Health News & Notes

Our Mission is to eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest Tribes in their delivery of culturally appropriate, high quality healthcare.

A Publication of the Northwest Portland Area Indian Health Board April 2012

Oral Health for Native Americans

Joe Finkbonner RPh, MHA Executive Director

American Indian and Alaska Native (AI/AN) populations have a higher prevalence of dental caries and untreated tooth decay in all age groups compared to the general U.S. population. **(see table page 19)**

Nationally, dental access for AI/AN people hovers around 25%. There are many barriers to dental access for AI/AN people including a lack of dental providers, long geographical distances between dental providers, and limited services available. To ration dental treatment, AI/AN people often are faced with complicated call-in systems and long waits for a dental appointment. Often the wait is weeks to months for an available appointment, depending on scheduling systems.

AI/AN populations become frustrated with cumbersome or niche systems that result in long delays to getting a dental appointment. They often neglect seeking care until it reaches a point of urgency and sometimes end up in emergency rooms seeking relief from pain and ultimately require more aggressive dental procedures or extraction for long term resolution.

Strategies to Improve Oral Health

First, develop strong prevention programs that target elimination of caries in our populations starting at the earliest possible age. This will begin to reduce the growth of the backlog of people seeking care for active caries lesions. Some suggestions include:

Prevention

- Build knowledge and motivation to improve oral health among Tribal Health Boards and other community leaders, health providers, and consumers.
- Develop models in collaboration with medical, dental, WIC, CHR, and Head Start staff to provide education, fluoride varnish, and other chemotherapeutics 3-4 times a year, beginning with eruption of the first tooth.
- Develop marketing campaigns to promote the daily use of fluoride toothpaste. Develop a system to provide low-cost toothpaste and toothbrushes to community members.
- Support school and community-based topical fluoride and sealant programs.
- Support community efforts to decrease tobacco use and to prevent and control diabetes.

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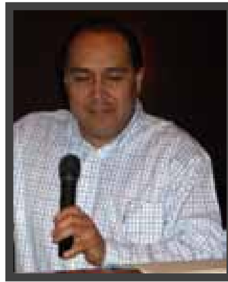
Supreme Court begins hearings on the Affordable Care Act



By Jim Roberts, NPAIHB Policy Analyst

Last month, the U. S. Supreme Court began three days of hearing oral arguments on whether the Affordable Care Act's (P.L. 111-148, P.L. 111-152) insurance coverage requirement is Constitutional. The health coverage requirement known as the individual mandate requires most individuals to maintain health coverage beginning in 2014 or be subject to a penalty payable in their federal income tax returns. If the Supreme Court justices rule the individual mandate and Congressional action are at odds with the Constitution, some or even all of the law (PL 111-148, PL 111-152) could be thrown out. Central to this issue is how the Indian Health Care Improvement Act (IHCIA) will be affected.

The IHCIA was included as an amendment to the Affordable Care Act and if the entire Act is ruled unconstitutional it would also strike down the amendments to the IHCIA and undo over ten years of work by Tribes and Tribal organizations. In January, the National Indian Health Board (NIHB) and 449 Tribes and tribal organizations filed an amicus brief with the Court to protect the IHCIA. The brief prepared by the law firm Hobbs, Straus, Dean and Walker (HSDW) explains that the IHCIA which was enacted in the ACA were developed over a period of ten years and had a separate legislative process from most other parts of the health reform law. The lead attorney in developing the brief at HSDW, Geoffrey Strommer, explains that "in order to escape a legislative log-jam, the Indian-specific provisions were put into the Senate's health care reform bill that became the ACA because it was a moving legislative vehicle. The IHCIA amendments were not part of or related to the minimum coverage component or other integral pieces of the general health care reform fabric."

When it comes to the individual mandate, the justices will be facing two distinct arguments. The first, offered by the Obama administration, will portray the "minimum coverage provision" as a valid exercise of Congress' power under the Commerce Clause and the Necessary and Proper Clause of the Constitution. In its brief, the government argues that the provision regulates how health care consumption is paid for, creating "an incentive for individuals to finance their participation in the health care market by means of insurance." Individuals without insurance still need health care services at some point, and most of the costs are transferred to others, the administration says. The government also contends that the requirement is "necessary to achieve Congress's concededly valid objective" of overhauling the health insurance market.

Supreme Court begins hearings on the Affordable Care Act

The National Federation of Independent Business and the 26 states and four individuals challenging the health care law are calling the mandate "an unprecedented law that rests on an extraordinary and unbounded assertion of federal power." They say Congress has authority under the Constitution to regulate commerce, but not to force individuals to engage in commerce by buying health insurance.

After hearing the oral arguments Strommer shared some insight into the hearings. "It is hard for me to guess how the court will address the severability question based on yesterday's argument," Strommer said. He further explained, "The justices are clearly struggling with where to draw the line and what provisions of the ACA should survive, if any, if they decide that the individual mandate is unconstitutional. Options discussed range from striking all provisions in the ACA and giving Congress a chance to come up with brand new legislation, striking only the Individual mandate, or striking the individual mandate and other provisions that are directly connected to the mandate. I was pleased to hear several of the Justices refer to the Indian provisions in the ACA in their comments. Justice Ginsberg was the first to do so when she discussed the Indian provisions in connection with provisions in the ACA that are not connected at all to the individual mandate and other provisions related to the mandate. Justice Breyer and Chief Justice Roberts both made similar references to the Indian provisions. References to the Indian provisions in this way are very helpful because if the Court ultimately decides to strike down only the individual mandate or only the individual mandate and other provisions in the bill that are directly connected to the mandate (both options that are most consistent with previous Supreme Court cases on severability) chances are good that the Indian provisions will survive." The Supreme Court is expected to issue its final ruling on the case this summer.

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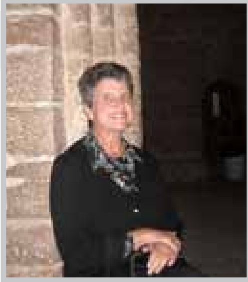
Has Your Tribal Council Started Talking About Tribal Sponsorship of Individuals in Health Insurance Exchanges?



By Mim Dixon, NPAIHB Consultant

It is still 18 months before the first person can enroll in a state Health Insurance Exchange plan – however, it is not too early for Tribal Councils to be discussing their plans for this opportunity to increase revenues from health services.

Northwest Portland Area Indian Health Board (NPAIHB) has been working with three other Area health boards under an agreement for a Tribal Education and Outreach Consortium (TEOC). TEOC has been preparing materials for Tribes to be able to make informed choices about their level of participation in Health Insurance Exchanges.

Health Insurance Exchanges are a key provision in the Affordable Care Act (ACA), the health care reform legislation passed in 2000 that also includes the permanent re-authorization of the Indian Health Care Improvement Act (IHCIA). Every State will have an Exchange where people can go on-line and purchase health insurance. The Federal government will subsidize the cost of premiums on a sliding scale up to 400 percent of the federal poverty level (FPL). The law has special provisions for American Indians and Alaska Natives (AI/AN), including monthly enrollment periods, no deductibles or co-pays, and no penalty for not enrolling.

If the uninsured people who use tribal and IHS and urban Indian clinics were covered by this health insurance, then the clinics could bill the insurance for the services that they provide. Also, the insurance would pay for emergency care, specialty medical care and hospital stays. This would save money for Contract Health Services.

We know that most people will not enroll in health insurance plans if they have to pay for it when they can get their health services without charge at their Indian health clinic. Some Tribes are considering paying premiums for all or a portion of their clinic users, as a way to remove the barriers to enrollment in health insurance. This is called Tribal sponsorship of individuals in Exchange plans.

