sharing variations whereby the IHCP is able to decide whether and in what form to issue a referral.

2. **Comment:** A comprehensive referral is the same thing as a 02/Z-CSV and as such cannot meet congressional intent.

Response: A comprehensive referral does not have the result of converting a 03/L-CSV into a 02/Z-CSV. Access to cost-sharing protections under the 02/Z-CSV never requires a referral for cost-sharing. Access to cost-sharing protections at non-IHCPs under the 03/L-CSV always requires a referral. A plan-year or comprehensive referral satisfies this

¹⁰ ACA section 1402(d)(1)(B).

¹¹ The term “contract health services” was renamed “Purchased/Referred Care” in the Consolidated Appropriations Act of 2014.

referral requirement. Imposing additional requirements beyond what was established by Congress, though, could frustrate congressional intent.

In addition, in states that have not yet implemented an ACA section 2001 Medicaid expansion, the comprehensive referral aligns the cost-sharing protections for AI/ANs who would otherwise be eligible for Medicaid with applicable American Recovery and Reinvestment Act (ARRA) Indian-specific cost-sharing protections under Medicaid.

3. **Comment:** A “comprehensive referral” is too costly to the federal government and to the QHP issuer compared to providing a series of more limited referrals.

Response: The costs to the QHP issuer and to the federal government should not be significantly different under a single comprehensive referral for cost-sharing and a series of more limited referrals for cost-sharing. And to the extent there is a difference in the cost, the cost under multiple narrow referrals might be higher.

Under both scenarios, the QHP issuer will make payments to providers for items and services rendered. Under both scenarios, the QHP issuer will advance cost-sharing protections on behalf of AI/AN enrollees. And under both scenarios, the federal government will reimburse the QHP issuer for cost-sharing advanced on behalf of AI/AN enrollees. *But under no scenario should a referral for cost-sharing be viewed as, or converted in practice to, a mechanism to require and secure prior authorization for a service.*

Unless there are unwarranted barriers to accessing essential health benefits, the volume of services should be assumed to be the same under both scenarios. (It is important to note that under neither scenario will a referral for cost-sharing override a prior authorization requirement that a QHP might impose on enrollees.) If there are unwarranted barriers to needed health care services, this is an unacceptable approach to calculating costs, or achieving savings, under one or the other scenarios.

Costs might be slightly higher, if at all, under a scenario whereby a greater percentage of services are provided through IHCPs, rather than non-IHCPs, to the extent that payment rates to IHCPs are higher than otherwise due to IHCPs leveraging section 206 of the Indian Health Care Improvement Act. In addition, costs might be slightly higher under a series of narrower referrals as a result of increased administrative costs to issue and track the referrals.

4. **Comment:** A QHP issuer is burdened by additional costs if a comprehensive referral is issued versus a series of narrower referrals.

Response: Similar to the response above, QHP issuers will not assume greater costs under a comprehensive referral than under a series of narrower referrals. Either way, essential health benefits would be provided to the plan enrollee. If a QHP issuer is

counting on the paperwork involved with IHCPs issuing service-specific referrals to result in reductions in access to essential health benefits, this should not be an acceptable rationale or approach to cost-containment. Referrals for cost-sharing should facilitate, not retard, timely access to essential health benefits.

In addition, the QHP issuer retains the ability to impose prior authorization requirements or other cost-containment mechanisms without regard to the type of referral for cost-sharing issued by an IHCP. This permits QHP issuers to continue to apply a permissible cost containment mechanism.

Finally, if IHCPs are blocked from continuing to issue comprehensive referrals for purposes of securing cost-sharing protections under the 03/L-CSV, the QHP issuers (as well as the IHCPs) will experience increased administrative costs. Handling and processing paper referrals for each item or service received outside of IHCPs will generate significant costs and consume a portion of the ACA-limited administrative funds. QHP issuers, along with non-ICHCPs, also are likely to have to resubmit and re-process numerous claims, as AI/AN QHP enrollees secure referrals for specific items and services retroactively.

5. **Comment:** Referrals should be provided by an IHCP only after a determination is made that an item, service, or treatment is not reasonably available or accessible from an IHCP.

Response: Congress did not include any such limitation in the plain language of Section 1402 of the ACA, and it would be inappropriate to invent such restrictions. In addition, given the limited budgets and provider shortages at many IHCPs, the very fact that an individual is referred out of the I/T/U system might itself free up a provider to offer other services necessary to avoid making such treatments unavailable or not accessible. This should be a determination for the IHCP to make, not a dictate from CCIIO.

Furthermore, the QHPs and the federal government should not create unnecessary limitations on where AI/ANs seek care. This could be construed as discrimination against AI/ANs who have paid their premiums for health insurance and should be entitled to the same networks of providers and same services as non-AI/ANs.

Additionally, it would be difficult or impossible for the QHPs or the federal government to enforce the language in this statement. Exactly how would they determine that the item, service or treatment is “not reasonably available or accessible”? It may be available, but not on a timely basis which would make it inaccessible. It might be accessible in some outdated version that offers lower quality, such as inferior equipment for tests, which would make it not available. If it is left to the Tribe to make this determination, there is no need for this “test” to be included in the referral.

6. **Comment:** PRC programs that issue comprehensive referrals today, and would expect to do so for enrollees under Marketplace coverage, are not permitted to do so under IHS policies.

Response: IHS policies do not prevent the issuance of comprehensive referrals. In addition, IHS rules are not binding on tribal health programs operating ISDEAA programs. The law allows for cost-sharing exemption referrals to be made by IHS, Tribes and urban Indian programs. Each have different approaches to managing PRC programs, and urban Indian programs generally do not even have PRC programs. IHS direct service programs use a referral form and process that is not replicated in many of the self-governance Tribes that operate their own programs. It is not appropriate for CMS to restrict referrals to the IHS direct service model, and CMS should not impose any model used by IHS on to Tribes.

7. **Comment:** IHS issues either PRC referrals for specific items or services or referrals for episodes of care. IHS does not issue open-ended comprehensive referrals. Because IHS does not issue comprehensive referrals under its PRC programs, other IHCPs are not permitted to issue comprehensive referrals under PRC programs.

Response: IHS policies are not binding on tribal health programs operating ISDEAA programs.

8. **Comment:** IHCPs are expected to apply the priority system operated under a PRC program to referrals under Marketplace coverage.

Response: Under a PRC program, the priority system applies to “authorizations” for payment for services. The priority system does not apply to “referrals” for services. Imposing the funding constraints on authorizations for payment under an IHCP’s PRC program to the issuance of referrals for cost-sharing protections would defeat the purpose of enrolling in comprehensive health insurance coverage. The goal of Tribes enrolling Tribal members in the Marketplace is to facilitate access to all essential health benefits without imposition of arbitrary funding caps, and to receive the services without requiring enrollees (or Tribes on their behalf) to incur out-of-pocket costs, as was intended by Congress in enacting the provisions.

9. **Comment:** Referrals must be limited to residents of Contract Health Service Delivery Areas (CHSDAs).

Response: Referrals for cost-sharing are not limited to residence in a CHSDA, or to PRC priority levels. The ACA is designed to increase access to care, so the limitations of PRC authorizations are not relevant for AI/ANs with insurance purchased through a Marketplace, or previously for AI/ANs with Medicaid or other types of health insurance coverage. CHSDAs were established to ration care based on the limited resources of IHS, and for budgeting purposes to distribute the funding provided by Congress for PRC

to different service units. The Affordable Care Act and Marketplaces expand the available resources for AI/AN patients regardless of their place of residence. In addition, Self-Governance Tribes can design their programs differently from IHS, including covering different people than IHS-operated PRC programs.

10. **Comment:** Requiring a referral for each item or service, and for each episode of care, would not disrupt access to care or increase costs to IHCPs.

Response: IHCPs operate their PRC programs in a manner that balances numerous program goals. Restraining the flexibility of IHCPs in issuing referrals would disrupt current practices, including the practice for many PRC programs of issuing comprehensive referrals for individuals enrolled in comprehensive health insurance coverage. Dictating the form of referrals also would limit the flexibility of IHCPs in how referrals are physically issued, likely resulting in greater administrative costs to PRC programs and additional time and travel costs imposed on plan enrollees to the extent the plan enrollee is required to travel to obtain a referral.

11. **Comment:** If implemented according to Tribal recommendations, the 03/L-CSV would be far more generous than other non-Indian-specific cost-sharing protections and would be far more costly than that intended by Congress.

Response: At the present time, very few people across the country are enrolled in 03/L-CSV plans, and the cost for their care is insignificant to the federal budget, particularly when the marginal cost of coverage to the federal government for AI/ANs is compared to the cost for such coverage if the coverage were provided under the generally-applicable PTC and CSV rules. As Medicaid Expansion is adopted by additional states, the number of people in 03/L-CSV will likely decline as those under 100 percent of the federal poverty level will be enrolled in Medicaid with no premiums, co-pays or deductibles.

Z-CSV plans and L-CSV plans (with absence of deductibles and copayments) assist the Federal government in meeting its trust responsibility to people who are members of federally recognized Tribes and shareholders in Alaska Native corporations. The Affordable Care Act is intended to cover uninsured Americans, including AI/ANs who have the lowest rates of insurance and highest rates of health disparities and to whom the federal government has promised health care at no cost.

The actuarial value of both the 02/Z-CSV and the 03/L-CSV plans are 100 percent, according to CMS, as a result of the comprehensive cost-sharing protections provided for under each plan variation. This compares to an actuarial value ranging from 87 percent to 94 percent for modest income individuals enrolled in silver level coverage. Although the Indian-specific cost-sharing protections are greater, this is only slightly so when compared with other categories of Marketplace enrollees.

Additional Recommendations

In addition to the above comments and recommendations regarding referral forms, the Tribes across the country support the recommendations made by ANTHC to address the Moda Health requirements that are frustrating access to comprehensive cost-sharing protections in Alaska, and to ensure such impediments are not repeated elsewhere. We recommend that CCIIO—

- Indicate in guidance to all QHP issuers that Purchased/Referred Care (PRC) programs are operated by Indian health care providers (IHCPs)¹² and that efforts to impose requirements on an IHCP's PRC program are not permissible.
- Reiterate to all QHP issuers that, pursuant to 45 CFR §156.410(a), persons enrolled in 03/L-CSV plans are in fact eligible for cost-sharing protections and that the cost-sharing protections under the 03/L-CSV plans are to be applied when the cost sharing is collected, without regard to whether a referral for cost sharing has been issued. (Any overpayments or underpayments would be reconciled using the procedures described under 45 CFR §156.410(c).)
- Reiterate to all QHP issuers that, pursuant to 45 CFR §156.40(g), a QHP issuer is prohibited from reducing payments to IHCPs, and to non-IHCPs when the service is being provided pursuant to a referral from an IHCP, by the amount of the cost sharing that otherwise would have been due except for the cost-sharing protections.
- Indicate to Moda Health and other QHP issuers not to seek to impose requirements on IHCPs that exceed the parameters outlined in the CMS guidance document issued on May 9, 2014 and any subsequent guidance issued by CCIIO, unless agreed to by the IHCP.

Conclusion

According to data released by HHS, as of June 1, 2015, only 3,916 AI/ANs were enrolled in a 03/L-CSV plan through a Federally-Facilitated Marketplace. This figure represents a tiny fraction of all AI/ANs and an infinitesimally small number when compared with the total U.S. population.

Hopefully, the comprehensive cost-sharing protections under each of the two Indian-specific cost-sharing variations will prove attractive to a sizable number of AI/ANs in order for the Marketplace to serve as an additional vehicle for meeting the federal government's trust responsibility, as envisioned by Congress. To date, though, ACA implementation in Indian Country is a work in progress. Most of the AI/ANs enrolled in plans with limited cost-sharing have a portion of their premiums paid by Tribal Sponsorship programs. We believe IHCPs in general—and those Tribes who are helping to pay the premiums in particular—are in the position to determine the most workable policies and protocols for issuing referrals. We believe CCIIO's

¹² Indian health care providers include Indian Health Service, Indian Tribe, Tribal health organization, and urban Indian organization providers and are sometimes referred to as "I/T/Us."

focus is best aimed at assuring that QHPs are reimbursed for cost-sharing reductions for those who are eligible and to avoid fraud on the part of QHPs. To this end, we continue to offer our support to CCIIO and cooperation with QHP issuers in order to facilitate reasonable reporting requirements. We believe the May 9, 2014, CCIIO guidance to QHP issuers has served to meet these objectives and to facilitate the effective implementation of the 03/L-CSV. This is achieved through the guidance by imposing modest reporting requirements on QHP issuers and recognizing the authority of IHCPs to issue referrals pursuant to their PRC programs.

We appreciate your attention to implementation of the Indian-specific provisions in the Affordable Care Act. We hope that CCIIO will give full consideration to the recommendations made here. Doing so, we believe, will increase the likelihood that AI/ANs enroll in Marketplace coverage and ultimately experience greater access to critically needed health care services as a result of the elimination of cost-sharing.

Sincerely,



W. Ron Allen,
Tribal Chairman and CEO, Jamestown S'Klallam Tribe
Chairman, Tribal Technical Advisory Group

Cc: Kevin Counihan, Chief Executive Officer, CCIIO/CMS
Vikki Wachino, Director, CMCS/CMS
Robert McSwain, Acting Director, Indian Health Service
Kitty Marx, Director, DTA, CMCS/CMS
Eugene Freund, CCIIO/CMS
Patricia Meisol, CCIIO/CMS
Nancy Goetschius, CCIIO/CMS
Carol Backstrom, CMCS/CMS



DEPARTMENT OF VETERANS AFFAIRS
UNDER SECRETARY FOR HEALTH
WASHINGTON DC 20420

7J

October 7, 2015

Dear Tribal Leader:

We are writing to facilitate tribal consultation on the Department of Veterans Affairs (VA) effort to improve continuity of care and health care access via the development of a non-VA care core provider network utilizing agreements with high quality partners who also share the privilege of serving Veterans.

In July 2015, Congress passed the VA Budget and Choice Improvement Act, which calls for VA to develop by November 1, 2015 a plan to consolidate and streamline VA community care. In this plan, we would like to reference the Indian Health Service (IHS) and Tribal Health Programs (THP) as members of our core provider network. Inclusion in the core network of providers would preserve and build on VA's existing relationships with IHS and THP and facilitate future collaboration to improve health care services provided to all eligible, enrolled Veterans. Future collaborations may focus on streamlined credentialing processes and enhanced care options for Veterans.

We are seeking tribal consultation regarding the inclusion of IHS and THP as part of the proposed core provider network, as well as VA's efforts to streamline the provision of non-VA care to Veterans. We note that VA will be seeking additional tribal consultation on its VA community care plan after November 1, 2015.

Written comments may be submitted to tribalgovernmentconsultation@va.gov by October 26, 2015. For additional information regarding this effort please contact Marvin Rydberg at Marvin.Rydberg@va.gov or (202) 904-7287.

We appreciate your support and partnership as we move forward to enhance and improve the experience for our Veterans.

Sincerely,

A handwritten signature in black ink, appearing to read "David J. Shulkin", is written over a horizontal line.

David J. Shulkin, M.D.



October 15, 2015

Secretary Sylvia Mathews Burwell
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Re: Secretary's Tribal Advisory Committee Follow up items from September meeting

Dear Secretary Burwell,

On behalf of the Secretary's Tribal Advisory Committee (STAC), we thank you and your staff for the productive meeting that was held from September 15-16, 2015. The agency's willingness to hear our concerns and address key issues in a responsive, and frank manner is always appreciated and we look forward to working with you to advance many of these priorities in the months to come.

The following letter presents the STAC's key issues from the September meeting. While there are many other topics that are important, these we feel are the top priorities.

Inter-Agency and Inter-Departmental Cooperation

In June 2013, President Obama announced the establishment of the historic White House Council on Native American Affairs. According to Executive Order 13647 which created this body, "The Council shall improve coordination of Federal programs and the use of resources available to tribal communities." Yet, two years later, Tribes still experience federal departments that do not appear to be coordinating in several key areas including alcohol and substance abuse; marijuana policy; implementation of the Employer Mandate under the Affordable Care Act; implementation of P.L. 102-477 programs; and Indian Child Welfare Act enforcement.

- Please provide STAC with information on how HHS works with other agencies to address issues that are cross-departmental such as the Affordable Care Act (ACA) employer mandate and excise tax, alcohol and substance abuse, suicide prevention, and implementation of the ACA.
- How can Tribes be more heavily involved in the actions of the agencies to work jointly to administer federal programs to Indian Country?
- How can STAC and other Indian Country tribal leaders interact directly with the White House Council on Native American Affairs and its subcommittees?

Mental Health and Suicide Epidemic

In the STAC's follow-up letter to our June meeting, dated June 30, 2015, the Committee expressed several priorities and concerns relating to effective treatment and prevention of mental health in Indian Country. We listed priority areas such as implementation of traditional healing methods, deployment of Commissioned Corps officers to Indian Country for mental health and additional research on the impacts of historical trauma in Tribal communities. We also noted inter-departmental and inter-agency coordination as key concerns for addressing this epidemic in Indian Country.

We appreciate the detailed and thoughtful response given by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the response letter provided to the STAC on September 16, 2015, however, STAC was hoping to also hear responses from other Department of Health and Human Services (HHS) agencies who have jurisdiction over these key issues (such as the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), National Institutes of Health (NIH), and the Indian Health Service (IHS)). This only serves to emphasize our request that the Secretary exercise her authority to break down silos within HHS, to increase flexibility in use of program funds and lessen the tribal administrative burden to permit tribal control, and to decrease the conveyance of funds by competitive grant to the fullest extent possible. As the Tribal advisory committee for all of HHS, STAC requests that responses are conducted in a coordinated, and thoughtful way by all relevant agencies of jurisdiction.