The TEOC has created several tools that can help Tribes learn more about the Tribal sponsorship opportunity. These include:

- One-page summaries of Tribal sponsorship and 2012 Federal Poverty Levels.
- A 25-minute video about the Fond du Lac Band of Chippewa Indians which has experienced success with a Tribal sponsorship program for the Medicare Part D prescription drug program and is building on that experience to plan for the Exchange in their state of Minnesota.
- The final report for case studies with three different Tribes (small, medium, and large) estimating the costs and benefits of Tribal sponsorship with different scenarios.

Building on the methods developed for the case studies, the TEOC is creating a tool that any Tribe can download from the TEOC website and use to estimate their own costs and benefits for Tribal sponsorship. This tool and the website should be available this summer.

Based on the case studies, Tribes can expect that every dollar they spend on Tribal sponsorship will return to the Tribe between $1.75 and $6.00 in combined revenue and CHS savings. Larger Tribes and those with higher rates of poverty will have greater financial benefits from Tribal sponsorship, compared to smaller Tribes and wealthier ones. The greatest financial benefit for most Tribes will come from Medicaid Expansion, which will cover everyone under 133 percent of the FPL, including single adults, with no premiums, deductibles or co-pays. Even though Tribes will not have an expense for premiums for Medicaid Expansion, they will have to spend additional funds and perhaps hire additional people to engage in a community outreach and education campaign to enroll people who are eligible.

Tribal funding must be available for a communications plan, staff training, outreach and enrollment starting in July 2013. Depending on your Tribe's budget cycle, now may be

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Has Your Tribal Council Started Talking About Tribal Sponsorship of Individuals in Health Insurance Exchanges?

the time to start planning and to decide on the best course of action for your Tribe. Some Tribes may want to start slowly, by enrolling primarily people who are eligible for Medicaid Expansion, and then use those revenues to expand their sponsorship to cover people with high cost medical needs (such as those with diabetes, or people between the ages of 50 and 64), and eventually cover all of the uninsured.

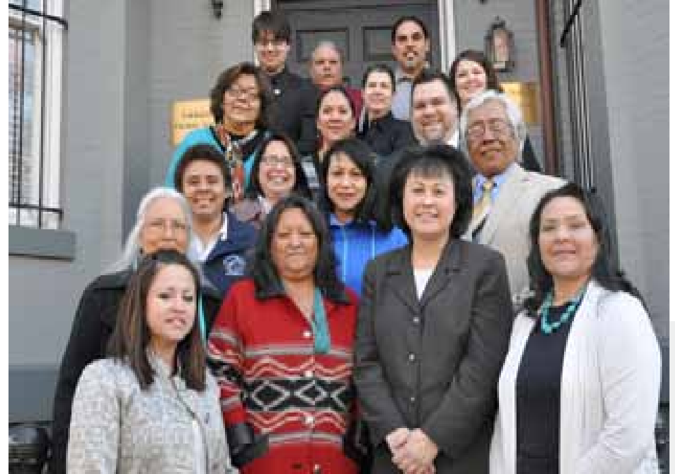
NPAIHB and other organizations are working with States in the Pacific Northwest to help make Tribal sponsorship possible. While Federal regulations permit Tribal sponsorship, the State Exchanges get to decide whether to allow aggregate premium payments by Tribes, as well as the terms and conditions of Tribal sponsorship. Exchanges are required to consult with Tribes as they develop these policies. Whether or not your Tribe decides to pay premiums for individuals to enroll in Exchange plans, it is important to keep this option open and to advocate for rules that make sponsorship flexible, easy and efficient for Tribes.

***Mim Dixon, PhD**, is a consultant who specializes in policy, research, planning, and facilitating in the field of American Indian and Alaska Native health care. Her work for tribes and tribal organizations has included managing large tribally-operated health care systems, as well as serving as Policy Analyst for the National Indian Health Board. She is the author, co-author or editor of four books and numerous articles.*

A National Partnership to Increase Awareness about Health Reform

The National Indian Health Outreach and Education Initiative:
A National Partnership to Increase Awareness about Health Reform

The National Indian Health Outreach and Education Initiative (NIHOE) is a national partnership between the Indian Health Service (IHS), the National Congress of American Indians (NCAI), the National Indian Health Board (NIHB), and representatives from each of the 12 IHS Areas. The partnership's purpose is to develop effective, streamlined, consumer-oriented materials to assist American Indians and Alaska Natives in understanding their rights and new opportunities under the Affordable Care Act (ACA) and the Indian Health Care Improvement Act (IHCIA). Together, the partners plan to provide local trainings, national marketing tools, and e-resources that clearly explain health reform changes and their impact in tribal communities.



The partners met in early February to kick off the NIHOE initiative. During the two-day meeting, representatives identified barriers, obstacles, and opportunities in educating tribal communities about the ACA and IHCIA. In addition, area representatives leading NIHOE initiatives in their community worked to develop a national outreach plan, including the development of Native specific educational materials. National partners also laid ground work for their education and outreach campaigns and set goals to better assist the areas in their efforts.

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"Navigating" the Affordable Care Act

By Doneg McDonough,
NPAIHB Contractor

The Importance of Tribes and Tribal Organizations Serving as Navigators to Facilitate Enrollment through an Exchange

How are we going to figure out which of the health insurance options to be made available under the Affordable Care Act we should pick, if any?

The Affordable Care Act's Navigator program

The Affordable Care Act (or ACA) recently passed its 2nd year anniversary. But even though it was enacted by the United States Congress and signed by President Obama in March of 2010, a central component of the law – the creation of new health insurance options – will not be implemented until January of 2014. And two related provisions that were established in the ACA that help individuals and small employers access these new insurance options: 1) the creation of health insurance "Exchanges" that list the available health plans and indicate the cost to individuals (after including any Federal assistance) for plan premiums and cost-sharing (if any); and 2) a "Navigator" program intended to help individuals and businesses choose the insurance option best for them, are to be implemented prior to 2014 as well.

So, the ACA created new, more-afffordable health insurance options that start January 1, 2014. An "Exchange" is to be created in each State prior to 2014 to enable individuals to select from among these insurance options. And, *"Navigators" will be created and funded by the Exchanges (hopefully by at least October of 2014) to assist individuals in picking the best plan for them.*

American Indians and Alaska Natives (AI/ANs) are not required to take any of these insurance options, but doing so will likely expand an individual's access to health care services and bring additional and substantial Federal revenues into tribal health programs.

First, what is an Exchange?

Most simply, Exchanges are where many Americans will go to pick a health insurance plan. Someone might "go to" the Exchange through the Internet, by calling a toll free phone number, or by walking in to a designated office. Today, some States, such as Massachusetts and Utah, operate something like an Exchange. In addition, the Federal Employee Health Benefits Program is a version of an Exchange that has been in place for Federal government workers and is now available (beginning May 1) to employees of Tribes, tribal organizations, and urban Indian organizations. An Exchange will list the health insurance coverage options, list income and other eligibility requirements for each, and indicate how much the premiums and cost-sharing will be for each available option.

What insurance options will be available through an Exchange?

Medicaid, CHIP and subsidized private insurance plans will be available through an Exchange.

The ACA expanded the Medicaid program to be available (effect January 1, 2014) to all individuals, including American Indians and Alaska Natives, who have family income under 133% of the Federal poverty level. For an individual, the income cut-off will be approximately $15,000, and for a family of four the income cut-off will be approximately $30,000. For low-income adults without dependent children who are generally not covered under State Medicaid programs today, this new option will provide comprehensive coverage, without any premiums, and without (for AI/AN) any cost-sharing requirements.

What are Navigators?