- We request that STAC receive responses from all relevant agencies of jurisdiction on suggestions made in the June 30, 2015 letter to HHS.
- Can HHS detail how it plans to address mental health/ suicide crisis in Indian Country through inter-agency cooperation?
- How can tribal leaders work with HHS break down barriers between agencies and departments to ensure that the mental health crisis in Indian Country is being tackled from all areas of the federal government?

Arizona Medicaid Expansion Waiver – Centers for Medicare and Medicaid Services

In March, Arizona passed SB 1092, which will require the Director of Arizona's Medicaid program, Arizona Health Care Cost Containment System (AHCCCS), to apply for an 1115 waiver to the Centers for Medicare and Medicaid Services (CMS) by March 30 of each year for permission to institute cost-sharing requirements, work requirements and lifetime limits for adults receiving AHCCCS benefits.

Some of the requirements of SB 1092 include the following:

1. Institute a work requirement for all able-bodied adults receiving AHCCCS services, excluding long term care, to become employed, actively seek employment, attend school or a job training program, or both at least 20 hours a week, and to verify compliance with this requirement and any change in family income.
2. AHCCCS will verify when a person is seeking employment and to confirm changes of family income and re-determine eligibility for services
3. AHCCCS can ban an eligible person for one year if the individual knowingly fails to report family income changes or makes a false statement regarding work related requirements
4. Place a five-year lifetime limit of benefits on able-bodied adults that begins on the effective date of the waiver or amendment to the current waiver, excluding any previous time a person received AHCCCS benefits.

These requirements will have lasting negative and devastating impacts on the American Indian population in Arizona and adversely affect 100,000 Tribal members in Arizona who are currently enrolled in the AHCCCS, as there are few job opportunities and employment resources for Tribes in Arizona. Imposing these requirements on the most impoverished areas in the State only compounds the hopelessness and lack

of adequate health care that prevail. In the response letter provided to STAC, CMS noted that the waiver was currently undergoing review. However, we believe that this review should absolutely include thorough and meaningful Tribal consultation.

- Please comment on CMS' plan to consult with Tribes in Arizona as they review the implications of this 1115 waiver request by the state of Arizona.

Federal Medical Assistance Percentage (FMAP) Expansion

The States of South Dakota and Alaska have submitted proposals asking CMS to expand the current policy on 100% FMAP to Purchased & Referred Care (PRC). CMS has conducted two All Tribes Calls and held a consultation session the National Indian Health Board's Annual Conference in September 2015. During these consultation sessions, CMS explained that Alaska has requested 100% FMAP for emergency and non-emergency medical transport and transportation-related expenditures as well as for services provided through PRC referrals; and that South Dakota has requested 100% FMAP for telehealth services, specialty services provided through collaborative arrangements, and services provided by community health representatives. We applaud CMS for reconsidering its past policy position that 100% federal reimbursement only applied to care provided inside the four walls of IHS facilities. Section 1905(b) of the Social Security Act provides that it applies to all services "received through," the IHS or tribal health facilities, and the PRC program is a program provided through the IHS and tribal health facilities. Expanding CMS's existing interpretation to cover PRC services will benefit IHS and Tribal health programs by allowing States to expand coverage for AI/ANs, either by covering additional population groups or additional services.

- We respectfully request that CMS approve the 100% FMAP proposals for Alaska and South Dakota, as well as the rest of the Indian health system.

Employer Mandate in the Affordable Care Act

Tribal governments continue to seek relief from the employer mandate in the Affordable Care Act. The Employer Shared Responsibility Rule, otherwise known as the Employer Mandate, states that all employers must offer health insurance to their employees or pay a penalty. Tribal governments are currently counted as large employers for application of this rule. American Indians and Alaska Natives (AI/ANs) are exempt from the Individual Mandate to purchase health insurance. This is in recognition of the fact that AI/ANs should not be forced to purchase healthcare that is obligated by the federal government's trust responsibility and which is delivered through IHS. Requiring Tribal employers to provide AI/ANs with such coverage anyway, and penalizing them if they do not, functionally invalidates the AI/AN exemption from the individual mandate by shifting the penalty from the individual to the Tribe itself.

While the vast majority of Tribal employers have always provided health insurance to employees, and will continue to do so, for several Tribal employers, this is an impossible choice. Because Tribes do not have the luxury of raising prices or taxes to offset costs, many Tribes are left deciding to lay off workers, cut services, or pay unaffordable fines. STAC recognizes that the HHS and the Department of Treasury

both have jurisdiction over this issue, and therefore, encourage HHS to take the lead in initiating an inter-departmental effort to provide relief for Tribes.

While the Internal Revenue Service (IRS) does not believe it has the legal authority to issue such an exemption through the regulatory process, tribes believe HHS and IRS possess all necessary authority to interpret provisions of the ACA favorably for tribes that would fully or partially mitigate the consequential burden on tribes that was unintended by the Congress. The recent district court decision in *Northern Arapaho Tribe v. Burwell* (Case No. 14-CV-247-SWS) that noted the employer mandate does apply to Tribes is both not directly on point and represents the significantly high threshold that must be overcome for a court to overrule the administration's interpretation of statute. The HHS and IRS and tribes in consultation may collaborate to implement the ACA through readily applicable interpretations of its provisions in regulation without injuring tribal interests by issuing a clarifying regulation.

- STAC requests the HHS and IRS work together in consultation with tribes to clarify regulations that appropriately interpret Tribal employers in the Employer Mandate in the Affordable Care Act.
- We request that HHS and IRS collaborate to delay the enforcement of the employer mandate provision for one year so that there is more time for the agencies to consult with Tribes and determine a path forward.

Winnebago Service Unit CMS Certification Termination

On July 23, 2015, CMS terminated certification for the Winnebago Service Unit which serves the Winnebago and Omaha Tribes, making the facility ineligible to bill Medicare or Medicaid for services provided. This CMS termination was a direct result of the findings of a series of successive CMS investigations into the IHS's management and operation of this facility. In fact, during the course of successive CMS surveys, there were deaths at the hospital which CMS found to be directly related to the Winnebago Hospital's failure to provide adequate medical care.

All of Indian Country stands in unity with the Winnebago and Omaha Tribes as they seek to find a solution to this problem. It is nothing short of unacceptable that American Indians and Alaska Natives should have to suffer this standard of care at the hands of an IHS-run hospital. STAC calls upon the Indian Health Service working with HHS and CMS to take all necessary steps to correct deficiencies at the Winnebago Hospital, keep the Winnebago and Omaha Tribes fully informed of its plans and actions, and to include the Tribes as fully as they wish to be in all aspects of the operation and improvement of the Winnebago Hospital, including the financial status of the Hospital.

- Please provide a detailed outline of how HHS will exercise its leadership to coordinate an improvement plan at the Winnebago Service Unit so that no person's life is put at risk again.
- STAC requests regular updates to Tribes of any information or assessments it may have regarding any deficiencies, risks to certification, consideration of substantive changes in operations, or other matters that could affect quality of care at, access to, and financial viability of, any other hospital operated by the Indian Health Service.

Employee Contract Settlement – Indian Health Service

On May 22, Acting Director of the IHS Principal Deputy Director Robert McSwain notified Tribes that the Indian Health Service had reached an agreement with employee unions. On July 29, an update letter was sent by IHS to the Tribes. In the response to STAC on September 16, IHS noted that most of the settlement payment was borne largely by the service units. While STAC recognizes the need to provide settlement funds, Tribes where the facilities are in question are still concerned about the amount of funds that would be used to pay the settlement. Tribes are also concerned about what purpose the extra funds were intended to be used for at the service unit level when IHS is funded at only 59% of actual need.

- Please provide a detailed account about where the settlement funds came from, and the response each unit provided IHS of what each service unit had intended the unobligated balances to be used for.

Contract Support Costs – Indian Health Service

The STAC is highly encouraged by the actions of the Administration to move forward on full-funding of contract support costs (CSC). The budget proposal this year to enact mandatory appropriations for CSC is an important first step in ensuring that these costs are fully funded. The IHS' CSC workgroup has also been working to come to an agreement on how we work on issues around incurred cost mythology. Tribes would like to initiate a pilot project to would allow agency to determine best way to reconcile CSC on a contract by contract basis and consider imposing CSC for 3-5 years.

- Please discuss the feasibility of this suggested pilot project and how we can move forward in a collaborative way.

Marijuana Policy

As noted in our previous letter, Tribes continue explore pathways to pursuing both medical and recreational marijuana enterprises on Tribal lands. Congress has provided that states are free to regulate in the area of controlled substances, including marijuana, provided that state law does not positively conflict with the Controlled Substances Act (CSA) (21 U.S.C. § 903). States have not “legalized” medical marijuana, but instead exercised each state’s reserved powers to not punish certain marijuana offenses under state law when a physician has recommended its use to treat a serious medical condition.

State laws qualify for prosecutorial discretion from the U.S. Department of Justice (DOJ) when robust regulatory regimes are implemented, and not all states regulations are suitable in the view of DOJ. DOJ issued memoranda and guidelines for tribes, postulated as eight law enforcement priorities directed to marijuana activities on tribal lands, however, these application of these priorities remains unclear, especially in the context of consequences for tribes’ HHS funding, and tribes continue to seek specific answers from HHS and DOJ. We appreciate your response that the Department of Justice has primary jurisdiction on enforcement and are encouraged by your confirmation that Tribal HHS would not be adversely impacted if they operated a marijuana grow or dispensary on Tribal lands as long as federal funding was not used. The 2011 letter from IHS Chief Medical Officer issued “findings” on the medical uses of marijuana. These “findings” mischaracterized applicable law in a “finding” that under Article 6 of the Constitution, States are violating federal law by legalizing medical marijuana, and in asserting that

health care providers at IHS-funded facilities would not be covered by the Federal Tort Claims Act (FTCA) if they failed to meet the requirements of the Controlled Substances Act. This statement does not accurately reflect the case law on applicability of the FTCA. HHS has a key role in how a drug can be rescheduled in the CSA. HHS FDA would recommend rescheduling and provide a scientific and medical evaluation of the drug. The Drug Enforcement Administration (DEA) must find that the drug does not meet the requirements for inclusion in any schedule. DEA would then engage in rulemaking to remove or reclassify the drug from its schedule. In 2011, the Governors of the states of Washington and Rhode Island petitioned HHS to have marijuana rescheduled as a Schedule II drug.

- STAC urges HHS to engage in conversations with DOJ to determine how it would enforce marijuana on Tribal lands.
- STAC also encourages HHS to engage jointly with DOJ in Tribal consultation with those Tribes who intend to legalize marijuana.

Implementation and Expansion of P.L. 102-477

Since 1992, the 477 program has allowed Tribes and tribal organizations to consolidate programmatic employment related funding from the Departments of Interior, HHS, Labor, while streamlining program approval, accounting and reporting mechanisms, thus offering a model for Administrative flexibility. The law allows for increased efficiency, decreased administrative burdens, and empowers self-determination. STAC was pleased to hear the agency confirm that the Community Services Block Grant is eligible for the 477 program. However, we were disappointed to hear that HHS considers LIHEAP and Head Start funds to not be eligible for 477.

- Please provide legal justification as to why the determination was made not to add LIHEAP and Head Start to the 477 program.

Head Start – Administration for Children and Families

Head Start programs provide vital services to Tribal communities, despite the fact that only 16 percent of age-eligible Indian child population is enrolled in Head Start. Only about 188 Tribes have access to the program, and few of those programs actually have sufficient funding to implement the necessary program improvements that would result in better outcomes for our young people. The Indian Head Start programs are on the frontline in the struggle to preserve Native language and culture, which have proven to be key elements in Native student confidence and success in later years.

STAC echoes the recommendations of the National Indian Head Start Directors Association outlined in their Comments on RIN 0970-AC63, “Head Start Performance Standards.” These recommendations include concern over the loss of slots that will occur due to the cost of the Proposed Rule’s mandates, particularly, the full-day and full-year requirements. Several of the proposed requirements are not compatible with distinct cultures and needs of our communities. Several areas are drafted in a state-centered way, creating requirements that are not consistent with the unique government-to-government relationship between Tribes and the federal government. Finally, the Indian Head Start Directors Association and STAC are concerned that several provisions in this Proposed Rule call for research-based practices, yet research-based practices have not been developed for AI/AN communities and existing research has excluded AI/AN children and families.

- We urge the Office of Head Start to revise the Proposed Rule so that it is compatible with the distinct needs of Indian Head Start programs and adopt Indian-specific exemptions where appropriate.
- We urge the Office of Head Start to maintain flexibility and local control of Indian Head Start programs in order to honor the unique needs of Native communities, families and children.

Effective Implementation of the Indian Child Welfare Act – Administration for Children and Families

Today, AI/AN children still face serious obstacles to receiving the full protections provided under the Indian Child Welfare Act (ICWA). AI/AN children are disproportionately represented nationally at 2.0 times their population rate and among individual state foster care systems as much as 10 times their population rate.¹ While no single federal agency is provided full responsibility to monitor and ensure compliance with ICWA, the Administration for Children and Families (ACF) has oversight over much of state child welfare practice, including data collection, ensuring appropriate outcomes, and assisting states to improve their practice and policies to be in compliance with federal law. ACF has a critical role in helping collect important data, promoting effective tribal/state collaborations, assisting states as they build capacity to comply with ICWA, and reversing the inequities and disparate treatment that can occur when ICWA is not followed. In order to support the Administration's priority to improve ICWA implementation and related HHS activities we note the following priorities of STAC.

- We are pleased that ACF has committed to establishing new ICWA related data elements in Adoption and Foster Care Analysis and Reporting System (AFCARS) and the development of a report detailing how states are doing in implementing the Title IV-B requirement that requires them to consult with Tribes on measures to comply with ICWA. These efforts will contribute significantly to an increased understanding of how AI/AN children are doing in state child welfare systems, areas where improvements need to be made, and the status of state and tribal relationships with regard to implementing ICWA. However, we are very concerned at the slow pace at which these initiatives are moving ahead. The intent to publish an AFCARS Supplemental containing proposed ICWA data elements was published in the Federal Register on April 2, 2015, which included a statement that ACF has determined that it has authority under Title IV-E to collect this data. This followed a general AFCARS notice of proposed rulemaking (NPRM) where several Tribes and Indian organizations provided strong support for including ICWA data elements in AFCARS and comments on suggested ICWA data elements to be included. Furthermore, the American Public Human Services Association, which is a membership organization of state human services programs, has previously gone on record to support the addition of ICWA related data elements in AFCARS. If the AFCARS Supplemental is not published very soon it is at serious risk of not being able to become a Final Rule during this Administration. These are the top two priorities of STAC related to improving ICWA implementation and we appreciate your efforts to make these initiatives a priority in this quarter.
- The report on how states are doing in meeting their obligations under Title IV-B to consult with Tribes regarding ICWA implementation has been in process for over a year and was originally promised to be released at the June STAC meeting. This is a report that contains public information

¹ Summers, A., Woods, S., & Donovan, J. (2013). Technical assistance bulletin: Disproportionality rates for children of color in foster care. National Council of Juvenile and Family Court Judges: Reno, NV.

derived from existing aggregate data that ACF tracks and which does not contain any new policy interpretation or guidance. As with the AFCARS data initiative, this is a high priority for STAC, so we urge ACF to have the report disseminated before the next STAC meeting so tribal leadership may have time to review and participate in dialogue with ACF at the next STAC meeting.

- Consult with Tribes on efforts between the DOJ, Department of Interior (DOI), and HHS regarding the Attorney General's ICWA initiative and Administration's priority on improving ICWA compliance. The Attorney General's ICWA initiative acknowledges the need for greater federal collaboration on efforts to ensure compliance with ICWA and the disastrous effects that ICWA non-compliance has had on AI/AN children, families, and communities. We appreciate the updates on what HHS is doing with regards to ICWA implementation, but would like to hear more on how the work HHS is doing with the DOI and DOJ, and other activities that are being discussed. We also encourage having DOI and DOJ appear at STAC to provide updates as well.

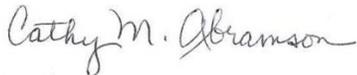
Timeliness in Response

As noted above, STAC appreciates the work done by HHS to respond thoroughly and thoughtfully to respond to STAC's letters at the conclusion of each meeting. These letters make it possible for the Committee to track key issues and understand the latest status on a variety of topics. We use the information provided in the response letters to determine our priorities to address at each meeting. However, the last response letter was not received until almost immediately before the STAC met with the Secretary. This does not give STAC members and technical advisors adequate time to read the response letter and adjust our requests accordingly.

- STAC requests that any response to this letter be received in the preparation materials that are provided at the STAC meeting, and at a minimum, a full 24 hours in advance of the STAC meeting commencing. This will enable STAC to utilize our limited time more effectively and to make measurable progress issues that are important to the health and well-being of Indian Country.

In conclusion, we would like to reiterate our appreciation for your willingness to work with us and for your prioritization of issues in Indian Country. We look forward to continuing a strong relationship with you and to hearing your response to these requests.

Sincerely,



Cathy Abramson
Chairperson
Secretary's Tribal Advisory Committee



Portland Area Indian Health Service Influenza Action Plan 2015-2016

Executive Summary

The Indian Health Service (IHS) has adopted the Healthy People 2020 (HP 2020) goal to immunize 70% of all American Indians/Alaska Natives (AI/AN) served against influenza annually. Each IHS Area has been asked to develop plans to meet this goal, beginning with the 2015-16 influenza season. This document provides critical scientific data necessary to understand the rationale of the HP 2020 goal, recommendations for strategies that can be used and identification of the primary and secondary drivers that should be addressed to achieve this goal.

Each year, the world experiences an epidemic in the form of influenza. Enormous amounts of money, time and energy are expended by the world's nations to combat this annual epidemic. Immunization against influenza remains one of the primary methods by which influenza can be prevented. The population coverage needed to avert or mitigate the impact of an influenza epidemic depends on the vaccine effectiveness and the infectivity (measured by R_0) of the specific influenza strain.

The Indian Health System operates under many constraints including chronic personnel shortages and inadequate funding. Yet, this system delivers high-quality healthcare under some of the most austere and remote conditions to be found in the US. To ensure a successful influenza campaign, it is critical to understand these constraints and develop plans that are achievable given the current Indian Health System.

Three strategies have been identified that can lead to an increase in influenza vaccine coverage:

- 1. Starting sooner** simply means that we are vaccinating as many people as possible as soon as the vaccine arrives.
- 2. Sustain maximum vaccination rate longer** means vaccinating at the maximum rate usually seen in October and continuing that effort throughout the month of November.
- 3. Increase weekly vaccination uptake by some percent (e.g, 25%)** requires that the clinics/systems adapt to provide more vaccinations/week than the previous year.

Models of these three strategies show that no single strategy above, by itself, is adequate to achieve the goal of 70% coverage for the 2015-16 influenza season. However, a combination of these strategies could achieve the HP 2020 goal. For each of these individual strategies, specific primary drivers should be addressed to achieve success (See Table 4, page 9). For example, **starting sooner** will require addressing clinic capability by planning flu-shot clinics earlier, ordering adequate supplies and ensuring staff are trained. Community readiness also needs to be cultivated by ensuring that information is distributed in ways that are acceptable to the community and that immunization sites in the clinic and the community are accessible. **Vaccinating longer** is driven by clinic capability and community demand or acceptance. By addressing the primary and secondary drivers for each strategy chosen, our clinics will be better positioned to improve influenza vaccine coverage and increase the likelihood of preventing a more serious epidemic of influenza this season.

Background

Each year, the United States experiences an epidemic of influenza. The timing of the epidemic has shifted since the 2009 (A California) H1N1 pandemic strain emerged. Prior to 2009, influenza activity in the Northwest typically began in late January to mid-February. Activity peaked in late February or early March. Since 2009, influenza activity has begun much earlier, typically in late November or early December, with peak activity in late December or early to mid-January. Because influenza vaccine is not delivered until September, the amount of time available to adequately vaccinate the population prior to the earlier onset of influenza transmission is significantly compressed.

Recently, the Indian Health Service (IHS) has tasked each Area to develop a plan to achieve increased population coverage with annual influenza vaccine. The goals put forth in this plan state that by 2020, 70% of all American Indian/Alaska Natives served by IHS would receive influenza vaccination (Appendix 1).

The purpose of this document is to lay out the rationale and strategy for planning an effective influenza vaccination campaign for the 2015-2016 flu season in response to the IHS plan.

Rationale

Vaccine Effectiveness

Various studies have demonstrated the effectiveness of influenza vaccine to prevent illness from influenza and secondary pneumonia, to prevent hospitalization and mortality from these specific causes as well as all-cause mortality^{1,2,3}. The vaccine effectiveness (VE) for each of these outcomes varies with each influenza season, by vaccine type, by age and by the setting in which the estimates are derived. Table 1 shows average VE by age group for influenza seasons from 2007/08, 2010/11, 2011/12, 2012/13, 2013/14².

Table 1. Pooled Average Vaccine Effectiveness (VE)

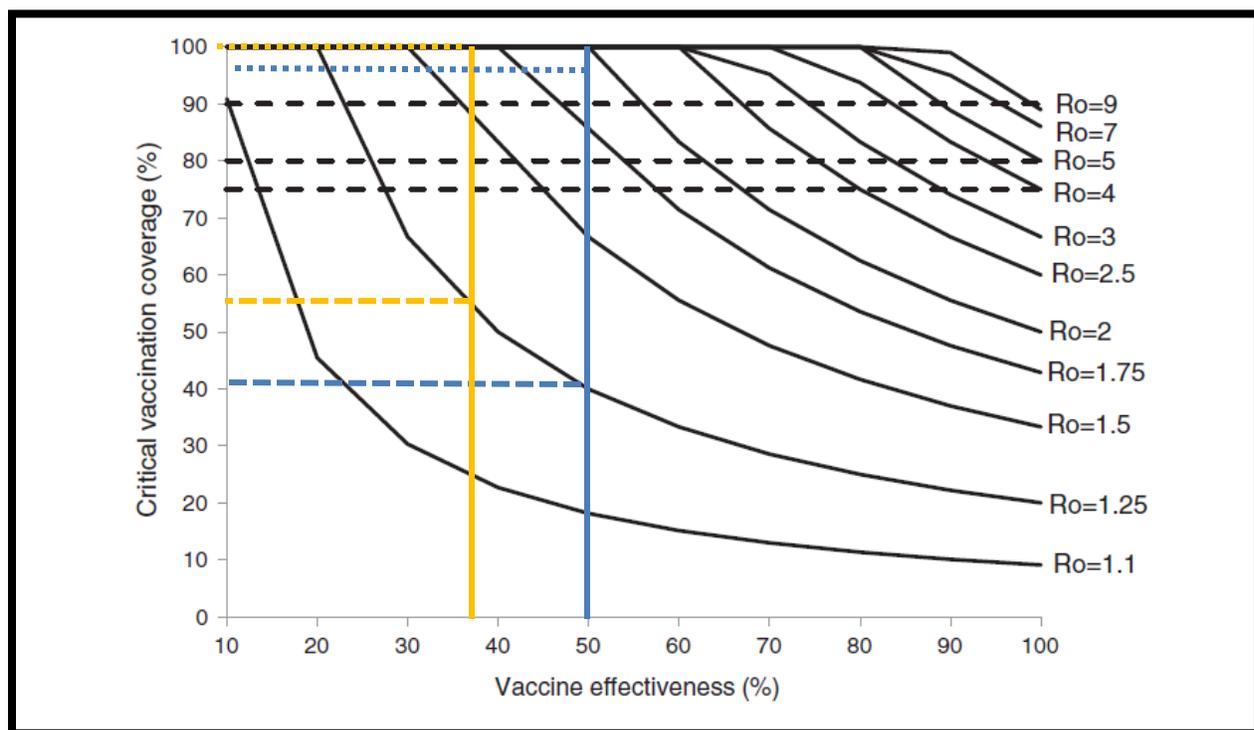
(Adapted from Foppa, *et al.* Vaccine, 2015)²

Age range (yrs.)	Average VE	Range
0.5–4	52%	39%-67%
5–19	50.25%	46%-59%
20–64	50%	46%-52%
≥65	37.5%	32%-43%

Herd Immunity and Reproductive Number (R_0)

The concept of herd immunity describes the setting in which people who are unvaccinated or vaccinated but still susceptible (e.g., the elderly population) are protected because of sufficiently high levels of vaccination uptake in the rest of the population. By definition, achieving herd immunity will prevent an epidemic of disease. Herd immunity depends on a number of variables including the relative infectivity of the strain of influenza, the proportion with prior immunity, age distribution within the population and measures of distribution and interaction between those who are infected, immune, and susceptible. These factors are used to derive the reproductive number (R_0)⁴. Figure 1 shows the level of vaccine coverage that would be required to prevent an influenza epidemic based on different levels of R_0 and VE. For any given R_0 , herd immunity (critical vaccination coverage) decreases as VE increases.

Figure 1. Critical Vaccination Coverage as a function of Vaccine Effectiveness for given level of R_0 (Adapted from Plans-Rubio, 2012)⁴



Seasonal Influenza Coverage 6 mos-64 yrs	— — — — —
Pandemic Influenza Coverage 6 mos-64 yrs
Seasonal Influenza Coverage ≥65 yrs	- - - - -
Pandemic Influenza Coverage ≥65 yrs

Analysis of numerous estimates specific to the 1918-19 pandemic A/H1N1 influenza virus show a median R_0 of 1.84 (interquartile range of 1.47-2.27). Estimates for other pandemic years range from 1.46 (2009-10 A/H1N1) to 1.80 (1968 A/H3N2) and for non-pandemic seasonal strains the median was 1.28 (interquartile range 1.19-1.37).⁵

Initial Healthy People 2020 goals for achieving sufficient vaccine coverage to achieve herd immunity were 80% in healthy persons and 90% in those at high risk for severe disease. Revisions to the Healthy People 2020 goals, which form the basis of the IHS plan, call for 70% vaccine coverage universally (all people aged 6 months and older). Based on the estimates of VE^2 , R_0^5 , and herd immunity⁴ the Healthy People 2020 goal would not be adequate to prevent an influenza pandemic nor could it prevent a more than average severity seasonal influenza epidemic with an $R_0 > 1.5$ given current levels of VE (Figure 1 and Table 2-3)⁴.

Table 2. Estimated Critical Vaccine Coverage Needed for Typical, Seasonal Influenza

Age Group	VE	R_0	Critical Vaccine Coverage Needed
6 months to 64 years	50%	1.28 (1.19-1.37)	~40%
≥ 65 years	37.5 %	1.28 (1.19-1.37)	~55%

Table 3. Estimated Critical Vaccine Coverage Needed for Severe/Pandemic Influenza

Age Group	VE	R_0	Critical Vaccine Coverage Needed
6 months to 64 years	50%	1.84 (1.47-2.27)	>90%*
≥ 65 years	37.5 %	1.84 (1.47-2.27)	100%*

* Even with 100% coverage, the limited VE would mean that an epidemic could not be prevented

Achieving 50-55% influenza immunization coverage should be considered the minimum coverage needed to achieve herd immunity in a typical influenza season with the pooled average VE estimates available (Table 1). Small decreases in VE or increases in R_0 would necessitate a large increase in the critical vaccine coverage needed for herd immunity (Figure 1). For severe or novel pandemic influenza seasons, unless VE is improved, even complete (100%) coverage could not prevent the pandemic. In such a scenario, we will need to accept and assume that a lower level of population coverage can at least mitigate the impact of influenza and prevent a certain number of infections, hospitalizations and deaths.

Improving Influenza Vaccine Coverage in the Portland Area IHS

Strategies to increase the uptake of influenza vaccine in the Portland Area IHS hinge on actions taken by clinic administration and staff as well as those actions taken at the community level, through tribal health programs, employment policies, schools and individuals.

Within the clinic, single strategies can be grouped into three single categories, and a fourth category made up of combinations:

- 1. Starting sooner** simply means that we are vaccinating as many people as possible as soon as the vaccine arrives. The models that follow project starting as much as 3 weeks sooner, which is admittedly a stretch. Even starting 1 or 2 weeks sooner would increase the early uptake of vaccine.
- 2. Sustain maximum vaccination rate longer** means taking the four weeks with the highest vaccination rates (# people vaccinated/week), usually the month of October, and extending a running average of those four weeks for four more weeks (until Thanksgiving holiday). The advantages of this strategy is there is no expectation of starting earlier, which is dependent on vaccine supplies, and the clinics (systems) already have a proven capacity to vaccinate at this rate.
- 3. Increase weekly vaccination uptake by some percent (e.g, 25%)** requires that the clinics/systems adapt to provider more vaccinations/week than last year. This could include adding additional evening or weekend clinics or adding community-based vaccine sites/efforts. And it requires the increased effort to be maintained throughout the flu season, though once the “goal” is achieved the effort could be tapered off.
- 4. Combination Strategies** would be to use more than one of these strategies in combination.

The driver diagram (Table 4) and projection models (Figures 4 and 5) that follow provide more details that may help sites choose which strategies to adopt as well as information to improve success.

It is first important to look at the capabilities of the current system. Figure 2 shows the weekly counts of influenza immunization that were given in the 2014-15 influenza season as reported in the Influenza-Like Illness Awareness System (IIAS). A description of this surveillance system is published elsewhere.⁶ The weekly immunization counts rose sharply in mid-September through mid-October but then fell off rapidly during November and December. The maximum number of vaccines given per week was about 1000 (80% of these were given to adults). There was a small increase in vaccination activity after the first of the year but this was only sustained for 2-3 weeks. Figure 3 shows the cumulative percent of the active clinical population that received at least one dose of influenza vaccine. The percent of children and adults vaccinated by November 30th is only 32 and 33%, respectively, well below the 50% minimum threshold needed for herd immunity. By this same time, ILI activity has already begun to rise and has

reached the “epidemic threshold” of 2% indicating the start of the influenza season. These two figures emphasize the need to vaccinate as early as possible and to continue efforts to vaccinate at the maximum level for longer than four weeks if we are to reach the goal of 50% coverage for all ages by the end of November.

Figure 4 depicts the projected influenza vaccination coverage that could be achieved using three individual strategies—starting sooner, maintaining the maximum vaccination rate longer, or vaccinating 25% more individuals each week. Note that all three strategies would be predicted to increase the level of immunization by the target of November 30th by 37-41% but none of the strategies alone could achieve the minimum herd immunity threshold of 50% by that date. It is clear that more than one strategy will need to be employed to reach 50% coverage by the end of November. Figure 5 shows projections of immunization coverage for three such combination strategies—starting sooner and sustaining the maximum vaccination rate, sustaining the maximum vaccination rate and increasing the total number of vaccinations each week by an additional 25% or employing all three strategies.

These immunization coverage projections provide a realistic view regarding the effort that would need to be expended in order to achieve the minimum herd immunity immunization threshold of 50% by the end of November, before influenza activity exceeds the epidemic threshold.

For severe influenza seasons or pandemic influenza situations, achieving high levels of influenza immunization coverage (90-100%) would be a monumental undertaking. The sheer number of doses of influenza vaccine that would be needed represents a barrier that cannot be overcome in the near future.

Special Population Considerations

The American Committee on Immunization Practice (ACIP) and the Centers for Disease Control and Prevention (CDC) have identified special populations at high risk for severe disease or complications from influenza.⁷ These include: Children younger than 5 (especially children younger than 2 years old), adults 65 years of age and older, pregnant women, residents of long-term care facilities, American Indians and Alaska Natives, people who have medical conditions including: asthma, neurological and neurodevelopmental conditions, chronic lung, heart disease, blood disorders, endocrine disorders, kidney disorders, liver disorders, metabolic disorders, weakened immune system due to disease or medication, people younger than 19 years of age who are receiving long-term aspirin therapy, people who are morbidly obese (Body Mass Index, or BMI, of 40 or greater).

Although it is important to protect those special populations with influenza vaccination, because of reduced VE in some of these same populations, further protection can be added by increasing the influenza immunization coverage among healthy children and younger adults since they experience a greater VE and thereby may reduce the probability of infection spreading to those at higher risk for severe disease or complications from influenza.^{8,9,10}

Immunization of Health Care Providers (HCPs)

IHS does not currently have a policy to require HCPs to receive influenza immunization each year. Most clinical sites, however, offer it free of charge to all employees and strongly encourage their employees to receive the immunization. Data from healthcare systems that have implemented mandatory influenza immunization for HCPs have shown favorable outcomes regarding employee acceptance and compliance.^{11,12} Data on the effectiveness of HCP influenza immunization as a control strategy is more limited but at least one study has demonstrated a positive impact on influenza immunization uptake among patients in a primary care setting.¹³

Limitations

The immunization coverage projections shown in Figure 4 and Figure 5 are based on actual data from the most recent influenza season (2014-15). However, these projections may not be generalizable to all influenza seasons because of special circumstances surrounding the 2014-15 season. Chief among these was the emergence of antigenic drift in the circulating strains of influenza A H3N2 virus resulting in a vaccine mismatch that was highly publicized early in the influenza immunization season. This may have caused people who might otherwise have gotten immunized to choose not to, thereby reducing uptake of immunizations. A brief glance at 2012-13 and 2013-14 influenza seasons shows that while higher coverage was achieved by the end of the season, early season coverage was the same (30-35% by week 48; 40% by week 52). Another limitation is that not all possible combinations of strategies or all possible scenarios (e.g. starting 1 week or 2 weeks earlier) were modeled. Finally, the data used for these projections do not represent all clinical sites in the Portland Area but only those that participate in the IIAS.

Table 4. Driver Diagram for Improving Influenza Vaccine Coverage

Strategy (or Change Concept)	Primary Drivers	Secondary Drivers	Constraints
<p>Start vaccinating sooner</p>	<p>Clinic Readiness</p>	<ul style="list-style-type: none"> • Pre-scheduled walk-in flu vaccine clinics • Pharmacists, MAs and nurses trained and ready to vaccinate • All necessary supplies in place prior to arrival of vaccines (gloves, syringes, needles, alcohol wipes, Band-Aids, VIS, etc.) 	<p>Highly dependent on timely vaccine supply delivery to clinic</p>
	<p>Community Readiness</p>	<ul style="list-style-type: none"> • Pre-placed articles/ads in local newspapers about when flu vaccines will be given, benefits of flu vaccines, etc. • Messaging throughout the community- posters, brochures, PSAs, video-messages, Social Media, radio, etc. • Community-based vaccine days/sites pre-planned 	

Strategy (or Change Concept)	Primary Drivers	Secondary Drivers	Constraints
<p>Sustain period of maximum vaccination rate longer</p>	<p>Clinic Capability</p>	<ul style="list-style-type: none"> • Ensure adequate staffing throughout the month of November • Extend/maintain flu vaccine walk-in clinics • Ensure adequate supplies to last for the duration of the extend flu vaccine campaign 	<ul style="list-style-type: none"> • Dependent on a sustained demand from patients/community • May require additional efforts to vaccinate outside of the clinic
	<p>Community Demand or Acceptance</p>	<ul style="list-style-type: none"> • May need to develop new messaging strategies or repeat messages multiple times • Anticipate and provide information about the benefits of flu vaccine specific to any issues that develop (vaccine mismatch, adverse events, reported “severity” of the circulating flu strain, special populations. 	<ul style="list-style-type: none"> • Mistrust of IHS/CDC • Negative media messages

Strategy (or Change Concept)	Primary Drivers	Secondary Drivers	Constraints
<p>Increase weekly number of vaccines given per week by some percent (e.g., by 25%)</p>	<p>Clinical systems change to increase capacity</p>	<ul style="list-style-type: none"> • Remove barriers to getting flu vaccine (standing orders, walk-in clinics, offering universally to all patients, etc.) • Provide multiple types of vaccine (live attenuated, preservative free, high-dose, quadrivalent, etc.) • Providers educated and committed to providing flu vaccine to all patients • Providers and staff get vaccinated • Create new vaccination venues- evening/weekend clinics, community-based clinics, etc. 	<ul style="list-style-type: none"> • System must increase its daily capacity to give vaccines (staff must work harder than previous years) • Staff reluctance to promote vaccine or reluctance to receive their own flu vaccine • Insufficient staff to provide evening/weekend vaccination clinics

Figure 2. Weekly count of influenza vaccine doses given in Portland Area IHS for the 2014-15 influenza season. Vaccination activity rises 3-4 weeks after earliest vaccine arrival. Vaccine uptake is steepest from 10/4/14 to 11/1/14 as indicated by the red shaded area, then declines through the 2nd week of January. A small, late-season surge is seen after the 2nd week of January.