Navigators will be non-profit organizations funded to assist individuals navigate these health insurance options available through an Exchange. Indian Tribes, tribal organizations, and urban Indian organizations are listed as entities eligible to serve as Navigators.

The Navigator provisions will be implemented by HHS as part of its overall implementation of state health insurance Exchanges. Navigators must "conduct public education activities" to raise awareness about qualified health plans, distribute "fair and impartial information" regarding premium tax credits and enrollment, facilitate plan enrollment, provide referrals for enrollees who

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FY 2013 IHS Budget Update

By Jim Roberts, NPAIHB Policy Analyst

The President's FY 2013 budget provides $4.4 billion for Indian Health Service (IHS) programs, an increase of $115.9 million (2.7%) over the FY 2012 enacted level. The Northwest Portland Area Indian Health Board (NPAIHB) estimates that the President's request will fall short by over $287 million just to maintain current services. The Board estimates that it will take at least $304 million in FY 2013 to maintain the current levels of health care provided by the Indian health system. Anything less will result in Indian health programs having to absorb the mandatory costs of inflation, population growth and increased administrative costs.

The FY 2013 request is the lowest amount of funding requested by the Obama Administration for Indian health programs. The past President's requests included increases of $453 million (12.7%) in FY 2010; $354 million (8.7%) in FY 2011; and $554 million (13.6%) in FY 2012.[1] While the Congress did not completely fund this combined increase of $1.4 billion, it did result in a $725 million increase over three years for IHS programs. Despite the limitation of the President's FY 2013 request, the past budget increases from FY 2010 to FY 2012 have built a very good base budget for applying meager budget increases. In the eyes of the Administration during these difficult economic times this may not be a bad thing. However, for Indian health programs the lack of funding will be felt because services will likely be reduced.

Brief Analysis of the Request

The Congressional justification reports that the President's budget provides a $115.9 million to support activities identified by the Tribes as budget priorities including increasing resources for the Contract Health Services (CHS) program; funding Contract Support Costs (CSC) shortfall; funding for health information technology activities, and providing routine facility maintenance. Despite the insignificant increase, the IHS Congressional Justification explains that the overall increase is adequate to "sustain the Indian health system, expand access to care, and continue to improve oversight and accountability."

FY 2013 Current Service Requirements *Dollars in Thousands*	
Mandatory Cost to Maintain Current Services	*Increase Needed*
CHS Inflation estimated at 5.5%; and Population Growth	$64,112
Health Services Account (not including CHS) inflation	$167,058
Contract Support Costs (unfunded)	$99,300
Population Growth (estimated at 1.6% of Health Services accounts)	$72,722
Total Mandatory Costs	$403,192

NPAIHB projections indicate that this will not be the case and an additional $287 million will be needed to stay the program at the current levels of care. Inflation and population growth alone using actual rates of medical inflation extrapolated from the Consumer Price Index (CPI) and IHS user population growth predict that at least $304 million will be needed to maintain current services (see attached worksheet). Compound this with the fact that nearly half of the proposed increase is for staffing and operation of six new facilities ($49 million), which will only leave $66 million to cover current services. Estimates developed by the IHS during the FY 2013 budget formulation process and used during Tribal Consultation to develop Tribal recommendations on the FY 2013 budget, estimate current services at $136.8 million for pay act costs, inflation and population growth.[2] These are IHS estimates and not Tribal estimates, thus there should be no question about the validity of these projections.

1. The President's FY 2012 budget built on the FY 2011 requested increase for IHS since Congress had not enacted a final budget when the President's budget was due to Congress. Thus it compounded the 2011 and 2012 increases into one requested increase. The final enacted budget provided a 5.8% increase

2. See FY 2013 IHS Budget Formulation Worksheets used during Area and National Budget formulation meetings. Available at: www.ihs.gov/NonMedicalPrograms/BudgetFormulation/

Budget Control Act & Sequestration

By Jim Roberts, Policy Analyst

On August 2, 2011, President Obama signed into law the Budget Control Act of 2011 (BCA). The BCA allows the President to increase the debt ceiling by up to $2.8 trillion, but also requires that the federal deficit be reduced by $2.3 trillion over 10 years. The importance of this to Indian health programs is that at least $840 billion of this amount must be cut from discretionary programs. Since the Indian Health Service (IHS) budget come entirely from discretionary funding, the BCA is likely to impact IHS.

There are two procedures that the BCA proposes to cut the federal deficit. The first is to through automatic "caps" on categories of spending. The automatic caps exempt some mandatory programs like Social Security, Food Stamps, and Medicare. The second procedure was to be negotiated by a "Super Committee" of twelve Congressional members; however this process failed. The Super Committee was supposed to develop a deficit reduction plan to be enacted into law by Congress. Since members of the committee and Congress could not agree on a spending plan, automatic cuts will now be triggered, through a process of "sequestration".

What is Sequestration?

Sequestration is a budget mechanism through which automatic, across-the-board spending cuts are made. The BCA will initiate a sequestration if Congress approves spending higher than caps set forth in the law or if a plan from the Super Committee fails to become law. Since the Super Committee failed to achieve its objective the sequestration process has been triggered in FY 2013. The BCA creates two slightly different sequestration procedures for each scenario.

The first scenario assumed that the Super Committee would succeed in developing, and Congress approving, a deficit reduction plan. The target was to cut $841 billion to $2.3 trillion over the next 10 years. The Super Committee was charged with producing a plan to reduce the deficit $1.5 trillion beyond the initial $841 billion in spending cuts achieved through the discretionary caps. If the Super Committee was successful and produced a plan (that became law) that contained less the target amounts, then the sequestration procedure would still have been triggered to achieve the spending cuts.

The second scenario invokes sequestration if the Super Committee does not produce a report or if the report does not become law – which has become the case. Under this scenario spending will be lowered by $1.2 trillion, with $109.3 billion in cuts per year (beginning in FY 2013), half of which, $54.7 billion, comes from the Defense Department and the other half from the rest of the budget. These cuts affect both mandatory and discretionary spending with proportionate cuts to both, but Social Security and Medicaid are protected while Medicare providers would see, at most, a two percent reduction in payments.

How will Sequestration affect the IHS Budget?

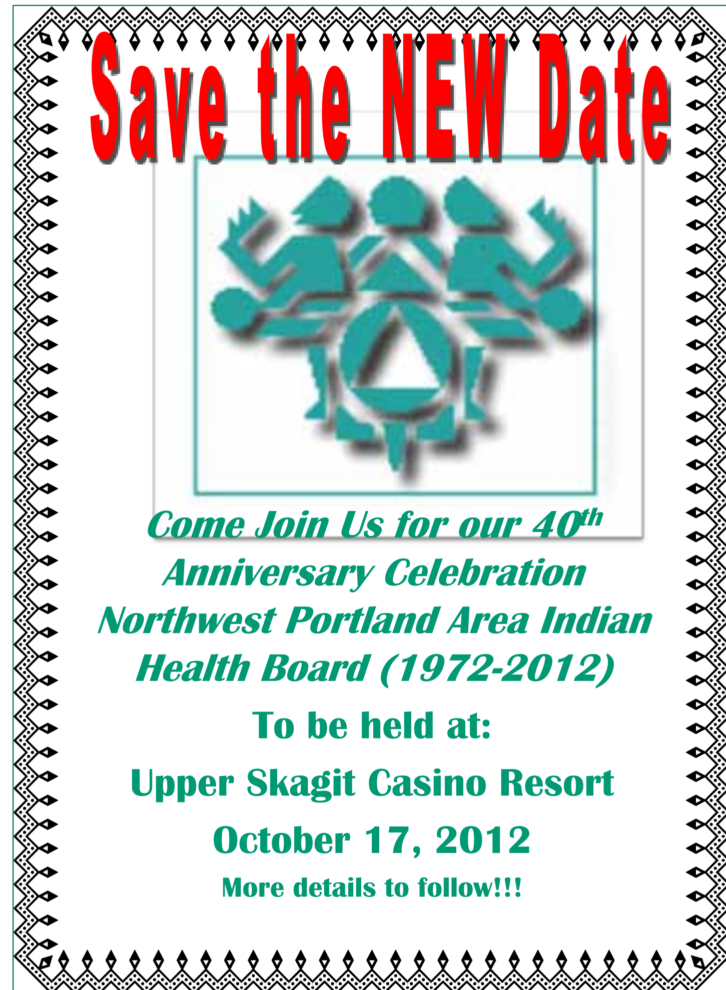
Certain programs are exempt from sequestration, and special rules govern the sequestration of others. These exemptions are contained in the Balanced Budget and Emergency Deficit Control Act (BBEDCA) of 1985. Section 255 of BBEDCA identifies programs that are exempt from sequestration, which include most mandatory programs, and a few discretionary programs, most notably programs administered by the Department of Veterans Affairs (VA), Community Health Centers, and the IHS.