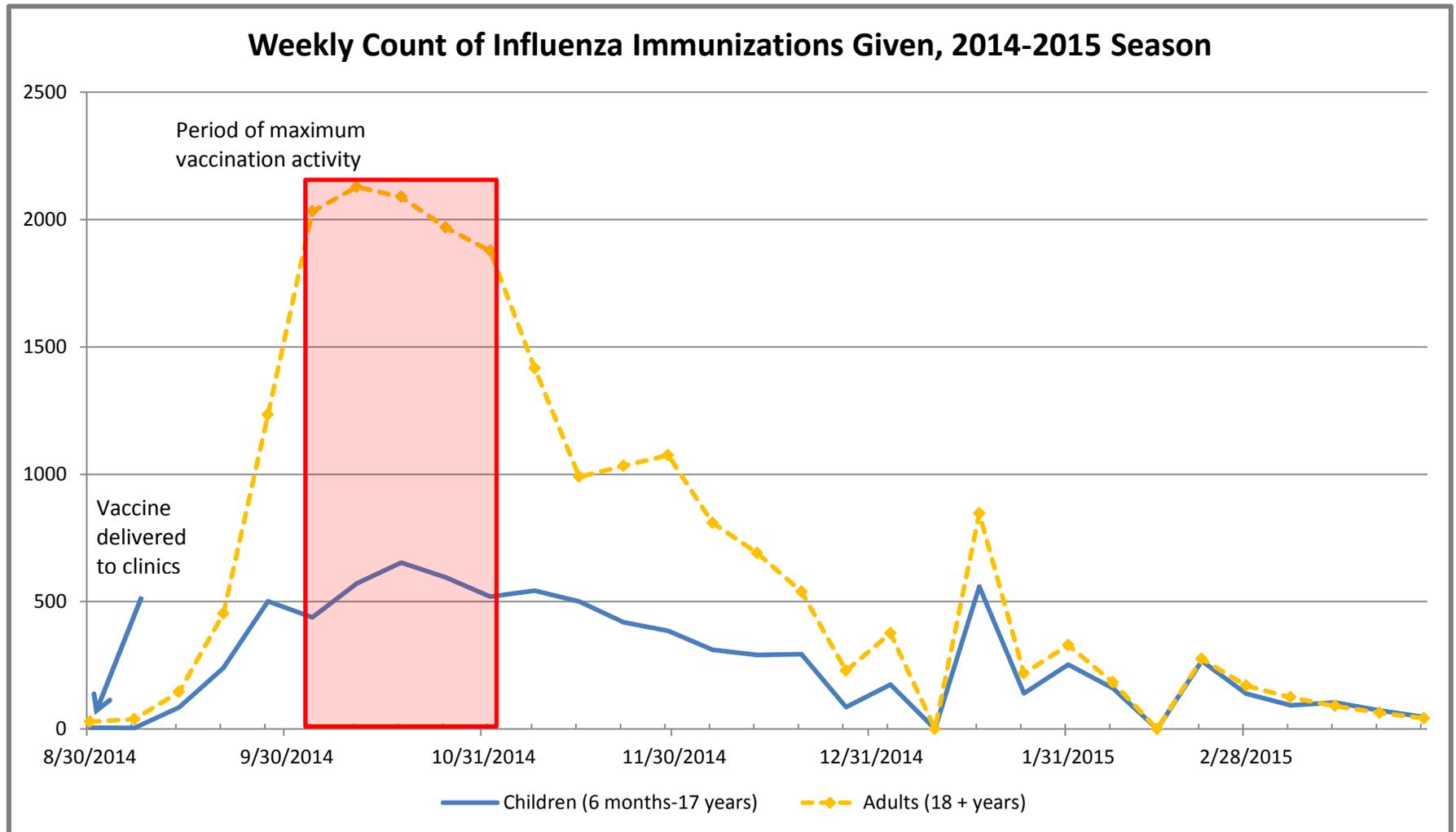


Figure 3. Cumulative percent of active user population that received at least one dose of influenza vaccine, Portland Area IHS, 2014-15 influenza season. The period of maximum vaccine uptake as indicated by the red shaded area ends approximately 1 week before ILI transmission starts to increase. The rate of vaccine uptake is much lower throughout the period of maximum ILI activity (purple dashed curve).

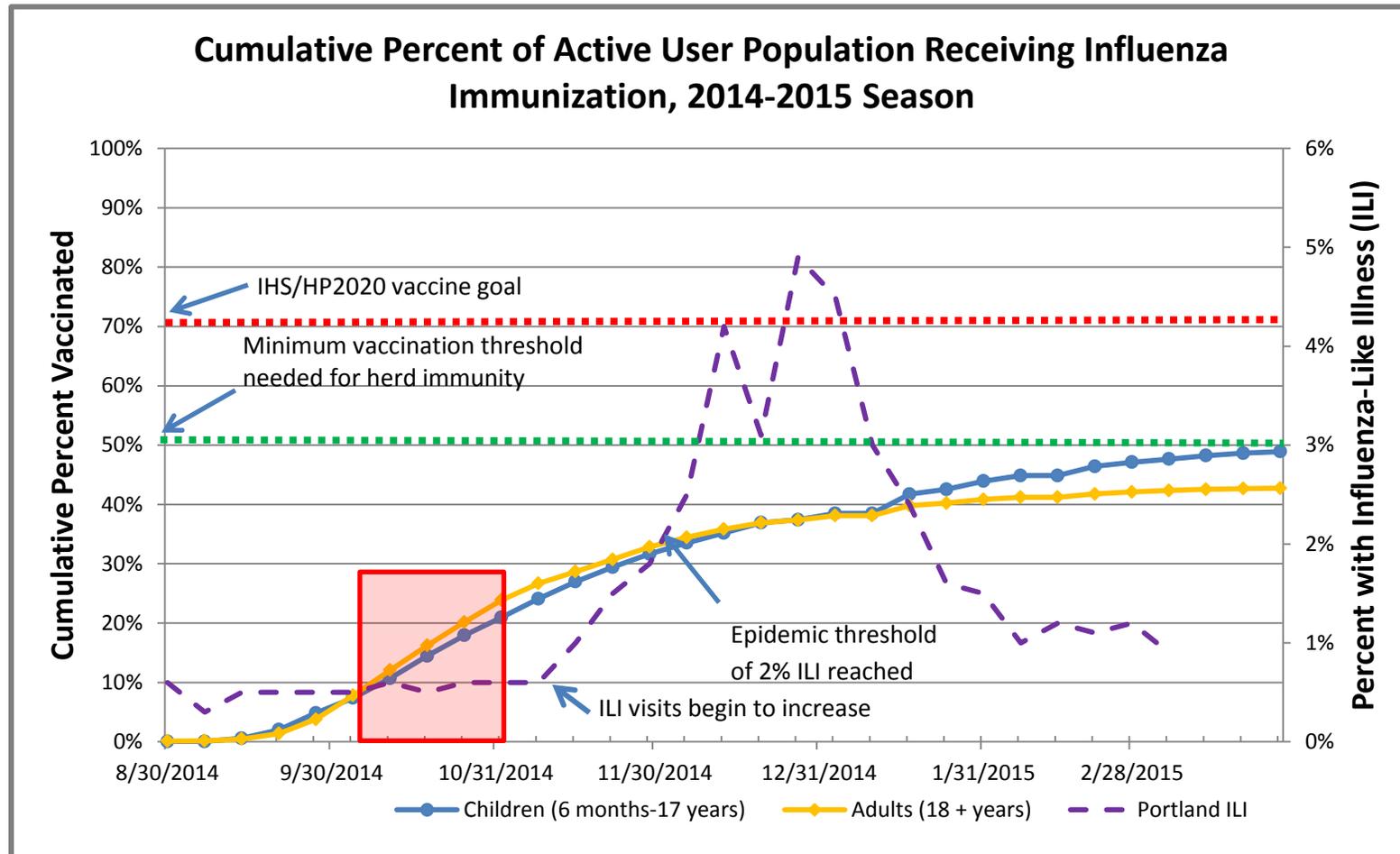


Figure 4. Projected cumulative influenza immunization rates using three single strategies compared to current practice. Minimum herd immunity threshold to be reached by 11/30/2015 is shown in red. All three strategies are projected to show increased coverage but no single strategy will reach the goal of 50% before ILI activity would be expected to begin.

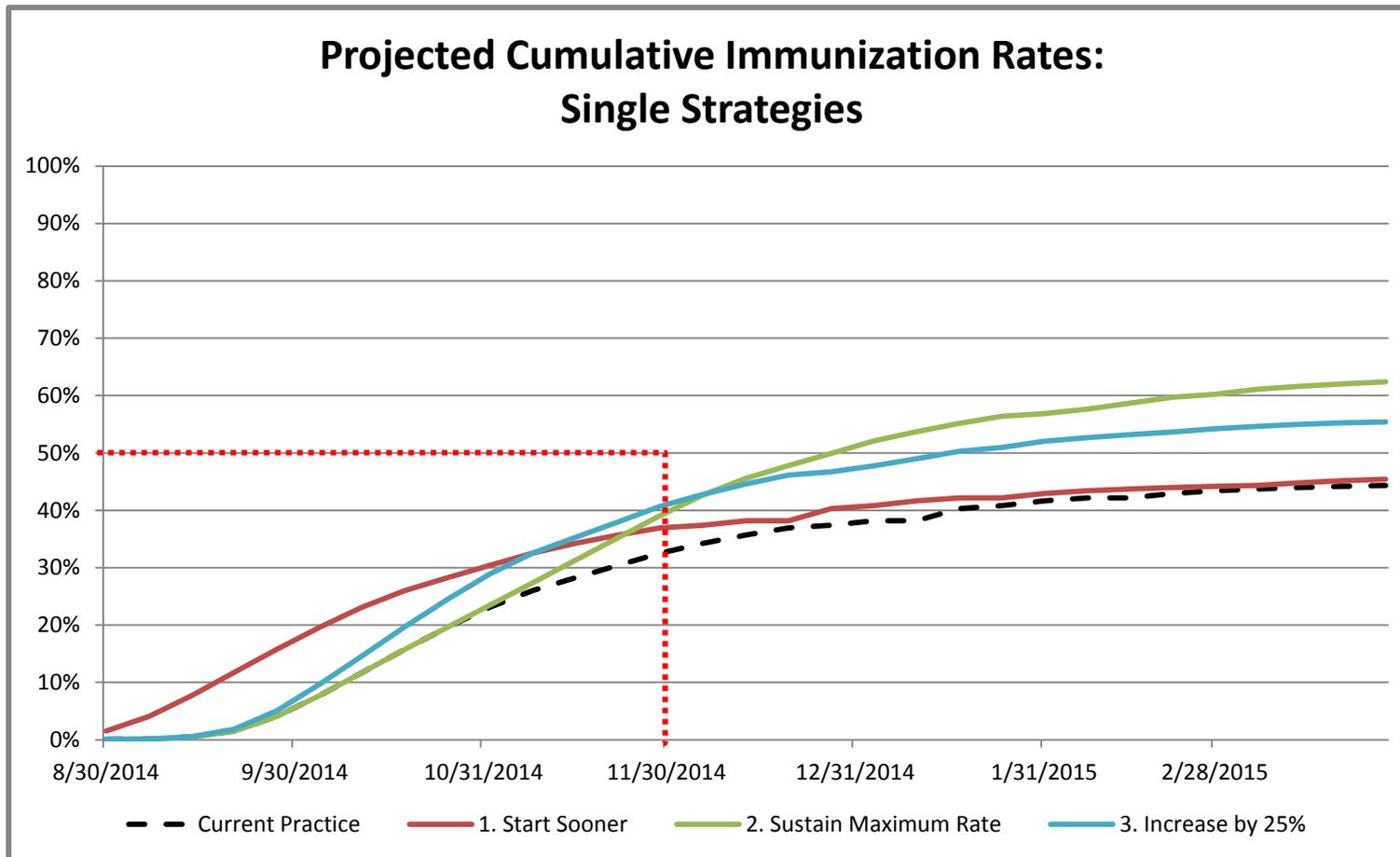
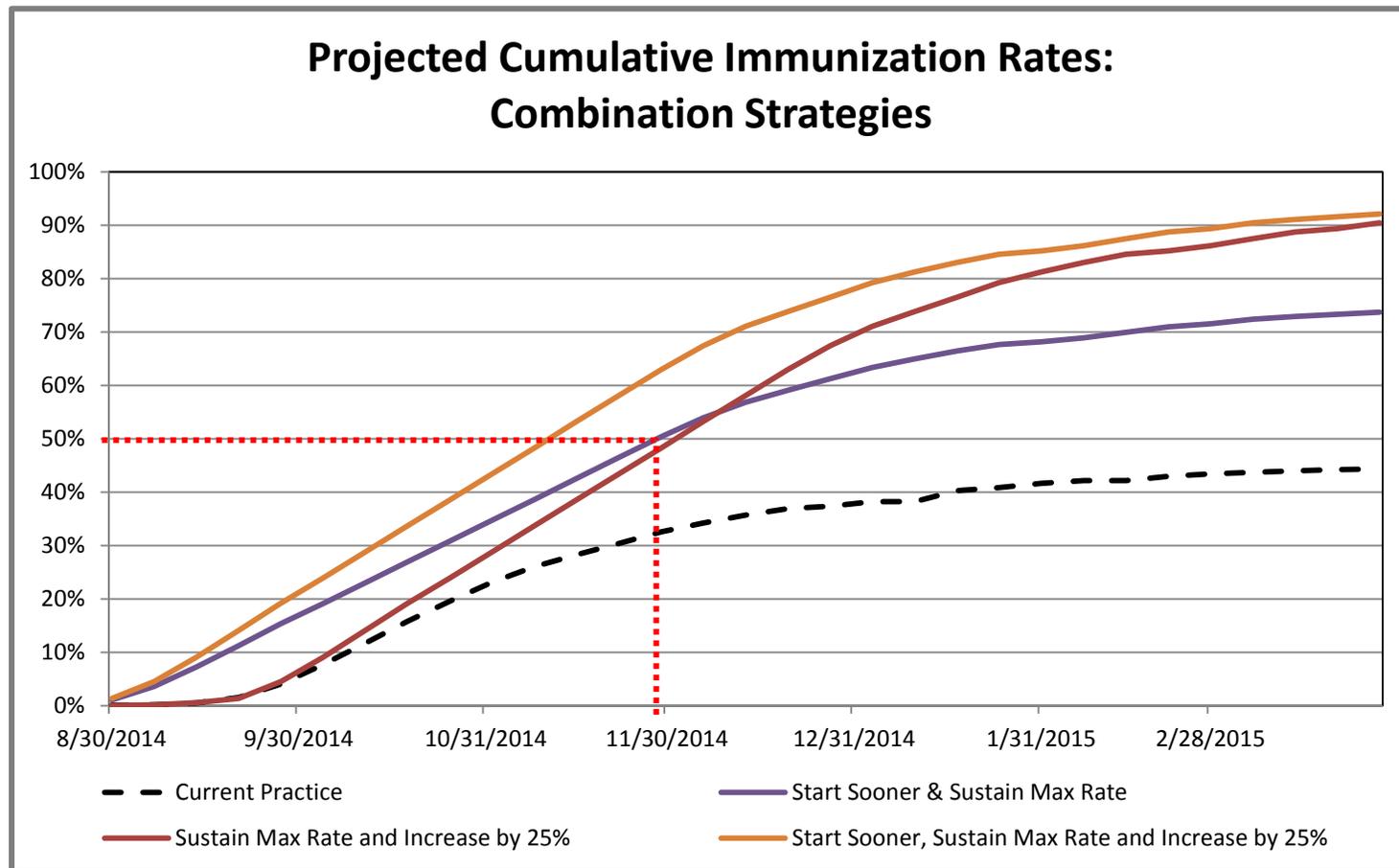


Figure 5. Projected cumulative influenza immunization rates using three combination strategies compared to current practice. Minimum herd immunity threshold to be reached by 11/30/2015 is shown in red. All three strategies are projected to meet or exceed the goal of 50% before ILI activity begins. All strategies could meet the IHS/HP 2020 goal of 70% coverage for the flu season but only on (using all three single strategies) will achieve this goal before ILI activity would be expected to peak.



Recommendations

Clinical sites in the Portland Area should review their local influenza policies and practices as well as data on levels of influenza immunization achieved in prior years to determine where attention should be placed to achieve immunization levels that approach the IHS goal of 70% coverage for all aged 6 months and older. The data projections in this plan (Figures 4 and 5) demonstrate that more than one single strategy will likely need to be employed to reach the goal.

The strategies outlined in the driver diagram (Table 4) can be achieved by adopting new policies and practices aligned with the primary and secondary drivers shown and by addressing the constraints for each. Support for these activities include technical and subject matter expert advice coordinated through the IHS Division of Epidemiology and Disease Prevention as outlined in the Appendix 1. Further support, particularly with data analysis and various media/outreach materials (posters, postcards, PSAs and articles for local publication) will be provided by the Portland Area IHS through the Office of the Director and the Division of Clinical Support. Appendix 2 is a toolkit for engaging patients and communities through conversation, outreach and multimedia. The resources in this toolkit should be an integral part of any campaign or plan to improve influenza immunization coverage.

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Appendix 1. IHS Strategic Plans for Improving Influenza Immunization

1. IHS Division of Epidemiology and Disease Prevention (DEDP) will host monthly flu update calls throughout influenza season. For 2014-2015, these will occur on the 3rd Wednesday of every month at 3pm EDT/EST.
 - a. Oct. 15th
 - b. Nov 19th
 - c. Dec. 17th
 - d. Jan. 21st
 - e. Feb. 18th
2. IHS Chief Medical Officer will send out monthly report to all Area CMOs and Area Directors with influenza vaccine coverage by Area for children 6 months – 17 yrs, adults 18 years and older, and overall coverage for everyone 6 months and older.
3. IHS Public Affairs will contact and facilitate the distribution of radio PSAs developed for AI/AN communities to Tribal radio stations.
4. IHS Public Health Nursing (PHN) program will host at least 2 webinars for PHNs to highlight PHN influenza vaccination strategies.
5. IHS PHN program will establish goals for each Area re: number of flu shots to be administered by PHNs at the start of each influenza season, using data from the 2013-2014 influenza season.
6. IHS Chief Medical Officer will include Influenza vaccine coverage goals as part of the SES performance plans. For FY 2015, the goal will be to achieve 70% coverage with influenza vaccine among adults 65 years and older. During the 2013-2014 season, IHS achieved coverage of 68.1% of adults 65 years and older. Table 1 includes a breakdown of the number of adults 65 years and older that need to be vaccinated in each Area's federal facilities to meet this goal.

Increasing Community Engagement

7. IHS DEDP will work in conjunction with the CHR program to develop training for CHRs re: adult immunizations, including influenza, and communication strategies CHRs can use to educate their communities on the importance of vaccines.
8. IHS DEDP in collaboration with the CHR program will host a webinar for CHRs to provide information about influenza and the importance of vaccination.
9. IHS DEDP in collaboration with the Great Plains Tribal Epidemiology Center is working with KAT Communications to develop PSAs on the importance of adult immunizations. These PSAs will be made available for IHS and Tribal sites that currently use GoodHealth TV in their facilities.

For 2016-2017 and beyond

1. Change GPRA Influenza Measure – A developmental measure to measure coverage with influenza vaccine among children 6 months – 17 years and adults 18 years and older, will be included as part of the Clinical Reporting System Version 15.1 that will be released in the summer of 2015. These data will be used to justify the change in the GPRA measure and presented to OMB to establish goals for IHS with this new influenza measure, starting in FY 2016 or 2017.
2. Identify Health Promotion and Disease Prevention activities to promote importance of Flu vaccination at local community activities.
3. Work with PHN Programs to improve outreach and patient education on the importance of Flu vaccination.

Appendix 2. Community Outreach and Media Resource Toolkit

The goal of this appendix is to identify resources that can be used for educating providers about the importance of influenza vaccination for patients and themselves and to identify resources that are targeted to patients and community members about the importance of influenza vaccination. It has been suggested that for healthcare personnel, the following priorities should be addressed¹:

1. Educate ourselves and other health care workers about influenza
2. Recommend vaccination to our high-priority patients
3. Set up systems for promoting vaccination in our practices
4. Evaluate our efforts and provide feedback to providers
5. Consider new locations for vaccine delivery
6. Get ourselves and our staff immunized.

1. Educate ourselves and other health care workers about influenza

Numerous opportunities exist for healthcare personnel to learn about the importance of influenza vaccination to protect themselves, their patients and even their families. Below are a few resources that can make a difference:

- <http://www.cdc.gov/vaccines/hcp.htm>
- <http://www.immunize.org/>
 - <http://www.immunize.org/handouts/influenza-vaccines.asp>

2. Recommend vaccination to our high-priority patients

A strong recommendation to patients to get vaccinated is one of the most influential actions we can take to help get patients get the vaccines they need. It is important to talk with patients and parents in an open, non-judgmental tone and to use language that is easier for them to understand. Written materials should target a 6th grade reading level. Assessing a patient's or parent's literacy level could help improve the method and manner used for communicating complex health topics like immunizations. Motivational interviewing techniques can be used to help patients understand and accept influenza vaccination.

- <http://www.cdc.gov/vaccines/ed/patient-ed.htm>
- <http://www.cdc.gov/vaccines/hcp/patient-ed/conversations/conv-materials.html#talkpvi>
- <http://www.immunize.org/talking-about-vaccines/>
- <http://www.immunize.org/resources/>
- http://www.ecbt.org/index.php/strategies_and_resources/article/education

3. Set up systems for promoting vaccination in our practices

Too often, vaccine information is given to patients only moments before they are being asked to make the decision about receiving the vaccine resulting in insufficient time to read and understand the benefits and risks to receiving the vaccine. Providing this information earlier in the visit and through multiple channels could prove to be helpful for patients who want to know more.

Other promotional materials besides the standard required CDC Vaccine Information Statement or VIS may also be helpful. For example Video or TV displays can carry informational messages, videos or digital stories from real patients or respected tribal leaders to encourage patients to get vaccinated. These can be more powerful if they include Native languages. Good Health TV (<http://www.goodhealthtv.com/native/>) is an excellent resource for video streaming health messages that are specific for Native people and often can include message in specific Native languages.

Brochures that explain the importance of influenza vaccination using simple language and including photos or art work from the local community can help build trust in the information and the services being offered.

4. Evaluate our efforts and provide feedback to providers

Improving immunization practice, including seasonal influenza immunization, is a complex undertaking. The clinic system must be designed to provide immunizations in the most efficient manner possible. Key recommendations include the efficient use of Electronic Medical Records (EMR); access to state Immunization Information Systems (IIS); real-time, two-way data exchange between EMRs and IISs; and developing policies to implement standing orders for immunizations. Setting these systems in place and evaluating them using the Model for Improvement (Plan –Do –Study –Act cycle) are needed to guide improvement efforts.

- <http://immunization.acponline.org/>
- <http://www.preventchildhoodinfluenza.org/>
- <http://www.adolescentvaccination.org/>
- <http://www.adultvaccination.org/>

5. Consider new locations for vaccine delivery

Community-based efforts to vaccinate at health fairs, elder programs, day-cares, preschools and schools can increase the number of people in the community who get influenza vaccines. The goal is to make the vaccine as available as possible and to make getting the vaccine as easy as possible. Successful venues have included providing flu vaccines at fun run events, drive-through vaccination campaigns, combining flu vaccination with colorectal cancer screening (Flu-FIT) and many others. Providing incentives to attract people to the event or for getting immunized can help increase your success. School-based influenza vaccination campaigns have also been shown to decrease influenza and increase school attendance.²

6. Get ourselves and our staff immunized.

IHS is considering a mandatory flu vaccine policy for healthcare providers. This is an effort to increase the level of vaccination for our employees which will have the double effect of: 1) protecting staff and patients from the flu; and 2) encourage patients to receive the flu vaccine by following our example. Many healthcare and professional organizations across the country are implementing mandatory flu vaccination for their employees. Regardless of whether your organization adopts mandatory flu vaccination of healthcare workers, providing information to encourage employees to get vaccinated and making the vaccine available free of charge to employees can help improve employee vaccine coverage.

- <http://www.immunize.org/hcw/>
- <http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html>

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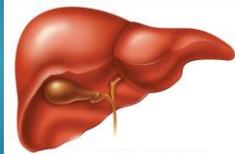
Hepatitis C The Silent Epidemic

CAPT Stephen "Miles" Rudd, MD, FAAP
 Chief Medical Officer/Deputy Director, Portland Area IHS
 Chairman, IHS National Pharmacy & Therapeutics Committee
 October 2015 Northwest Portland Area Indian Health Board - Quarterly Board Meeting
 Pendleton, OR

2

Hepatitis:

- ▶ A disease characterized by inflammation of the liver.
- ▶ Causes of hepatitis
 - ▶ Toxins
 - ▶ Certain drugs
 - ▶ Some diseases
 - ▶ Heavy alcohol use
 - ▶ Bacterial and viral infection
 - ▶ Hepatitis A, B, C



3

Viral Hepatitis (Alphabet Soup)

- ▶ Hepatitis A
 - ▶ Foodborne spread (contaminated food or water, fecal-oral route)
 - ▶ Acute illness (never chronic)
 - ▶ Usually improves without treatment
 - ▶ Vaccine preventable
- ▶ Hepatitis B
 - ▶ Spread through blood or body fluids
 - ▶ Can be acute or chronic
 - ▶ Vaccine preventable
- ▶ Hepatitis C
 - ▶ Spread through blood most commonly
 - ▶ Can be acute or chronic
 - ▶ No vaccine available



Hepatitis C:

4

- ▶ Contagious liver disease caused by the Hepatitis C virus (HCV)
- ▶ Spread:
 - ▶ Mostly by blood (needles, syringes, blood transfusion before 1992, unregulated piercing/tattooing)
 - ▶ Low risk for spread through sharing personal care items (razors, toothbrushes)
 - ▶ Low risk through sex
 - ▶ Risk increased for those with multiple sex partners, other STDs, HIV



Hepatitis C:

5

- ▶ Acute Hepatitis C
 - ▶ Short-term illness occurring in the first 6 months after exposure
 - ▶ Often has no symptoms (70-80%)
 - ▶ 15-25% of people infected with HCV will clear the infection.
- ▶ Chronic Hepatitis C
 - ▶ Long-term to life-long illness
 - ▶ Complications:
 - ▶ Chronic liver disease (60-70%)
 - ▶ Cirrhosis (5-20%)
 - ▶ Liver cancer (2-6% /yr of those with HCV-related cirrhosis)



Hepatitis C Statistics:

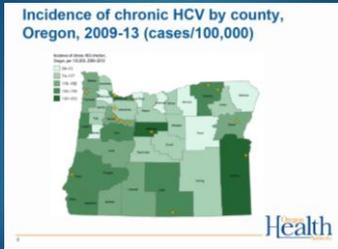
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- ▶ US population
 - ▶ 29,718 cases reported in 2013
 - ▶ ~2.7-3.9 million persons in US have chronic Hepatitis C virus infection
 - ▶ 15,106 deaths due to HCV in 2007
- ▶ VA
 - ▶ 175,000 cases in 2014
- ▶ IHS
 - ▶ 25,815 patients have a positive screening test for HCV (NDW, Dec. 2014)



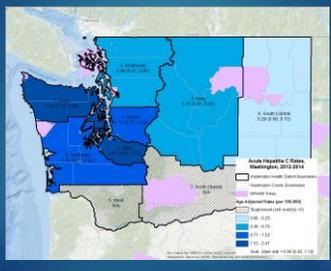
Hepatitis C in OR:

7



Hepatitis C in WA:

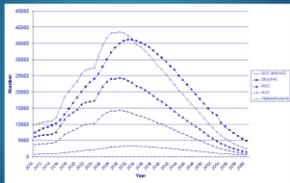
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Hepatitis C Forecast:

9

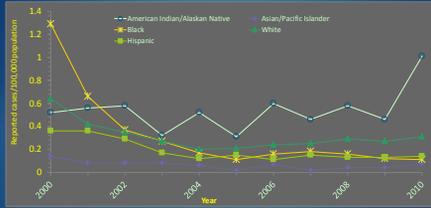
Forecasted Annual Incident Cases of Decompensated Cirrhosis (DCC), Hepatocellular Carcinoma (HCC), Liver Transplants, and Deaths Associated with Persons with Chronic Hepatitis C Infection and No Liver Cirrhosis in the United States in 2005



Rein, DK, Wiersch, JS, Weinbaum, CM, Saha, M, Smith, RD, Lentine, SB. Forecasting the Morbidity and Mortality Associated with Persistent Cases of Pre-Cirrhotic Chronic Hepatitis C Infections in the United States. *Journal of Digestive Liver Diseases* 2010.

Hepatitis C by Ethnicity:

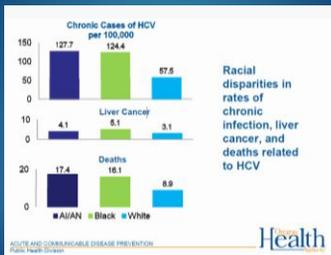
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Source: National Notifiable Diseases Surveillance System (NNSS)

Hepatitis C in OR:

11



ACUTE AND COMMUNICABLE DISEASE PREVENTION
State Health Division

Racial disparities in rates of chronic infection, liver cancer, and deaths related to HCV

Who is at risk for Hepatitis C:

12

- ▶ People at increased risk:
 - ▶ Injection drug users, current * or past (even one time)
 - ▶ Recipient of blood, blood products, or organs before 1992
 - ▶ Long-term hemodialysis patients
 - ▶ People who received tattoos or body piercing with non-sterile instruments
 - ▶ People with known exposures (healthcare workers with needlesticks)
 - ▶ HIV-infected persons
 - ▶ Children born to mothers with HCV (6%)
- ▶ Less common risk
 - ▶ Sexual contacts of persons infected with HCV
 - ▶ Those sharing personal care items that may have come into contact with blood from an infected person.



Hepatitis C: Symptoms

13

- ▶ Acute Hepatitis C
 - ▶ Fever
 - ▶ Fatigue
 - ▶ Loss of appetite
 - ▶ Nausea
 - ▶ Vomiting
 - ▶ Abdominal pain
 - ▶ Dark urine
 - ▶ Clay-colored bowel movements
- ▶ Joint pain
- ▶ Jaundice (yellow color in the skin or eyes)



Hepatitis C Screening:

14

- ▶ Blood test can be used to screen for antibodies against HCV.
- ▶ Screening recommended for:
 - ▶ High risk persons
 - ▶ Persons born between 1945 through 1965 (Baby Boomers)
 - ▶ 5x more likely to be infected
 - ▶ 3 out of 4 people with HCV infection are in this age group
- ▶ A positive antibody test (ever been infected) should be followed by a test for viral genes (still infected)

Why screen for HCV?

15

- ▶ Counseling on prevention of spread.
- ▶ Vaccination against Hepatitis A & B.
- ▶ Counseling on avoidance of alcohol.
- ▶ Counseling on avoidance of certain prescription pills, supplements, or over-the-counter medications that can damage the liver.
- ▶ Monitoring for chronic hepatitis and cirrhosis (and complications).
- ▶ Identifying patients that would benefit from treatment.

Hepatitis C Treatment:

16

- ▶ Two important definitions:
 - ▶ Sustained Virologic Response (SVR)- a marker for HCV cure
 - ▶ HCV is undetectable in the blood for 24 weeks after therapy.
 - ▶ HCV Genotype- differing strains of HCV (6)
 - ▶ Genotype 1 is most common (subtypes a & b)
 - ▶ Genotype 2 and 3 respond better to treatment
- ▶ Antiviral medications for the treatment of Hepatitis C infection have been available since the 1990s.
- ▶ Recently, there has been a rapid increase in newer medications.

Hepatitis C Treatment: 1990s

17

- ▶ Interferon and ribavirin
 - ▶ Required 24-48 weeks of treatment
 - ▶ Involved weekly injections (interferon) and twice daily pills (ribavirin).
 - ▶ Significant side effects
 - ▶ Flu-like symptoms (80%) - fever, headach, body aches
 - ▶ Depression and irritability (40%)
 - ▶ Other- low blood counts and thyroid inflammation.
 - ▶ 10-14% cannot tolerate therapy
 - ▶ SVR- genotype 1 (45-60%), genotype 2 & 3 (75-80%)
 - ▶ Cost: ~\$12,000 (24 week)-\$24,000 (48 week)



Hepatitis C Treatment: 2015

18

- ▶ Several newer options
 - ▶ Ledipasvir/sofosbuvir (Harvoni®)
 - ▶ Daclatasvir (Daklinza®)
 - ▶ Simeprevir (Olysio®)
 - ▶ Sofosbuvir (Sovaldi®)
 - ▶ Ombitasvir/paritapevir/ritonavir plus dasabuvir (Viekira Pak®)
- ▶ Typically 12 weeks of treatment
- ▶ Once daily dosing.
- ▶ Well tolerated (few side effects)
- ▶ SVR- greater than 90% (some approach 100%)
- ▶ Cost: ~\$38,00-\$91,000



Who should be treated?

19

- ▶ Cure of HCV results in improved survival, reduced morbidity, and higher quality of life.
- ▶ Safety and efficacy of newer regimens create a benefit for all patients with chronic HCV infection, except for those with a limited life expectancy due to non-related diseases (< 12 months)
- ▶ To treat the ~29,000 identified IHS patients with Harvoni® for 12 weeks would cost ~ \$1.1 billion.
- ▶ With limited resources, the recommendation is to prioritize treatment to those at highest risk
 - ▶ Advanced fibrosis
 - ▶ Transplant recipients
 - ▶ Severe extrahepatic manifestations
 - ▶ High-risk for fibrosis progression (HIV coinfection, diabetes, coexisting liver disease)

Risk Stratification

20

- ▶ The degree of liver fibrosis (scarring) is used as a measure for the severity of the liver disease
- ▶ The gold standard for determining fibrosis is a liver biopsy
 - ▶ Not the most practical test due to limited availability, costs, and risk.
- ▶ Calculation based on blood tests can be used to approximate fibrosis (APRI, FIB-4)
 - ▶ Hepatitis C Risk Stratification Panel
 - ▶ Export iCare panel into Excel tool
 - ▶ Automatically calculates APRI and FIB-4

Paying for Treatment

21

- ▶ CMS and some third party insurers will pay for antiviral therapy for HCV infection.
 - ▶ Why?
 - ▶ Liver transplant cost ~\$300,000 + \$25,000/yr for antirejection drugs
 - ▶ Cirrhosis cost ~\$25,000 per admission
 - ▶ Various eligibility criteria can still limit access
- ▶ Patient Assistance Programs
 - ▶ Drug company sponsored programs that provide free medication
 - ▶ Most meet low-income eligibility
 - ▶ Non-formulary status has been critical

Mandating Treatment

22

- ▶ VA announced in Feb. 2015 that they would provide treatment to all HCV patients.
 - ▶ Set aside \$700 million for drug cost
 - ▶ Completed depleted fund by June.
 - ▶ The budget shortfall required the VA to pull back and prioritize treatment
- ▶ IHS policy for federal IHS facilities is in early draft form.