Section 256(e) of BBEDCA, establishes special rules for exempt programs which stipulate that sequestration may only reduce funding appropriated to the certain accounts by 2% in any fiscal year. The IHS health services and facilities accounts are included in this exemption and may not be reduced by any more than 2% per fiscal year. However, IHS also receives reimbursements from Medicare, Medicaid, and the Children's Health Insurance

Budget Control Act & Sequestration

Program (CHIP) for services provided at IHS facilities. IHS also receives special funding for diabetes related care through the Special Diabetes Program for Indians (SDPI). The Congressional Research Service (CRS) reports that these "mandatory appropriation for the diabetes program is subject to sequestration; however, Section 255 of BBEDCA exempts both Medicaid and CHIP." A separate set of complicated rules apply to Medicare and it is not known at this writing how these rules will be interpreted.

The FY 2012 IHS budget is $4.3 billion. The health services accounts comprise $3.9 billion; while the facilities accounts comprise $440.3 million of the IHS budget. If the IHS budget was cut by the full 2% in the sequestration process, it would lose $86 million. To put this in perspective, the FY 2013 budget increase is only $115.9 million. Most dangerous about this process is that the decrease likely would not be applied on a pro rata basis. Certain preventive and other services accounts like CHRs, scholarships, PHNs, health education and others would be targeted for reductions to salvage hospital and clinic accounts in order to preserve the levels of care provided. The fact that the President included an increase for IHS in FY 2013, while many other Health and Human Service programs were cut, demonstrates continued support with the Administration for Indian health. The sentiment of Congress, at least in the House of Representatives, may not be the same. House republicans have an attitude to cut spending no matter what the cost or impact on services to people. This makes in vitally important for Tribes to become active in the FY 2013 appropriations process. The final analysis for IHS programs lies above the 2% cut and below the $115.9 million increase.



When AI/AN in the Category "Other" Is Not Good Enough:

By Ed Fox, Ph.D, is a policy analyst and serves as the Tribal Health Director for the Port Gamble S'Klallam Tribe; Verne Boerner, MPH, in policy analyst and is a graduate student of Oregon Health and Sciences University

An immense research effort intent on developing good estimates of insurance coverage, rates of uninsured, and estimating the number eligible for Medicaid expansion and health exchange subsidies is underway by federal, state, and many local government agencies. Health Care Reform aims to provide insurance for all citizens and all legal immigrants who have resided in the U.S. over 5 years. This information is of critical importance in the design of the business plans to build health insurance exchanges, their web portals, their information technology infrastructure and the staffing to determine eligibility and enroll an estimated 30 to 40 million newly insured Americans. Fortunately, the federal government has produced estimates of income and insurance coverage for years. Federal, state and private organizations like the Kaiser Family Foundation (KFF) have produced valid and reliable estimates for the general population, but not for American Indians and Alaska Natives (AI/ANs). The KFF website, www.kff.org, provides estimates of uninsured, and income information relevant to Medicaid expansion and exchange plan subsidies. Unfortunately, these sources always lump data on AI/ANs in the category 'other.'

As planning continues for health insurance exchanges in Washington and Oregon an important census report will help guide these states in their planning and programming for covering uninsured AI/AN people . This report, the American Community Survey (ACS), is an annual survey that has included questions about health insurance coverage and access to IHS paid health care services since 2008 and in 2010 officially replace the 'long form' of the U.S. Decennial census. It enjoys a 95% response rate thanks to follow-up efforts and the legal requirement to respond. An estimated 30,000 AI/ANs complete the survey every year. three-year health insurance reports pool data from the years 2008, 2009, 2010 to increase sample size and lower error rates. In Washington this means these 3-year estimates are based on over 6,300 respondents, and over 3,400 in Oregon. The ACS provides the promise of improved estimates of health insurance status for AI/AN people. These improved estimates of national and state level estimates can provide extremely accurate estimates of coverage by employer-sponsored health insurance, Medicaid, Medicare, and rates of uninsured. In addition, an estimate of 'access to Indian Health Service' provides a first-ever look at this important variable for many geographic areas.

In addition to insurance status, the ACS also provides important income distribution information. With good estimates of how many residents are under 138% of poverty and how many are in the subsidies eligibility range of 138% to 400% of poverty, health planners can better prepare for implementation of the 2014 startup of health insurance exchanges.

Unfortunately, the ACS does not provide good estimates for what remains as the missing element in making firm estimates of the number of AI/ANs eligible for subsidies in the health insurance exchange. This is how many AI/ANs have 'offers of insurance' from their employers that are affordable and have benefits that meet minimum standards. Some questions on the Medical Expenditure Panel Survey (MEPS) provide estimates of offers of insurance for the general population, but sample sizes are too small to provide estimates for AI/ANs. Workforce participation is tracked by ACS and AI/ANs have very similar rates to non-Indians (both are between 60 and 70% in both OR and WA), a surprise to many, but this doesn't necessarily mean offers of insurance are similar to other races. In fact, it is very likely that AI/ANs work for employers that do not offer affordable plans nor do they offer plans that meet minimum benefits coverage. There is evidence that Tribal employees who are tribal members or AI/ANs eligible for IHS services often do not add coverage for their dependents due to costs and the availability of IHS-paid health care services at no cost to the employee's dependents.

Practical Application

How can we use insurance data to plan outreach and education? Who do you need to find? How do you endeavor to help these vulnerable and at-risk people? Where do you spend your resources: time, staff, and money to achieve the greatest impact? These are questions facing all health programs in the United States, but none so greatly as Indian Health Programs as AI/AN people experience the highest rates of uninsured of any population. Historically, there was little data to inform the planning processes. However, two resources now offer information specifically on AI/ANs: the 2010 US Census and the (ACS).

When AI/AN in the Category "Other" Is Not Good Enough:

These two data resources extend far beyond the count of people, they offer a wealth of information on populations as a whole. And, of particular interest to the implementation of the Patient Protection and Affordable Care Act (ACA), and the establishment of health exchanges and basic health plans, offer health insurance data that can help you direct your energies and resources. It can help you estimate how many AI/ANs in your area do not have coverage, how many have access to your Indian Health Program (IHP), how many have public insurance, and how many have employer-provided coverage. Once you have this information, you can select your targets; set your strategy for outreach; choose what modes and methods you will employ; determine how to allocate your resources, and prepare your eligibility staff for the changes in their roles and responsibilities. This information will assist your Indian health program prepare and plan for how it might use or access the navigator and application assistance programs.