Supports for Treatment

23

- ▶ Previously, many patients with HCV received treatment under the care of hepatologist or infectious disease specialist.
- ▶ The safety of newer treatments and the growing number of patients is shifting care more and more to primary care.
- ▶ Extension for Community Healthcare Outcomes (ECHO)
 - ▶ UNM developed model for teleconsultation
 - ▶ Multiple options
 - ▶ Univ. of WA
 - ▶ IHS- 1st Wed., 12:00-1:00 pm MDT



Recommendations

24

- ▶ Screen for Hepatitis C Infection (High-risk, Baby Boomers).
- ▶ Use a confirmatory test for all positives.
- ▶ Educate all HCV + patients on liver protection (alcohol/drugs), prevention of spread, and vaccinate against Hepatitis A & B.
- ▶ Create a HCV panel and risk-stratify patients.
- ▶ Use a multi-pronged approach to providing treatment (CMS, third-party, patient assistance programs).
- ▶ Utilize ECHO supports.

Questions?

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Dental Health Aide Therapists



BRINGING ORAL HEALTH CARE INTO THE 21ST CENTURY

NPAIHB QBM
WEDNESDAY, OCTOBER 28, 2015
PAM JOHNSON, ORAL HEALTH PROJECT SPECIALIST



Oral Health is important to overall health



YET MILLIONS OF PEOPLE LIVING IN TRIBAL COMMUNITIES CANNOT GET THE DENTAL CARE THEY NEED.



A Solution: Dental Health Aide Therapists

- Model began in the 1920s
- Dental therapists practice in 54 countries, including the US, Canada, England, Australia, New Zealand and The Netherlands
- Under supervision of dentists, dental therapists can practice in remote settings where there is need for additional provider capacity
- Evidence shows care provided by dental therapists is high quality, cost effective and safe
- History of providing routine and preventive care in community settings

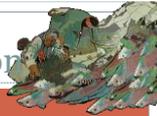


Dental Therapists

- Primary oral health care professionals
- Basic clinical dental treatment and preventive services
- Multidisciplinary team members
- Advocate for the needs of clients
- Refer for services beyond the scope of the DHAT's practice



Dental Therapists in Action



Alaska's Dental Therapists

- 35 dental therapists increased access to care for over 45,000 Alaska Natives
- Provide culturally competent care
- Produce high patient satisfaction rates
- Reduce amount of emergency care
- Increase preventive care
- Create jobs and generate economic impact
 - Created 76 full time jobs per year with total personal income of \$4.4 million
 - Net economic effect of program is \$9.7 million in Rural Alaska



Swinomish Dentist Rachael Hogan observes DHAT Savannah Bonorden on a recent learning trip to Sitka, AK



Why no DHATs in lower 48???

After losing the battle in Alaska to prevent DHATs from expanding services to Tribal communities, the American Dental Association was successful in inserting the following language in the re-authorization of the Indian Health Care Improvement Act:

Expansion of the Community Health Aide Program “shall exclude dental health aide therapist services from services covered under the program...”

“...shall not apply in the case of an election made 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...”



Swinomish Indian Tribal Community DHAT Initiative



Swinomish Chairman and NCAI President Brian Cladoosby announcing the Swinomish DHAT Initiative, June 2105

Swinomish Current Political and Legal Solution

-Swinomish Tribal Community worked for the past two legislative sessions with the Northwest Portland Area Indian Health Board and the Washington State House and Senate to craft a **Tribal Specific DHAT Authorization Bill**

-Lobbied heavily by the WSDA, no DHAT Bill—tribal or otherwise--got out of House or Senate Committees in Washington State for the past 10 years.

-Swinomish has determined that it has the power and obligation to address oral health systems change under Tribal Sovereignty

Solutions for Swinomish Provided by DHAT

- 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 Health Aide Therapist
- Analysis shows that the same procedures could have been covered with 50% Personnel cost savings-replace Dentist time with DHAT time
- DHAT Licensure Authorization would help I/T/U Clinics fill a huge gap in service demand across the Indian Health Service system for Native patients
- Work Force Development strategy of a DHAT based in the Community assures longer term Community and Public Health benefits

Our Current Systems Solution

-Swinomish has adopted 2 Tribal laws under its own regulatory framework:

•It has created a Division of Licensing, roughly equivalent to the State of Washington's and

•It has adopted a Dental Health Provider Licensing Code under which Dentists, Dental Hygienists, and Dental Health Aide Therapists will be licensed

History being made!



Swinomish Dental Health Provider Licensing Board and Staff: 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 Fisel, Board Member; Brian Wilbur, Board Member. Board members not pictured: Ruth Ballweg and Diane Vendiola.

Building a 21st Century Dental Team!

Swinomish has entered in to a Interlocal Agreement with the Alaska Native Tribal Health Consortium to provide DHAT Training to Swinomish members accepted into the program. The first trainee started the program this July, and after graduating in 2017 will come back to serve her community.



**Aiyana Guzman, SITC,
Class of 2017**

DHAT services begin in January 2016



Daniel Kennedy, experienced DHAT currently working for the Southeast Regional Health Consortium in Alaska will be joining the Swinomish Dental Clinic Team!

Analysis of the Swinomish Solution

-The Swinomish Solution is a huge step forward in advancing DHATs and dental therapists in the lower 48.

-Swinomish Solution develops a "replicable Tribal Model" under Tribal Sovereignty

-Unfortunately the Swinomish Model cannot be duplicated by all Tribes, especially resource poor tribes

-State Legislatures still need to authorize DHATs, especially in Tribal settings under current IHCIA language!

Oregon Tribes DHAT Pilot Project



Oregon Dental Pilot Projects were authorized by state legislation in 2011 to increase access and improve quality to oral health care by:

- Teaching new skills to existing providers,
- Developing new categories of dental providers, and
- Accelerating and expanding the training to current providers.

This year, 2015, legislation was passed to:

- Extend the sunset date from 2018 to 2025--acknowledging the slow start and lack of funding to the program since 2011
- Make sure new providers and services would be covered by Medicaid
- Oregon Health Authority funded for upcoming year to administer the program

The Northwest Portland Area Indian Health Board, working with Oregon tribes, has submitted a dental pilot project to the Oregon Health Authority to train and employ DHATs at Tribal Health and Dental Clinics. Proposed outcomes of the pilot are to:

- Expand access to consistent, routine, high quality oral health care in tribal communities;
- Grow the number of AI/AN oral health care providers available to tribal communities;
- Bring culturally competent care into tribal communities;
- Create a more efficient and effective oral health team that can meet the needs of the tribal communities;
- Establish cost effective solutions to oral health challenges in tribal communities;
- Bring care where it is needed most.

Initial Pilot Sites

- Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians
- Coquille Indian Tribe



Pilot Project Application

- First Pilot Project submitted to the state: Project 100!
- The application includes a full summary of project, training program, employment options, patient notification, evaluation and monitoring plan, and costs
- Last week it was deemed "complete" and sent to a Technical Review Board for a 30 day review.
- Final decision rests with the OHA Dental Director

Next Steps

- Work with pilot tribes to start informing and educating the tribal community about adding a DHAT to the dental team.
- Start recruiting 2nd DHAT student from CTCLUSI and 1st DHAT student from Coquille for July 2017 start of training
- Initiate training for the supervising dentist at CTCLUSI
- Start recruiting an experienced DHAT to begin providing services at dental clinic in mid-2017
- Explore setting up a regulatory structure/licensing code similar to Swinomish

Building a 21st Century Dental Team!

Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians has entered in to a Interlocal Agreement with the Alaska Native Tribal Health Consortium to provide DHAT Training to CTCLUSI members accepted into the program. The first trainee started the program this July, and after graduating in 2017 will come back to serve her community.



Naomi Petrie, CTCLUSI
Class of 2017



Northwest Portland Area Indian Health Board

*Indian Leadership for
Indian Health*

2222 SW Broadway, Suite 300
Portland, Oregon 97201
Phone: (503) 228-4285
Fax: (503) 228-8182

For more information please contact:

Christina Peters, Oral Health Project
Director
cpeters@npaihb.org
206.349.4364

Pam Johnson, Oral Health Project
Specialist
pjohnson@npaihb.org
206.755.4309

Northwest Tribal Epidemiology Center

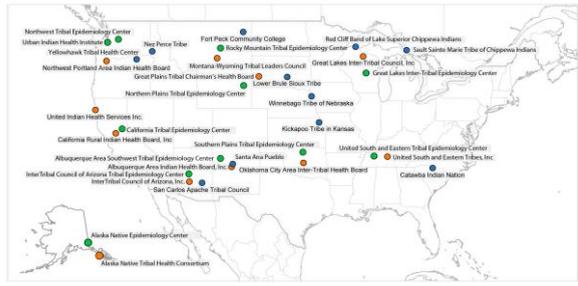
Wellness for Every American Indian to Achieve and View Health Equity- Northwest

WEAVE-NW
2014-2019



WEAVE-NW

Comprehensive Approach to Good Health and Wellness in Indian Country Awards (DP14-1421PPHF14)



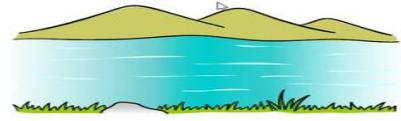
About WEAVE-NW...

Long-term Objective

To decrease cardiovascular disease, obesity, and type 2 diabetes

Upstream Projects

- ✓ Policy, systems, and environment (PSE) focus
- ✓ Culturally adapted prevention activities



What is a policy, system & environment (PSE) change?

Policy passing of or change to a law, ordinance, resolution, regulation or rule designed to guide or influence behavior

System involves change made to organizational procedures

Environment change made to the physical surroundings



10/22/2015 Northwest Portland Area Indian Health Board 4

Year 1 Highlights

- 5 Sub-awards**
- ✓ Logic Model and evaluation
 - ✓ Data Sharing Agreements
 - ✓ Site visits
 - ✓ Video conference calls
 - ✓ Dissemination of resources
- Trainings and Workshops**
- ✓ Risky Business Training
 - ✓ Native Fitness Training
 - ✓ Health Data Literacy Workshop



Northwest Portland Area Indian Health Board 5

Year 2-4 (2015-2019)



6

Technical Support for All Tribes

Monthly training modules
Resources & Technical Assistance



10/22/2015 Northwest Portland Area Indian Health Board 7

Year 2 Sub-award Announcement
Applications due 11/09/15

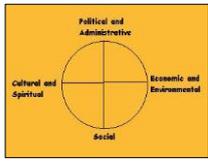
Maximum of \$25,000 a year for up to 2 years = \$50,000

- Funding for activities related to:
- ✓ Health policies
 - ✓ Health systems
 - ✓ Built environment

Quarterly updates and interim reports

Funding Restrictions:

- Research
- Clinical care
- Furniture
- Equipment
- Clinic and patient supplies
- Building (breaking ground)



8

Examples of Projects

Increase access to healthy traditional foods

- ✓ Community gardens
- ✓ Food policy in schools, elder centers, head start
- ✓ Farm to school, farmer's markets

Increase physical activity

- ✓ Walking path use
- ✓ Prescriptions/referrals to fitness opportunities



Breastfeeding initiatives

Reduce commercial tobacco use & secondhand smoke

Team-based care strategies for chronic disease

9



WEAVE-NW Team

Victoria Warren-Mears
Director Northwest Tribal Epidemiology Center

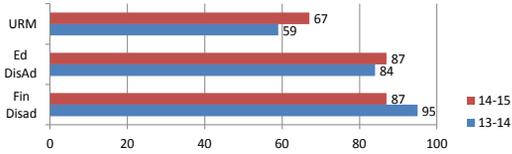
Nanette Star Yandell
Project Director

Nora Alexander
Project Specialist

Jenine Dankovchik
Project Evaluator

Ryan Swafford
Tobacco Project Specialist

OREGON HEALTH & SCIENCE UNIVERSITY **Scholarship Recipient Data** School of Nursing



A Passion for Nursing
www.ohsu.edu/son

OREGON HEALTH & SCIENCE UNIVERSITY **Year One Trainee Data** School of Nursing

- 41/44 retained through Year 1 (93.2%)
- 15 students graduated
- 12/14 passed their license exam on first try – 85.7% pass rate (better than national pass rate of 81.74%)
- 9/12 (75%) of graduates working in a medically underserved area

A Passion for Nursing
www.ohsu.edu/son

OREGON HEALTH & SCIENCE UNIVERSITY **Students say.....** School of Nursing

"Thank you for this great opportunity. This scholarship is fantastic! I am going up to Salem with my mentor tomorrow to spend the day with ORANA (Oregon Association of Nurse Anesthesia) on their legislative day. I am very excited."

OHSU Ashland Student



A Passion for Nursing
www.ohsu.edu/son



Questions

School of Nursing

What is the role of nurses in improving the health of Native Americans in our region? How could it be improved/expanded?



Is it an interest/priority for tribal leaders to increase the number of Native American nurses in the workforce?



If so, how can we partner with Native American groups throughout the state to increase Native American student interest in nursing?

What advice do you have for us?

A Passion for Nursing www.ohsu.edu/son



Thank you

School of Nursing

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) Nursing Workforce Diversity Program Grant Number D19HP25901 Advancing Health Equity through Student Empowerment & Professional Success (HealthE STEPS), \$1.05 million. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Diverse nurses make a difference in the communities they serve.



Become a nurse at the OHSU School of Nursing!

A Passion for Nursing www.ohsu.edu/son



NATIVES HELPING NATIVES



Michelle Singer (Navajo)
 The Center for Healthy Communities
 Oregon Health & Science University (OHSU)

PRESENTATION OVERVIEW

- Native STAND 101
- Resources
- Indian Country Significance
- Opportunities
 - > Training – Application Opportunity
 - > Upcoming Webinar for Interested Applicants
- Contact Info



WHAT IS NATIVE STAND?

Native
Students
Together
Against
Negative
Decisions



RATIONALE & PURPOSE



- In Indian Country, tribal and community leaders are keenly aware of the challenges faced by their teens.
- Our challenge, in terms of community readiness is to move community leaders beyond recognition of the problem to actual commitment of resources to evidence-based interventions.



FROM STAND TO NATIVE STAND

BACKGROUND

- STAND created by Mike Smith, Mercer University SOM, was the developer of the STAND curriculum.
- Reps. of National Coalition of STD Directors/I.H.S./CDC developed a work group.
- Native Work Group adapted the original STAND.
- Reviewed by Native Youth & Professionals.
- Validated in 4 BIE schools & 1 reservation community.
- Evaluated with findings.



NATIVE STAND

THE CURRICULUM

CORE ELEMENTS

1. **Facilitator's Manual**
 2. **Peer Educator Manual**
 3. **Resource Manual**
- 29 ~ 90 min. sessions
 - ❖ Culture and Tradition
 - ❖ Honoring diversity / respecting traditions
 - ❖ Healthy relationships
 - ❖ Negotiation and refusal skills
 - ❖ Decision making
 - ❖ Being a peer educator

- Uses active learning
- Uses primary prevention techniques
- Non-judgmental attitudes
- Information sharing
- Advocating specific behaviors
- Positive role modeling
- Promoting personal commitment
- Healthy, positive sexual expression in relationships

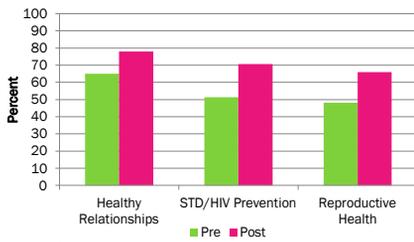
PAST EVALUATION FINDINGS



1. Students demonstrated significant improvements in knowledge of:
 - STD/HIV/AIDS Prevention
 - Reproductive Health
 - Healthy Relationships
2. Tribal youth reported providing 1-on-1 peer education and referrals.
3. Adult facilitators learned how to better communicate & teach about sensitive topics.
4. Program was well received; recognition in addressing critical gaps in sexual health education.



FINDING: NATIVE STAND IMPROVES KNOWLEDGE!



Pre- n=70 youth Post- n = 34 youth

CENTER FOR HEALTHY COMMUNITIES NATIVE STAND PROGRAM



This activity is funded by the CDC Prevention Research Center and the IHS NW NARCH as part of the efforts to eliminate health disparities for Tribal youth.

PROGRAM PARTICIPANT BENEFITS

- 1-week of hands-on free training with curriculum materials.
- 2-year implementation funding (\$5K each year)
 - ✓ Signed MOA
 - ✓ IRB Local Review Approval
 - ✓ Attend & Complete Training
 - ✓ Confidentiality Agreement
 - ✓ Submitted Action Plan
 - ✓ W-9 or Tax ID Form
- Technical assistance
- Data Collection & Evaluation



SUMMER TRAINING PROGRAM OPPORTUNITY
 JUNE 26 TO JULY 1, 2016

- 1 week in Portland
- Native STAND curriculum
- Practice at THRIVE
- Human subjects protection
- Technical Assistance
- Leave with action plans for home communities



EVALUATION

RE-AIM =

- REACH
- EFFECTIVENESS
- ADOPTION
- IMPLEMENTATION
- MAINTAINANCE



SIGNIFICANCE: COMMUNITY DRIVEN

- 50+ educators and AI/AN organizations trained
- Train-the-Trainer opportunity.
- Snowball Effect: Add new youth & allies
- Pre- and post- data on key indicators:
 - ❖ (+/-) Changes in youth
 - ❖ Community Awareness & Engagement
 - ❖ Capacity Building
 - ❖ Leverage



“NATIVES HELPING NATIVES”

The Native STAND Project Commitment:

- Build the capacities of tribal communities to engage in research.
- Allow individual communities to better access and understand data that would benefit their communities toward eliminating health disparities.