The American Community Survey Data from the 3-year (2008-2010) Database

In any education and outreach strategy, it is important incorporate evaluative measures in order to modify and adjust the programs to ensure effective use of resources. The goal of most programs will be to reach 100% of the uninsured-knowing how many that is helps measure progress in reaching the goal. It is now feasible to reach even smaller areas to analyze variation within states to further refine outreach efforts.

Eastern Washington AI/ANs have an uninsured rate of 28% compared to 22% statewide. AI/ANs in Eastern Washington report a higher rate of access to IHS at 38% compared to 26% of AI/ANs statewide. Private insurance coverage varies by 10% with Eastern Washington at just 40% compared to 50% statewide.

The uninsured rates for Eastern Oregon and Oregon statewide are 29% and 27% respectively just a 2% difference. However, the rates of access to IHS differ greatly in Eastern Oregon (42%) and Oregon statewide (18%). Private insurance varies by 6% with just 43% covered by private insurance in Eastern Oregon.

In Eastern Oregon and Washington, given the high rate of individuals with access to an Indian health program(IHP) combined with the high rate of uninsured, the IHP would benefit greatly from individuals enrolling in an exchange program; patients would now have a payer for their health services (revenue for the IHP). It is clear that Indian health programs in Eastern Oregon and Eastern WA (and all of Idaho) have greater direct exposure to their uninsured AI/AN patients and can turn this to their advantage by connecting patients to insurance in their clinics and social service programs. This suggests that education and outreach efforts

2008-2010	ACS population estimate	Uninsured	Medicaid	Medicare	IHS	Private	Military VA
Idaho	15,231	5,313	3,140	1,712	8,525	6,351	421
Oregon	105,003	28,053	26,447	9,351	18,585	50,936	4,537
Washington	183,385	40,617	52,214	17,741	47,934	92,389	10,195
2008-2010	ACS population estimate	Uninsured	Medicaid	Medicare	IHS	Private	Military VA
Idaho		35%	21%	11%	56%	42%	3%
Oregon		27%	25%	9%	18%	49%	4%
Washington		22%	28%	10%	26%	50%	6%

Data developed by the California Rural Indian Health Board 2012 and used with permission.

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Oregon's Coordinated Care Organizations & Tribal health programs

By Jim Roberts, Policy Analyst

Over the past year, Oregon has been involved in a significant health system transformation to create and implement Coordinated Care Organizations (CCOs). On March 2, 2012, Governor Kitzhaber signed S.B. 1580—together with H.B. 3650 that passed during the 2011 session—which will launch CCOs to serve over 600,000 people enrolled in Oregon's Medicaid program. CCOs are a more rigorous Medicaid managed care system that are being touted as a new and improved way delivering health care. They will be the umbrella organizations that govern and administer care for Oregon's Medicaid clients.

What are CCOs?

CCOs are local health entities that will deliver health care and coverage for people eligible for the Oregon Health Plan (Medicaid), including those also covered by Medicare. CCOs will be accountable for health outcomes of the population they serve. They will have one budget that grows at a fixed rate for mental, physical and ultimately dental care. Oregon expects that CCOs will bring forward new models of care that are patient-centered and team-focused. They will have flexibility within the budget to deliver defined outcomes. They will be governed by a partnership among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk. Many other states are also considering similar approaches for delivering Medicaid services.

Tribal Concerns

While CCOs are being advertised as a marked improvement to providing health services in the Medicaid program, Indian health providers are very concerned about their interaction with CCOs. Initially, Tribal health programs in Oregon did not know if they would be able to provide services for Indians enrolled in CCOs; or if CCOs would be required to reimburse Indian health programs for providing services to Indians enrolled in CCOs. Indian programs also wanted their tribal members to be able to opt-in or opt-out of mandatory enrollment in CCOs on the basis that tribal clinics are their medical home. As H.B. 3650 was making its way through the Oregon Legislature, Tribes were able to get important provisions included in the legislation to address these issues.

H.B. 3650 includes provisions that exempt American Indian and Alaska Natives (AI/AN) from mandatory enrollment in CCOs. Another provision requires CCOs to reimburse Indian Health Service (IHS), Tribal and urban Indian health providers when providing services to clients enrolled in CCOs. There are also federal statutes that will protect the status of Tribal health providers in their role as Medicaid providers with CCOs. These immediate concerns seem to be addressed in the provisions contained in H.B. 3650 and under federal statute. However Tribes continue to be concerned about coordination of care issues related to shared patients of CCOs, accessing specialty care, and contracting requirements to be recognized as in-network providers with the CCOs.

CCOs and Oregon's Medicaid Waiver

Oregon estimates that potential cost savings for CCOs will be substantial and be at least $3 billion over the next five years. The mechanism to implement CCOs to achieve this cost savings will be through a Medicaid 1115 Demonstration Waiver to the Centers for Medicare & Medicaid Services (CMS). Under Section 1115 of the Social Security Act, states may apply for program flexibility to test new or existing approaches to financing and delivering or expanding Medicaid and CHIP services. The Oregon Health Plan (OHP) was created in 1994 under a Section 1115 Demonstration Waiver. This waiver of federal laws and regulations allowed Oregon to create a Medicaid managed care delivery system, develop the Prioritized List of Health Care Services, and expand coverage to parents and childless adults with incomes below 100 percent of the Federal Poverty Level.

On March 1, 2012, Oregon submitted a Request for an Amended Waiver to CMS. Oregon believes that most of what it hopes to achieve through its Health System Transformation can be accomplished through current waivers, but there is some additional waiver authority needed. Oregon requires additional federal flexibility in several areas to implement CCOs that include:

1. Developing alternative payment methodologies to reimburse providers on the basis of outcomes and quality through shared savings and incentives.

Oregon's Coordinated Care Organizations & Tribal health programs

2. The ability to reimburse non-traditional health care workers such as community health workers, peer wellness specialists, Doulas, and personal health navigators.

3. Flexibility to provide services that may not always traditionally be reimbursed as a Medicaid State Plan service but help keep people living in the community.

4. Developing an alternative payment methodology to allow a unique prospective payment system/ alternative payment methodology for Federal Qualified Health Centers (FQHC).

While all these issues are important to the Indian health system, the alternative payment methodologies and potential changes in the FQHC reimbursement system have Tribes most concerned. The CCO legislation requires the Oregon Health Authority (OHA) to encourage CCOs to establish alternative payment methodologies that reward value and good health outcomes rather than continuing to pay on the current fee for service system. Because of this, CCOs will likely develop payment structures other than fee-for-service that promote prevention, provide person-centered care and reward comprehensive care coordination. Tribes and in particular the Native American Rehabilitation Association (NARA) are worried about this process. Most Tribes in Oregon are billing Medicaid on a cost-based rate according to the Prospective Payment System (PPS). Tribal programs have an option to be reimbursed under HCFA-IHS memorandum of agreement using the IHS-OMB encounter rate or under on a cost-basis under the PPS. However, NARA does not have this option and is reimbursed as an FQHC. If alternative payment mechanisms are established for FQHCs by CCOs, Tribes could always convert their payment mechanism, however urban Indian health programs do not have this ability under the 1996 HCFA-IHS memorandum of agreement. While the state has indicated it would protect Indian health programs from such changes, the rules for CCOs and their payment structures are not final.

CCO Request for Applications

The Oregon Health Authority (OHA) issued a request for applications from qualified applicants to be certified and awarded contracts as CCOs. The OHA expects to award at least one contract for each area (county) beginning on August 1, 2012, or on a date that OHA determines appropriate. All current Medicaid contracts will expire December 31, 2013, and thereafter may be renewed for one-year periods at OHA's discretion, for a period of up to six years. Following this application process, CCO contracts will be re-solicited in six years.

There are specific requirements dealing with Indian health providers and services to AI/AN people included in the CCO Request for Application (RFA). The RFA requires applicants develop standards on how they will meet certain types of criteria. These standards require all applicants to include:

- An explanation of how the applicant will develop meaningful relationships with social and support services in their areas - which include Tribes, tribal organizations, urban Indian organizations, Indian Health Services and services provided for the benefit ofAI/AN population.

- Applicants are also required to explain how their care management network and delivery system network serving Medicaid and dually eligible members will interact with Tribal and urban Indian health services, whether employed by the applicant or under subcontract.

- Applicants are required to describe their experience and ability to provide culturally relevant Coordinated Care Services for the AI/AN population.

- There is also a standard that requires applicants to explain their experience working with IHS and Tribal 638 facilities with specific examples of how the applicant deals with referral processes when the IHS or Tribal 638 facility is not a participating panel provider; and how applicant will deal with prior authorization when the referral originates from an IHS or Tribal 638 facility that is not a Participating Provider.

The public comment period on the draft RFA closed on March 13th with the final RFA posted on March 19th. There was a non-binding letter of intent due on April 2nd, from

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Portland Area Meaningful Use News

WHAT'S GOING ON WITH MEANINGFUL USE??

In a continued effort to incentivize providers to implement health care information technology, Secretary Kathleen Sebelius stated that HHS will delay Stage 2, allowing providers to adopt health IT in 2011 without meeting the new requirements until 2014. Under the current timetable, providers attesting Stage 1 standards in 2011 must attest Stage 2 standards beginning in 2013. The extension of Stage 2 implementation will affect only those providers who attested to Stage 1 in 2011.

PORTLAND AREA EHR INCENTIVE PROGRAM UPDATE

There were 13 clinics within Portland Area Indian Country that attested to the Medicare and Medicaid EHR Incentive Program(s) by the February 29th, 2012 deadline. Once approved, this will bring in over $1.1 million dollars to those 13 clinics for Stage 1 of Meaningful Use over the next several weeks.

This year, 20 more clinics are on track to attest to Stage 1 of Meaningful Use; bringing in over $2 million dollars. There is still a lot of work ahead as CMS recently released their proposed rule for Stage 2 of Meaningful Use-making it open for comments until May 7th, 2012. The Final Rule from CMS for Stage 2 will be published this Summer.

But it's not just about receiving the money. Meaningful Use is about improving the quality of patient care, improving safety, efficiency, and reducing health disparities. It's engaging patients and families in their healthcare, improving care coordination and Health Information Exchange.

OREGON STATE MEDICAID UPDATE

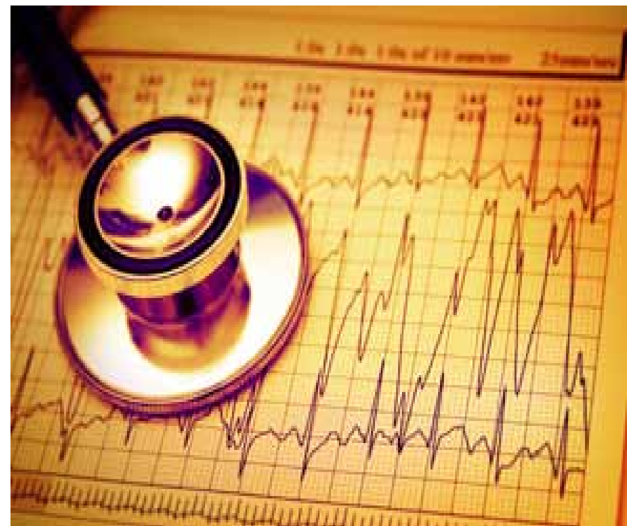
Oregon Medicaid made one Menu Set Performance Measure a Core Set Performance Measure requirement for demonstration of Meaningful Use. "Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice," is now a Core Set Performance Measure. For those EP's who are in their second year of Stage 1, of the Medicaid EHR Incentive Program, this must be met, (and for all future participation years-unless this ruling is changed by the State).

WASHINGTON STATE MEDICAID UPDATE

There is an important rule addition for the 2012 EHR Incentive Program related to completing applications. If their records indicate that you have not completed and submitted your state application within 90 days since registering with CMS, your application will be deemed expired. This new rule went into effect March 2012. Should you reach the 90-day expiration limit, your existing record will be deemed inactive in the state's EHR Incentive Program application system. If you wish to apply for 2012 participation (or a future year) you will be required to start the program's application process again, beginning with registering with CMS. ***So if you have recently registered with CMS or have had an application in their system and have not taken action on it, please be mindful of this change!***

IDAHO STATE MEDICAID UPDATE

The Idaho EHR Incentive Program is expected to launch this Summer. To prepare for early attestation, make sure you have either your Vendor Letter from IHS or your commercial EHR software contract/invoice. If you are running RPMS, setup and run your Patient Volume Report or have your billing vendor retrieve your paid Medicaid patient volume for 2011. Stay tuned for more updates.



For questions or information about Meaningful Use, please contact Angela Boechler either by phone at 503.416.3260 or by email at Angela.Boechler@ihs.gov.

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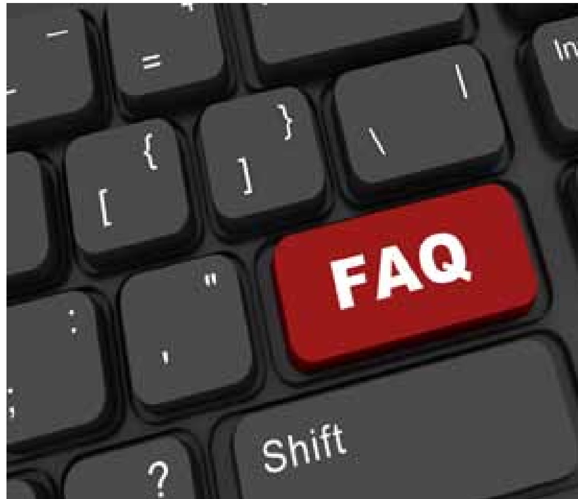
Portland Area Meaningful Use News

CMS FREQUENTLY ASKED QUESTIONS



Can an eligible professional (EP) implement an electronic health record (EHR) system and satisfy meaningful use requirements at any time within the calendar year for the Medicare and Medicaid EHR Incentive Program?

For a Medicare EP's first payment year, the EHR reporting period is a continuous 90-day period within a calendar year, so an EP must satisfy the MU requirements for 90 consecutive days within their first year of participating in the program to qualify for an EHR incentive payment. In subsequent years, the EHR reporting period for EPs will be the entire calendar year.

With regard to the Medicaid EHR Incentive program, EPs must have adopted, implemented, upgraded, or meaningfully used certified EHR technology during the first calendar year. If the Medicaid EP adopts, implements or upgrades in the first year of payment, and demonstrates MU in the second year of payment, then the EHR reporting period in the second year is a continuous 90-day period within the calendar year; subsequent to that, the EHR reporting period is then the entire calendar year.

Under the Medicaid EHR Incentive Program, is there a minimum number of hours per week that an EP must practice in order to qualify for an incentive payment? Could a part-time EP qualify for Medicaid incentive payments if the EP meets all other eligibility criteria?

Yes, a part-time EP who meets all other eligibility requirements could qualify for payments under the Medicaid EHR Incentive Program. There are no restrictions on employment type (e.g., contractual, permanent, or temporary) in order to be a Medicaid eligible professional. However, any EP demonstrating MU, who works at two practices/locations must have at least 50% of their patient encounters during the EHR reporting period at a practice/location equipped with certified EHR technology capable of meeting all of the MU objectives.