OPPORTUNITIES & RESOURCES

Online Application Available at www.oregonprc.org

Due – February 1, 2016

1. One hour Live Webinar for Interested Applicants – Nov. 19
2. View Center’s Website
3. Contact Project Manager for consult



**NATIVE STAND CORE TEAM
COLLABORATIVE PARTNERS**

OREGON PRC

Bill Lambert
Michelle Singer
Tosha Zaback
Ashley Thomas
Tom Becker



NPAIHB

Stephanie Craig Rushing
Jessica Leston
**Adolescent Tribal Health*
**NW Tribal Epi Center*





Contact Information



The Center for Healthy Communities
Native STAND Project
www.oregonprc.org

Michelle Singer (Navajo), Project Manager
singerm@ohsu.edu
503-418-2199





Photo courtesy of We R Native

Native STAND

Students Together Against Negative Decisions

What is Native STAND?

Native STAND is a comprehensive culturally-appropriate curriculum for Native American high school students that promotes healthy-decision making. The curriculum is intertribal, drawing on teachings from many tribes and communities across the country. Native STAND focuses on positive

youth development to support the prevention of sexually transmitted infections, HIV/AIDS, and to prevent teen pregnancy. The curriculum also addresses drug and alcohol use, suicide and healthy relationships. Native STAND is highly interactive.

The 1.5 hour lessons are comprised of large group discussions, small group work, individual activities, and many lessons containing stories from various tribal communities that ground learning in cultural teachings. The curriculum is flexible and can be easily adapted to include specific cultural stories and traditions from the site where it is being implemented.

Native STAND consists of 29 sessions which focus on positive personal development, including team building, diversity, self-esteem, goals and values, negotiation and refusal skills, and effective communication. Sessions have been delivered in school settings, at community centers, and in afterschool programs in various communities.



Native STAND youth on field trip. Photo courtesy of H.E.Y. (Healthy Empowered Youth)

Benefits of participating in this project:

- Free training (paid airfare and hotel costs) to become a Certified Native STAND Educator
- Up to \$10,000 in funds for implementing Native STAND
- Free curriculum materials, including a facilitator's manual, a resource manual, and a peer educator's manual
- Curriculum that empowers Native youth to make healthy choices and to become leaders in their communities

From a Tribal teacher where Native STAND was implemented:

"Look at what pride we have in our youth because of the big, major things this program is doing and these kids are doing. I think it makes the community look at our youth as stronger, more competent people..."

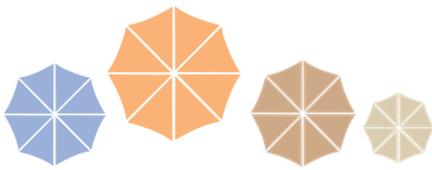
What is the Goal of the Native STAND Project?

The goal of the Native STAND Dissemination, Implementation, and Evaluation Project is to better understand how Tribal communities implement a program designed to help eliminate health disparities for high-school age American Indian/Alaska Native (AI/AN) youth. It is important to understand the factors that affect adoption and use of the Native STAND curriculum by measuring and evaluating the impact of the program in AI/AN communities and key indicators of healthy behavior in AI/AN teens.

This study is funded by the Centers for Disease Control and Prevention and Indian Health Service. The project is a partnership between Oregon Health & Science University's Prevention Research Center, the Center for Healthy Communities, and the Northwest Portland Area Indian Health Board. Participation in this project is open to Tribes and AI/AN organizations across the United States.



Photo courtesy of We R Native.



Center for Healthy Communities

OHSU, CDC Prevention Research Center

Learn About Native STAND

www.oregonprc.org

Michelle Singer (Navajo), Project Manager
Native STAND

Center for Healthy Communities
Oregon Health & Science University
3181 SW Sam Jackson Park Road, CB 669
Portland, OR 97239

Tel: 503.418.2199

Fax: 503.494.7536

E-mail: singerm@ohsu.edu



From former Native STAND youth participants:

“This class is very good. It helps you [learn] what you want to be in your life. You want to set your goals. It could really help you.” — High School Boy

“It [the program] really helped me deal with drinking. It helped me with my thinking.” — High School Girl

Important Dates in 2016:

February 1: Application Deadline

March 1: Site Selection for Project

June 26-July 1: Native STAND Certified Training

To Apply Visit

www.oregonprc.org

Requirements for Participating Tribal Communities

In order for Tribes and AI/AN organizations to be considered for participation in this project, they will need to commit to the following:

- Identify and support an individual (such as a health educator or prevention specialist) to receive the free, one-week summer Native STAND Certified Training Program.
- Complete and submit a full online application.
- Facilitators must ensure that they are able to attend and complete the entire one week certification training in Portland, Oregon. Native STAND will

provide participant's airfare, hotel and meal per diem.

- Communities must demonstrate access to a setting conducive to implementing the curriculum (school, community center).
- If accepted, a Memorandum of Agreement, local Institutional Review Board approval, and a valid W-9 IRS Form or appropriate Federal Tax ID will be required of sites before \$5000 per year will be distributed.
- Tribes and AI/AN organizations must allow the educator to implement the program through their current position.

- Accepted applicants will provide information to evaluators at the Center for Healthy Communities throughout the five-year duration of the project.

To learn more about the Native STAND Program, visit our website at www.oregonprc.org

To discuss eligibility requirements or for a program consult, please contact Michelle Singer, Project Manager at 503-418-2199 or singerm@ohsu.edu.



Photo courtesy of We R Native

The Center for Healthy Communities

Funded since 2004, the Center for Healthy Communities collaborates with communities to address health disparities in Native and other underserved populations. We are proud to be one of 26 CDC-funded Prevention Research Centers. (www.cdc.gov/prc)

Partners

Northwest Portland Area
Indian Health Board
www.npaihb.org

Native American Youth
& Family Center
www.nayapdx.org

Layton Aging and Alzheimer's
Disease Center
<http://www.ohsu.edu/xd/research/centers-institutes/neurology/alzheimers/>

Portland Area Indian Health Service
www.ihs.gov/FacilitiesServices/AreaOffices/Portland

OHSU Knight Cancer Institute
www.ohsu.edu/cancer

University of Northern Colorado
The College of Natural and Health Sciences
Audiology and Speech-Language Sciences
<http://www.unco.edu/nhs/asls/>



Staff

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Director

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Associate Director and Native STAND, PI
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Tosha Zaback, MPH
Program Manager
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Assistant Program Manager
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Michelle Singer
Native STAND, Project Manager
Tel: 503-418-2199 / E-mail: singerm@ohsu.edu

Contact Us:

Center for Healthy Communities
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www.oregonprc.org



The Center for Healthy Communities at OHSU is supported by Cooperative Agreement number U48DP005006 from the Centers for Disease Control and Prevention, Prevention Research Centers Program.

OHSU Prevention Research Center

Center for Healthy Communities



Photo courtesy of Fred Van Ronk
"Tsag-e-gal-el, "She Who Watches"
Columbia River Gorge

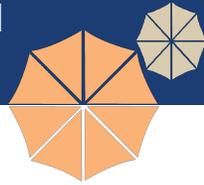


Promoting health in tribal communities





The Center for Healthy Communities is committed to addressing the health promotion and chronic disease prevention needs of American Indian/Alaska Native and other underserved communities through community-based participatory research, and through training, dissemination, and evaluation activities.



Research Projects and Training Programs

Native STAND Dissemination Project

Native STAND – Students Together Against Negative Decisions – is a culturally relevant healthy decisions curriculum for enhancing and promoting positive Native youth development and well-being. The intertribal curriculum is an evidence-based intervention for high-school age Native students, incorporating tradition and culture to address sexual health. Our Center will recruit, train, and support 50 AI/AN health educators to implement Native STAND and evaluate its adoption and impact.



(Contact: Michelle Singer, singerm@ohsu.edu)

Summer Research Training Institute for AI/AN Health Professionals

The Summer Institute is a three-week health research training for AI/AN health professionals and students. Tuition is waived for AI/AN participants. (Contact: Tosha Zaback, zabackt@ohsu.edu)

Dangerous Decibels Training

This two-day certification workshop prepares participants to present to K-12 classrooms on protecting their hearing from noise-induced hearing loss. (Contact: Deanna Meinke, deanna.meinke@unco.edu)



Oregon Community Cancer Research Collaborative

The Oregon Community Cancer Research Collaborative (OR-CCRC) is part of the CDC's Cancer Prevention and Control Research Network, a national network of academic, public health, and community partners who work together to reduce the burden of cancer, especially among those disproportionately affected. The OR-CCRC addresses the cancer prevention, early detection, and survivorship needs of rural, American Indian/Alaska Native, and other underserved communities, while emphasizing dietary and physical activity strategies.

(Contact: Paige Farris, pfarris@ohsu.edu)

Oregon Healthy Brain Research Network

The OrHBRN Collaborative Center, works to bring brain health research and culturally relevant messaging to diverse communities. The Center supports two projects:

- 1) Analysis of the Behavioral Risk Factor Surveillance System (BRFSS) survey data on cognitive impairment and caregiverburden.
- 2) SHARP – the Sharing History through Active Reminiscence and Photo-imagery pilot program will implement cognitive health maintenance with African Americans ages 55 and over. Participants will engage in neighborhood-based walking groups, on-line health education, and individual memory sessions. (Contact: Raina Croff, croff@ohsu.edu)



TOTS to TWEENS

This is a follow-up project to TOTS (Toddler Obesity and Tooth Decay Study). This project will survey and conduct dental exams with the original cohort of toddlers and their families to see if the early actions resulted in less caries and maintenance of preventive behavior over the last ten years. (Contact: Tam Lutz, tlutz@npaihb.org)

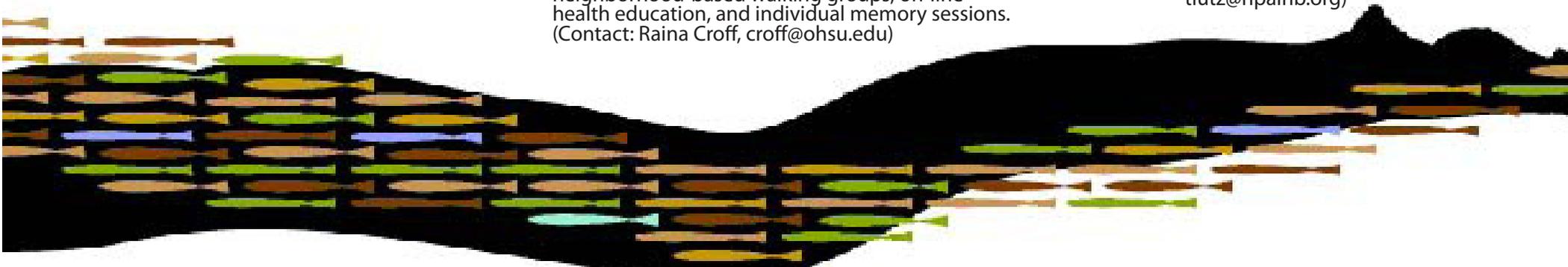
Native VOICES Adaptation

The Northwest Portland Area Indian Health Board is adapting a CDC-recognized intervention; Video Opportunities for Innovative Condom Education and Safer Sex (VOICES), and evaluating its effectiveness as an HIV/STD prevention resource for AI/AN teens and young adults 15-29 years old. (Contact: Mattie Tomeo-Palmanteer, mtomeo-palmanteer@npaihb.org)



Native Children Always Ride Safe: Dissemination

The project will build upon the success of the original Native CARS program to disseminate the tools, and intervention materials to other Northwest Tribal communities by engaging the original tribal member partners as experts. The team will develop an interactive website where the Native CARS Atlas (the toolkit for the intervention) will be available to download. (Contact: Tam Lutz, tlutz@npaihb.org)



Sexual Assault Resource and Response Circles
5 Year Project Summary

Ryan Swafford



Domestic Violence Preventative Initiative 2010-2015

Funded by: Indian Health Service; Domestic Violence Prevention Initiative (DVPI)



- 5 Year total award amount of \$722,000

Domestic Violence Preventative Initiative 2010-2015

Areas of Focus:

- Training and Technical Assistance for Sexual Assault Response & Resource Circles
- Sexual Assault Nurse Examiner Training
- Tribal Sexual Assault Dynamics Information
- Tribal Sexual Assault Advocacy Skills
- Public Awareness of Issue
- Tribal mini-grant funding for community based awareness activities

Domestic Violence Preventative Initiative 2010-2015

- 27 Community awareness events
- 23 Tribal partnerships through collaboration and training
- 21 Sexual assault advocacy trainings
- 17 Sub contracts awarded
- 3 Sexual Assault Nurse Examiner Trainings
- 1 Media campaign in collaboration with THRIVE

10/23/2015 Northwest Portland Area Indian Health Board 4

Media Campaign



10/23/2015 Northwest Portland Area Indian Health Board 5

Congratulations

- Burns Paiute Tribe
- Lower Elwha Klallam Tribe
- Quileute Tribal Council
- The Healing Lodge of the Seven Nations

10/23/2015 Northwest Portland Area Indian Health Board 6

 **Contacts**

For more information and resource material contact:
rswafford@npaihb.org

Veterans Committee

Tuesday October 27
Wildhorse Resort & Casino, Pendleton, OR

	Name and Title	Organization	Phone/FAX/E-mail
1	Toni Cordell Veteran Svcs Rep/Program Mgr	CTHR - Dept. of Children & Family Services	tonicordell@cthr.org 541-429-7389
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Northwest Portland Area Indian Health Board Quarterly Board Meeting Veteran Committee Meeting Minutes

October 28, 2015

Start Time:12:30 pm

Members Present: Toni Cordall

Members Absent: Bill Riley, Jim Sherill, John Daniels, Leo Stewart,Rena Wells, Velma Bahe

Staff Present: Ryan Ann Swafford

- Personnel update was not read
- *handed out the Warm Springs Veterans conference Flyer *Twila Teeman brought VA quick reference help books *Toni Cordall requested that IHS hold a webinar on the process of how IHS and VA work to bill for veterans medical.
- *Questions of how to improve screenings so veterans will not fall through the gaps *Telehealth was agreed upon but it found that it is not being implemented *VA Tribal Consultation- would like further expectation to start putting into use through billing

Legislative/Resolution Committee

Tuesday October 27
Wildhorse Resort & Casino, Pendleton, OR

	Name and Title	Organization	Phone/FAX/E-mail
1	Jim Polcott	NOMIHO	503 228 4185
2	Joe FinDonner	1	1
3	Leslie Waring	Susquamish	360 394-8466
4	Brent Simosky	James Ford	
5	Kim Lillyett	Shoalwater Bay	
6	Tim Gilbert	Yellowhawk	
7	Ed R	PentCombs S'Klallam	360 790 1166
8	Alan C. Fuller	Quemauet	
9	CHRYL RASDA	SNINOMISA	
10	Katie Johnson	NPAIHB	
11	Wynne A. Kennedy	cont. Encls of Grand Board	503-874-5211
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**NPAIHB Quarterly Board Meeting
Hosted by Confederated Tribes of the Umatilla**

Legislative Committee Report

October 29, 2015

Attendees – Cheryle Kennedy, Kim Zillyett, Pearl Capoeman-Baller, Leslie Wosnig, Brent Simcosky, Tim Gilbert, Ed Fox, Cheryl Raser, Katie Johnson, Joe Finkbonner, and Jim Roberts.

The Legislative Committee discussed the following issues:

- Preparation for White House Nations Meeting
- Preparation for 2016 Legislative Plan
- Resolutions

White House Meeting Issues:

1. IHS sequester under the BCA
2. IHS and cost incurred issues
3. ACA Employer issues: Employer mandate and Cadillac Tax, qualified health plan contracting issues and referrals issues
4. Self-Governance Philosophical issues at IHS around Information Technology and the proclaimed benevolence of the agency to take on initiatives on behalf of tribes but not consulting with them. E.g. GPRA patch.
5. Definition of Indian
6. IHS funds, unspent resources, and transparency
7. Suicide Prevention and substance abuse funding, Coordination issues among federal agencies and states around behavioral health strategic planning
8. CHEF thresholds – the need to lower since funds remains

Preparation for 2016 Legislative Plan

Adopt same issues included in Whitehouse meeting. Retain all other current issues in the Plan. A sample of the issues include the following:

- Permanent funding for EpiCenters
- Increase Alcohol and Substance Abuse and Mental Health funding
- Suicide Prevention
- Indian Definition
- QHP contracting issues
- Permanent authorization for SDPI

- Medicare-like rates
- IHS Advance Appropriations
- Make CSC mandatory funding
- Title VI legislation
- Tribal Public Health Infrastructure

Resolutions:

1. Interview Project with People Who Inject Drugs, Community, and Health Care Staff to Explore Community-Driven Education, Prevention, and Health Care Systems Improvement.
2. Support for Congress to Pass S. 1964, Family Stability and Kinship Care Act
3. Western Tribal Diabetes Special Diabetes Program for Indians
4. Tribal Exemption from the Patient Protection and Affordable Care Act Employer Shared Responsibility Mandate

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Public Health Committee

* Tuesday October 27
Wildhorse Resort & Casino, Pendleton, OR

	Name and Title	Organization	Phone/FAX/E-mail
1	Karen Hanson - Health Director	Kookerai Tribe of ID	208-267-5223 Fax: 208-267-8419 Karen@Kookerai.org
2	Susan Sheeships Health Commission	CTUIR	ssssheeships@gmail.com
3	Shawn Jackson Health Educator	Klamath Tribe	sjackson@klam.fort-had. ihs.gov
4	Kulu Litz	Coquille Indian Trib	kululitz@coquilletribe.org
5	Nanette Ste Vandell	NPAHB	nyvandell@npahb.org
6	Marilyn M. Scott	Upper Skagit Tribe	360 854-7039 marilyn.s@upper-skagit.com
7	Tom Weisler	IHS / NPAHB	
8	Michelle Stranger Hunter	OR Foundation for Reproductive Health	michelle@prochoice oregon.org
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**NPAIHB Public Health Committee
October 27, 2015**

Bridget Canniff, NPAIHB
Victoria Warren-Mears, NPAIHB
Marilyn Scott, Upper Skagit Tribe
Nanette Star Yandell, NPAIHB
Kelle Little, Coquille
Shawn Jackson, Klamath
Michelle Stranger Hunter, Oregon Foundation for Reproductive Health
Tom Weiser, MD, Indian Health Service
Susan Sheoships, CTUIR
Karen Hansen, Kootenai Tribe of Idaho

Washington Health Standards – Marilyn Scott

There is an overarching concern about the multiple reporting standards required by states, IHS, and other entities. In Washington, there was a Foundational Public Health Workgroup formed by Secretary of DOH. Under Results Washington, certain measures were identified for the State DOH. The Lead tracking agency for the state is DOH. A hope for coordination and connection and standards with GPRA measures, and what is happening with Medicaid via CMS. Currently there is a wide disconnect.