If an eligible professional is unable to meet the measure of an MU objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective under the Medicare and Medicaid EHR Incentive Programs?

Some Meaningful Use objectives provide exclusions and others do not. Exclusions are available only when CMS regulations specifically provide for an exclusion. EPs may be excluded from meeting an objective if they meet the circumstances of the exclusion. If an EP is unable to meet an Meaningful Use objective for which no exclusion is available, then that EP would not be able to successfully demonstrate Meaningful Use and would not receive incentive payments under the Medicare and Medicaid EHR Incentive Programs.

Are mental health practitioners eligible to participate in the Medicare and Medicaid EHR Incentive Programs?

Mental health providers would only be eligible for incentive payments if they meet the criteria of a Medicare or Medicaid EPs.

WHAT SHOULD I BE DOING NOW?

- If using RPMS-EHR, have your Clinical Applications Coordinator (CAC) establish your MU Clean Date (enable and set ten mandatory order checks for the system to run properly). Contact Angela Boechler to obtain this list.
- If you are using RPMS, setup your Individual EP and Group Medicaid Patient Volume Reports. This will allow you to run specific reports related to patient volume needed for attestation. Contact Angela Boechler for more information.
- Request a Vendor Letter from IHS if running RPMS. If running an EHR software other than RPMS, contact your vendor and ask them for a letter, contract, or invoice that states that you do indeed have a

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NPAIHB Regional Extension Center (REC) – Meaningful Use UPDATE

The REC and MU programs are off and running! Across the Portland Area, we have sites in all stages of EHR and MU preparations – from those still in the planning phases of EHR implementation to those who are actually meeting MU and awaiting and receiving incentive payments. The REC is here to help your site, regardless of where on this spectrum you might fall. As you may remember, the REC is funded based on 3 Milestones.

- Milestone 1 is securing provider agreements to work with the REC.
- Milestone 2 is "going live" with a certified EHR
- Milestone 3 is demonstrating Meaningful Use of that EHR

As of today, we have 121 providers signed up with the REC and we have been able to document "going live" for 63 of them. These Milestones are only related to the REC grant, and are not connected to the CMS EHR Incentive Program and the money that you will be applying for and that will be paid to your sites through the program. This is simply for the funding for the REC to provide services to you to help you meet MU and get the EHR Incentive Program money.

Many of you have already submitted applications to the Medicaid EHR Incentive Programs for your state, and a few have submitted applications to the Medicare program as well. For the first year for the Medicaid program, all you have to do is adopt, implement, or upgrade to a certified EHR. This is the easy part – you essentially just provide a Vendor Letter (provided by IHS for RPMS EHR or other documentation provided by your EHR vendor if on another EHR) to the state. The hard part has been getting/reactivating another set of password and log ins and finding the time to complete the online applications and interpreting the patient volume requirements for the Medicaid program and digesting all of the requirements of this new MU program. We are all in uncharted waters here and learning as we go. It can sometimes seem like we are spending so much time on the administrative tasks of the program that we are missing the bigger picture, which is to efficiently use our EHRs to improve patient care and reduce health disparities for our population. Do not be discouraged, I have hope that the "growing pains" of the first stages of the program are coming to an end. The first incentive payments will be coming soon (if they haven't arrived already) and there are many more exciting developments are on the horizon.

E-prescribing for RPMS – Officially released March 21st, but it is a controlled release. If you do not have an onsite RPMS pharmacy, you will need this to meet MU. There are many pre-requisites to meet before you can start e-Prescribing medications at your site, including 3 agreement forms that must be in place. Contact Katie Johnson (NPAIHB REC manager) and/or Neill Dial (Portland Area CAC/Pharmacy Consultant) at 503.414.5595 or by email at Cornelius.Daila@ihs.gov for more information. Currently the REC can pay for a contractor to optimize and get your drug file ready for e-Prescribing, which is one of the major pre-requisites. The REC is the process of assisting 6 sites with this now.

Notice of Proposed Rulemaking for Meaningful Use Stage 2 – Public comment period runs through May 6th. NPAIHB REC will be preparing comments. Individual sites are encouraged to make their own comments as well. Contact Katie Johnson if you are interested and would like to know what comments NPAIHB is preparing on the subject.

Other REC Services –

- Sites have been able to access help from lab consultants that would not otherwise have been available.
- Troubleshooting EHR issues
- Troubleshooting Medicare/Medicaid registration issues
- Working on sites' behalf with states and CMS on patient volume reports and eligibility questions
- Assisting in interpreting MU requirements on how RPMS EHR will meet them
- Workflow redesign discussions/suggestions
- Additional contractors (IT, HIM, etc) as needed for individual sites

Collaboration with Portland Area MU Consultant – Angela Boechler's contract as MU consultant has been extended for 6 more months by Portland Area Office. We'll continue to work closely together on MU and Angela will be able to continue the services she's been providing to you over the last year or so.

For more information please contact Katie Johnson at kjohnson@npaihb.org or by phone at 503.416.3272.

Public Health Improvement Program: Public Health Accreditation Trainings

By Rachel Ford, MPH

Public Health Improvement Program Overview

The Northwest Portland Area Indian Health Board (NPAIHB) was one of 8 tribal grantees chosen to participate in the Centers for Disease Control and Prevention's National Public Health Improvement Initiative (NPHII) efforts. The aim of the NPHII grant is to systematically increase performance management capacity and improve the ability to meet national public health standards. NPAIHB's Public Health Improvement program is meeting the goals of the NPHII grant by facilitating education and technical support to increase the organizational capacity and Quality Improvement (QI) efforts of its 43 member tribes, as well as promoting the integration of a "QI culture" and linking QI with public health accreditation of tribally-based health departments.

Public Health Improvement Program Goal

The goal of the Public Health Improvement program is to systematically increase the performance management capacity of tribal health departments and programs serving the 43 federally-recognized Northwest tribes, in order to ensure that tribal public health goals are effectively and efficiently met.

Public Health Improvement Program Objectives

The Public Health Improvement program has identified 2 objectives:

1. Establish and implement a Public Health Accreditation Performance Management Office that will provide education, technical assistance, and support to tribally-based health departments and programs, to engage in continuous performance improvement using the Public Health Accreditation standards.

2. Increase the number of tribally-based health program staff trained in performance management across key areas using Quality Improvement (QI) methods, by facilitating their participation in available trainings and webinars.

Public Health Improvement Program Year 2 Goal: Series of 3 Public Health Accreditation Trainings

The primary goal for Year 2 of the Public Health Improvement program is to bring a series of 3 public health accreditation trainings to the tribes. The trainings were chosen based upon data collected from a Public Health Improvement survey conducted in Year 1 of the program. The 3 trainings are:

1. Tribal Public Health Accreditation 101
2. Accreditation Readiness and Self-Assessment
3. Community Health Assessment and Community Health Improvement Plan

Tribal Public Health Accreditation 101

The first training of the series, Tribal Public Health Accreditation 101, was held February 9, 2012 at Little Creek Casino Resort in Shelton, WA. This training was also offered on April 6, 2012 at NPAIHB in Portland, OR. Tribal Health Directors, Clinic Managers, Health Board Delegates, Public Health Nurses, and other persons involved in public health leadership and delivery were all encouraged to attend. There were 33 people in attendance at the February 9th training, including representatives from 16 tribes, 2 Health Boards, 1 EpiCenter, and 1 State Department of Health.

The focus of the half-day Tribal Public Health Accreditation 101 training was teaching tribal representatives about the new national voluntary public health accreditation and what it means for tribes. Participants were taught an overview of the accreditation process, including costs, benefits, opportunities, and recommendations and considerations for application. In addition, the prerequisites of public health accreditation application, the Community Health Assessment, Community Health Improvement Plan, and the Agency Strategic Plan, were also reviewed. There was also a brief review of the accreditation standards and measures.