State should consider looking at GPRA measures that Tribes are already reporting on. The state should look at these indicators. There are various systems for data collection. Tribal information is not included in the State report. AIHC and Tribes have asked governor to the data system is not inclusive of tribal data. They would like to have tribes establish standards. State has agreed that they will look at it. Tribes opt in to data systems. NDW all information is exported by Tribes.

The Washing State wide youth survey was upsetting to Tribes and tribal leaders. Press release AI/AN was the highest group for suicide. No tribal schools were surveyed, the survey was conducted solely in public schools. The report would have been different if it was done inclusively. AI/AN Citizens in WA are not identified correctly.

Governor's performance measures committee. A tribal representative was appointed. Marilyn was designated to that community. Community public health improvement plan. Information did not include AI/AN. Child profile is one example. Some tribal health programs do not exchange information. Fifty two performance measures were identified. Slowly getting state's attention.

Victoria Warren-Mears (NWTEC/NPAIHB) participated with Foundational Public Health Workgroup. Had to remind the state about the contribution of tribes. Andrew Shogren

(Quileute) , Barbara Juarez (NWWIHB), Jan Ward Olmstead (AIHC), Marilyn Scott were on the committee, representing the Washington Tribes and tribal organizations.

Tom and Lou Schmitz were at the health informatics road map meeting. We need to continually emphasize the importance of engaging with the Tribes.

Bridget discussed NW Center inclusion of Tribes in the workforce survey. This involvement was limited at best and not representative of the Portland Area .

There was a question regarding how many Tribes were reporting GPRA at this time. Victoria contacted Mary Brickle, the Area Statistical Officer and GPRA analyst for the Portland Area. At this time, 26 of 44 sites report GPRA, which includes the Western Oregon Service Unit and the tribes. A list of current tribes reporting was provided to the Public Health committee members.

Data sharing for many tribes is a philosophical issue, it is important to continue discussions with tribes and leadership.

Injury Prevention

The Injury Prevention (IP) Program is in the process of rebuilding following completion of a foundational grant that the TEC has had for the last five years. We are seeking additional funding for the IP project. We have collaborated with NWWIHB. Currently the IP program has funding for updating IP toolkit. Additionally we are looking for a revitalization of the Injury Prevention Advisory Coalition. If you have an interest, please contact Bridget Canniff or Luella Azule (bcanniff@npaihb.org or lazulle@npaihb.org).

A discussion of vaccine injury was undertaken. There is a separate reporting system for this. We don't have area level vaccine surveillance system for vaccine injury. Individuals can self-report. The parent can report for the Child. Then parents can be contacted for follow-up.

It was mentioned that NIHB is conducting a survey regarding public health community capacity.

There is a listening session call next Tuesday.

- Please send topics for Public Health Committee to Victoria Warren-Mears, vwarrenmears@npaihb.org

Personnel Committee

Tuesday October 27
Wildhorse Resort & Casino, Pendleton, OR

	Name and Title	Organization	Phone/FAX/E-mail
1	Andrea Wagner HR Coordinator	NPAIHB	awagner@npaihb.org
2	Bonnie Sanchez Health SVS Director	Squaxin Island Tribe	bsanchez@squaxin.us
3	Shawna M Gavin Health Comm Chair	Umatilla	shawna.gavin@etu.org
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**Northwest Portland Area Indian Health Board
Quarterly Board Meeting
Personnel Committee Meeting Minutes**

October 27, 2015

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
 - 2 new hires
 - 1 internal hire
 - 1 promotion
 - 3 resignations
- CPR, AED & First Aid training was given to staff in August
- Preventing Harassment & Discrimination at NPAIHB training was given to staff in October
- NPAIHB won 2015 Oregonian Top Workplaces Award
- 1 Employee complaint which has been resolved was discussed

Behavioral Health Committee

Tuesday October 27
Wildhorse Resort & Casino, Pendleton, OR

Name and Title		Organization	Phone/FAX/E-mail
1	Health Director Kevin Collins	Stillaquamish Tribe	KCollins@stillaquamish.com
2	Elizabeth Buckingham HEALTH DIRECTOR	MAKAH TRIBE	360.645.2224 elizabeth.buckingham@tlis.gov
3	Charlotte Williams Council	Muckleshoot	charlotte.williams@ muckleshoot.nsh.us
4	Mara Starr	Muckleshoot	marie.starr@ muckleshoot.nsh.us
5	Julie Taylor	CTN12	Julie Taylor @ ctuir.org
6	Caroline M. Cruz	Conf. Tribes of Warm Spring OR	caroline.cruz@wstribes.org 541-615-0140 / 541-553-0497
7	Rebecca Proctor	Burns Paiute Tribe	PROCTOR.B@burnspaiute-nsh.gov
8	Cheryl Jan	Lummi Nation	Cheryl15@lummi-nsh.gov
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14		Michelle Johnathan Merrell @ lns.gov	
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Behavioral Health Committee

Quarterly Board Meeting – Pendleton, OR

October 27, 2015

Committee Participants: Kevin Collins, Health Director, Stillaguamish Tribe; Elizabeth Buckingham, Health Director, Makah Tribe; Charlotte Williams, Muckleshoot; Mara Starr, Muckleshoot; Julie Taylor, CTUIR; Caroline Cruz, Warm Springs; Rebecca Proctor, Burns Paiute; Stephanie Craig Rushing, NPAIHB; Colbie Caughlan, NPAIHB.

Agenda:

- **Integration of mental health and chemical dependency treatment:**
 - Attendees voiced concerns about Washington and Oregon's mental health and chemical dependency integration processes
 - In Oregon, we've been going through transformation for two years now, with repeated State level organizational changes... they are still shifting roles and responsibilities between the different departments/agencies. I'm concerned that we'll lose the progress we've made over the last five years professionalizing the prevention field.
 - (Good news: In Oregon, Tribal best practices can be reimbursed if it is part of the patient's treatment plan)
 - In Washington, the integration requirements aren't trickling down to the clinic level – Our EHR allows for integration, but chemical dependency is still requiring that we keep dual records.
 - Mandates are coming from the State without asking tribes how they will be impacted. The agencies haven't figured out what they want, and aren't providing sufficient guidance on how to integrate.
 - We are concerned that the 1115 Global Waiver is harmful to Tribes.
- **Joe/Jim: We need legal advice on how to share information between chemical dependency and mental health records, to make sure we're treating the whole person.**
- **SAMHSA Behavioral Health Agenda:**
 - Need to define Healthcare broadly (so that all medical services fall under HIPPA), to allow for a truly integrated system with mental health, physical health, and chemical dependency
 - We need a consistent definition of Behavioral Health
 - We need a consistent definition of Mental Health
 - Recognize Tribal Best Practices in patient treatment plans
 - Focus on prevention, and not separate prevention from mental health
 - Need cross-cutting funding for prevention and mental health/behavioral health

Input is due by Nov 6th. Stephanie and Colbie will submit to NIHB

- **Meth and Suicide Prevention Initiative (MSPI)**
 - There were more applicants in the NW than funding available, so not all grants were funded
 - We need additional MSPI carve out dollars, so that we don't have to compete with each other for MSPI funds
 - **Jim:** Please bring this issue up at the budget formulation meeting in December.

- **National Action Alliance for Suicide Prevention**
 - Includes an AI/AN Workgroup that will be working to increase the visibility of this issue, and develop tools and resources for Tribes.

- **Joe:** We really need someone at the Board who is dedicated to Mental Health, who will keep track of these issues, who can help keep the Tribes abreast of these issues.

Reporter: Charlotte Williams

Elder Committee Meeting Minutes

October 27, 2015

Wildhorse Resort & Casino

Pendleton, OR

Members: Bernadine Shriver-Grand Ronde, Denise Walker-Chehalis Tribe, Gladys Hobbs-Grand Ronde, Wanda Johnson-Burns Paiute, Janice Clements-Warm Springs, Kathleen Peterson-Confederated Tribes of the Umatilla, Andy Joseph-Colville

NPAIHB Staff: Clarice Charging

Janice opened the meeting with a prayer.

Dan was not able to attend the quarterly board meeting due to illness and requested Denise Walker, Chehalis Tribal Health Director, to attend the Elder Committee meeting in his place.

Bernadine motioned to approve April 2015 minutes. Gladys seconded.

Motioned approved.

Updates:

Umatilla: 475 elders attended their banquet. Yearly energy assistance checks were recently distributed to 575 elders. Senior lunches are served Monday-Thursday, Friday-breakfast only with meals on wheels service to 30 home-bound elders.

Grand Ronde: Elders currently meet third Wednesday of the month and will hold their Halloween party, Friday, October 30th. Elder housing is at

capacity. Tribal restoration pow-wow is November 21, 2015.

Warm Springs: Tribe is providing transportation for elders to shop in Madras.

Noon lunch is served Monday-Thursday to approximately 400 elders.

Warm Springs Veteran Summit will be held November 6 & 7th at the Warm Springs Community Center. Booths and staff will be available to assist Veterans and families with paperwork, answer questions and provide information.

Burns Paiute: Tribe has purchased land in the Beech Creek Ranch and Wanda also gave a historical brief on their tribe. Breakfast is served once a month with various program staff taking turns preparing and serving the meal.

Chehalis: Elder program will move and be included with the clinic. They are building a new elder center next to the clinic. Chehalis Tribal Health Director coordinates the meal program. New physician arriving next month. They are hoping the state will pass legislation Nurse Practitioners to allow medical visits homebound elders. The elders visited Memphis Tennessee for their yearly trip.

Colville: Seniors receive wood cords depending on the size of their home and the program also provides jobs for tribal members. Elder lunches are provided Monday-Friday. Quarterly elder dividends payments of \$350.00 will be disbursed November 2015.



**NORTHWEST
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Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Confederated Tribes of Colville
Confederated Tribes of Tribes of Coos,
Lower Umpqua, and Siuslaw
Confederated Tribes of Grand Ronde
Confederated Tribes of Siletz
Confederated Tribes of Umatilla
Confederated Tribes of Warm Springs
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Klallam Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinalt Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Upper Skagit Tribe
Yakama Nation

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RESOLUTION #16-01-03
**“Western Tribal Diabetes Special Diabetes Program for Indians
(SDPI) Grant”**

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 Northwest Portland Area Indian Health Board is a “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 Northwest Portland Area Indian Health Board is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the primary goal of the NPAIHB is to improve the health and quality of life of its member Tribes; and

WHEREAS, the Western Tribal Diabetes Project (WTDP) is a program administered by NPAIHB, within the Northwest Tribal Epidemiology Center (TEC); and

WHEREAS, the strategies and tools developed and evaluated by WTDP have served to build capacity among Indian Health Service, Tribal, and urban Indian Health (I/T/U) grantees of the Special Diabetes Program for Indians (SDPI), for improved ability to track, monitor, and use accurate health data for diabetes and its associated complications; and

WHEREAS, one such tool, the Health Status Report, returns the data from the Indian Health Service Diabetes Audit to the Portland Area SDPI programs, for use in program planning; and

WHEREAS, the data utilized in the Health Status Report is aggregate data and is only used to create the report back to the SDPI tribal programs for improved case management; and

WHEREAS, the WTDP provides technical assistance to SDPI programs for the diabetes registry, annual audit report, key measures, and grant reports; and

WHEREAS, the WTDP supports and encourages the use of the Indian Health Best Practices for Diabetes; and

WHEREAS, the WTDP has received funding under the SDPI based on a 5% area set aside; from the area funds; and

WHEREAS, the Department of Grants Management has required that the NPAIHB approve the 5% set aside funding to receive continued funding in 2016; and

WHEREAS, the SDPI community directed funds will not be impacted and will see an increase in funding.

NOW THEREFORE BE IT RESOLVED that the Northwest Portland Area Indian Health Board supports the application of the Western Tribal Diabetes Project to the SDPI for continued funding in 2016.

CERTIFICATION

NO. 16-01-03

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 29 for, 0 against, 0 abstain on October 22, 2015.

Andrew C. Joseph Jr.

Chairman

10.22.15
Date

Gregory J. Abraham
Secretary



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Kootenai Tribe
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Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinalt Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Upper Skagit Tribe
Yakama Nation

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Resolution # 16-01-01

**Interview Project with People Who Inject Drugs,
Community and Health Care Staff to Explore
Community-Driven Education, Prevention and
Healthcare Systems Improvement**

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 "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 primary goal of the NPAIHB is to improve the health and quality of life of its member Tribes; and

Whereas, in furtherance of this goal in 1997, NPAIHB established the Northwest Tribal Epidemiology Center (*EpiCenter*) in an effort to improve the quality of American Indian and Alaska Native (AI/AN) epidemiology data; and

Whereas, the *EpiCenter* has gained national recognition for developing and implementing many useful and innovative projects to improve the health and quality of life of Northwest tribes and has served as a national model for other Indian Health Service (IHS) areas to emulate in establishing their *EpiCenter* programs; and

Whereas, the Indian Health Service (IHS) has agreed to support a project supplementing the existing Health and Human Services Minority AIDS Initiative Funds, to determine the knowledge, attitudes, and beliefs around injection drug use, HIV and Hepatitis C in American Indian / Alaska Native (AI/AN) communities and assess feasibility of integrated interventions for effective use within AI/AN communities; and

Whereas, AI/ANs in Idaho, Oregon and Washington are affected by injection drug, HIV and Hepatitis C; and

Whereas, a primary aspect of this project will address contextual factors that impact injection drug use, HIV and Hepatitis C acquisition; and

Whereas, the goals of this initiative are consistent with the goals and objectives of both the NPAIHB and the *EpiCenter*; and

Whereas, a successful project would provide an opportunity for Northwest tribes to promote injection drug education, outreach, prevention, as well as health care and systems interventions.

Now therefore be it resolved, that the NPAIHB endorses and supports an effort by staff of the *EpiCenter*, under the guidance of the Executive Director, to the study entitled **"Interview Project with People Who Inject Drugs, Community and Health Care Staff to Explore Community-Driven Education, Prevention and Healthcare Systems Improvement.**

CERTIFICATION

NO. 16-01-01

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 29 for, 0 against, 0 abstain on October 22, 2015.

Andrew C. Joseph Jr.

Chairman

10-22-15
Date

Gregory J. Abraham
Secretary



**NORTHWEST
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Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Confederated Tribes of Colville
Confederated Tribes of Tribes of Coos,
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Confederated Tribes of Siletz
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Confederated Tribes of Warm Springs
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Cow Creek Tribe
Cowlitz Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Klallam Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
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Port Gamble S'Klallam Tribe
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Quileute Tribe
Quinault Tribe
Samish Indian Nation
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RESOLUTION #16-01-02

**Tribal Exemption from the Patient Protection and Affordable Care
Act Employer Shared Responsibility Mandate**

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 "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 primary goal of the NPAIHB is to improve the health and quality of life of its member Tribes; and

WHEREAS, the Patient Protection and Affordable Care Act (ACA) Employer Shared Responsibility Mandate is inconsistent with the federal trust responsibility to Tribes, denies many Tribal citizens the opportunity to take advantage of the benefits and protections designed for them in the Marketplace, and inhibits Marketplace enrollment for American Indians and Alaska Natives; and

WHEREAS, the ACA Employer Shared Responsibility Mandate is cost prohibitive for many Tribes and compliance will result in a decrease in Tribal services for Indian people; and

WHEREAS, the ACA Employer Shared Responsibility Mandate provided under Section 4980H of the Tax Code, as added by Section 1513 of the ACA, and Section 4980H of the Code does not specifically apply to Tribal governments, and Section 54.4980H-2(b)(4) of the ACA Employer Shared Responsibility Mandate regulations reserves application of special rules for government entities.

THEREFORE BE IT RESOLVED, Northwest Portland Area Indian Health Board respectfully requests the Internal Revenue Service exercise its legal authority to provide categorical relief from the ACA Employer Shared Responsibility Mandate for Indian Tribes; and Tribal Organizations as defined by Section 4(L) of the Indian Self-Determination and Education Assistance Act (ISDEAA); and Tribally Owned Entities.

CERTIFICATION

NO. 16-01-02

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 29 for, 0 against, 0 abstain on OCTOBER 22, 2015.

Andrew C. Joseph Jr.

Chairman

10.22.15
Date

Gregory J. Abraham
Secretary