SAVE THE DATE: Accreditation Readiness and Self-Assessment Training

The second training in the series, Accreditation Readiness and Self-Assessment, will be offered June 6 and 7, 2012 at the Northern Quest Resort & Casino in Airway Heights, WA.

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Public Health Improvement Program: Public Health Accreditation Trainings

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The cost of the training is FREE! Travel reimbursement is available for at least one representative from each tribe.

NPAIHB and Red Star Innovations will be presenting the 1 ½ day training. Training participants will:

1. Understand the public health accreditation process and the 3 prerequisites.
2. Become familiar with the Public Health Accreditation Board domains, standards and measures.
3. Be able to identify strategies for accreditation preparation.
4. Know how to use the Accreditation Readiness Self-Assessment Tool.

The Accreditation Readiness and Self-Assessment training will expand upon the information presented in the Accreditation 101 training, and bring teams together from each tribe to begin using the Public Health Accreditation Readiness Self-Assessment Tool. Teams of 3-4 representatives from each Tribal Health Department are encouraged to attend; including individuals with a strong knowledge of the department, such as Health Directors, Clinic Managers, Delegates, Public Health Nurses, Financial Managers, and other persons involved in public health leadership and delivery.

For more information please contact Rachel Ford at 503-416-3282 or rford@npaihb.org.

When AI/AN in the Category "Other" Is Not Good Enough:

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		Uninsured	Access to IHS	Private Insurance
Oregon	Eastern OR	29%	42%	43%
	OR statewide	27%	18%	49%
Washington	Eastern WA	28%	38%	40%
	WA statewide	22%	26%	50%
Idaho	Statewide	35%	56%	42%

Data from 2008-2010 ACS PUMS files compiled by Ed Fox, April 2012.

in Eastern Oregon could and should incorporate the Indian Health Programs in the education and outreach programs and expect to see greater impact than outreach efforts in Western Oregon.

Outreach and education efforts in Western Oregon and Western Washington may need to rely more on methods such as use of media, including print, broadcast and social media outlets to increase efficacy of outreach efforts. It is likely that an effort that only relies on direct 'marketing' through the Urban Indian health programs would not reach the majority of AI/ANs. While a focused approach is efficient, research also shows that multiple strategies are the 'best' with no one focus or media 'good enough'.

ORAL HEALTH FOR NATIVE AMERICANS

Continued from page 1

Second, reduce the backlog of active caries cases now by:

Access

- Support IHS's efforts to fill dental vacancies and advocate for increased salaries, loan repayment, and marketing strategies that recruit dentists who are committed to working in AI/AN communities.
- Train general dentists and their staff in caries stabilization techniques (ART) for use with young children.
- Explore training of mid-level dental providers, similar to the Alaska DHAT model.

Dental mid-level providers can provide ongoing, effective, culturally-relevant dental care in AI/AN communities. They can work as case managers to prevent and manage early childhood caries (ECC), avoiding expensive referrals to pediatric dentists. This model also frees up the dentists to see more patients who need complex dental treatment. Dental access could be greatly increased with the use of oral health mid-level providers, similar to the model of physician assistants and nurse practitioners in the medical field.

In order to achieve some of the activities for increasing access we need to address the policy and resource barriers that are in place currently. These include, but are not limited to;

Policy

- Advocate for increased funding for IHS and tribal dental programs.
- Advocate for policy to support mid-level dental providers.

ORAL HEALTH FOR PACIFIC NORTHWEST AIAN PEOPLE THROUGH THE LIFE STAGES

Life Stage	Key Issues	U.S. Comparisons
Young children	**Tooth Decay: 2-5 year olds** 62% had experienced dental caries in their primary teeth. 44% had experienced dental caries by the age of two years. 44% had untreated tooth decay	**Tooth Decay: 2-5 year olds** 27% had experienced dental caries in their primary teeth 19% had untreated tooth decay
School-Age Children	**Tooth Decay: 6-14 year olds** 87% had experienced dental caries 66% had untreated tooth decay 62% had at least one dental sealant **Tooth Decay: 15-19 year olds** 91% had experienced dental caries 68% had untreated tooth decay	**Tooth Decay: 6-19 year olds** 42% had experienced dental caries 14% had untreated tooth decay 32% had at least one dental sealant **Tooth Decay: 16-19 year olds** 68% had experienced dental caries 22% had untreated tooth decay
Adults	**Tooth Decay 35-44 year olds** 79% had lost at least one tooth 68 % had untreated tooth decay **Periodontal Disease 35-44 year olds** 96% had gingivitis (bleeding gums) 36% had early periodontal disease and 23% had advanced periodontal disease	**Tooth Decay: 40-59 year olds** 26% had untreated tooth decay **Periodontal Disease: 40-49 year olds** 24% had gingivitis 25% had lost 4mm or more of attachment
Elders	**Tooth Decay: 55+ years** 61% had untreated tooth decay **Periodontal Disease: 55+ years** 34% had early periodontal disease and 27% had advanced periodontal disease. **Tooth Loss: 55+ years** 21% were edentulous	**Tooth Decay: 60+ years** 19% had untreated tooth decay **Periodontal Disease: 60-69 year olds** 51% had lost 4mm or more of attachment **Tooth Loss: 65+ years** 21% were edentulous

These data are compiled from the 2010 Oral Health Survey of AIAN Preschool Children, 1999 IHS Oral Health Survey, the National Health and Nutrition Examination Survey 1999-2002, and the Behavioral Risk Factor Surveillance System.

A National Partnership to Increase Awareness about Health Reform

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In the coming months NIHOE partners will work to complete and implement several education tools for use in tribal communities. . These tools, as well as consumer-oriented education materials, will be available on a website specifically for tribal stakeholders at www.tribalhealthcare.org. NIHOE partners know that not everyone has access to the internet, therefore all materials on the site will also be available in printer-friendly format for easier dissemination.

NIHOE partners are hosting the National Tribal Health Reform Training April 18-19, 2012 at the Mystic Lake Casino Hotel. The training will assist communities in planning health reform education and outreach campaigns, provide information about the laws' impact in tribal communities, and share nationally developed outreach materials. All of the materials shared at the training will be available on www.tribalhealthcare.org.

NIHOE partners are collecting ideas and suggestions from all tribal communities. If there is anything the partners can do to assist you in outreach efforts in your community please contact Tyra Baer or Terra Branson at tbaer@nihb.org or tbranson@ncai.org.

"Navigating" the Affordable Care Act

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have grievances, complaints, or questions regarding enrollment or coverage, and provide information in a "culturally and linguistically appropriate manner.

***Doneg McDonough** leads the health care consulting firm Health System Analytics and advises clients on implementation of the Affordable Care Act.*

Doneg is under contract with the National Indian Health Board (NIHB), serving as a technical advisor to the Medicare, Medicaid and Health Reform Policy Committee (MMPC) and the Tribal Technical Advisory Group (TTAG) to the Centers for Medicare and Medicaid Services (CMS).

Doneg has extensive experience in the financing, restructuring, and management of health systems and programs and the formulation of health policy. Doneg previously held the position of Legislative and Policy Director for a national coalition representing over 34 million Americans working to enact the Affordable Care Act. Doneg is well-versed in Medicare, Medicaid, and other entitlement programs, having served as a Congressional staff member and having designed and implemented insurance expansions and reforms as a state government official. Doneg earned a BA in Sociology at the University of California, Berkeley and a Master of Public Administration from Columbia University in New York.

Oregon's Coordinated Care Organizations & Tribal health programs

Continued from page 13

prospective CCOs. The Board did file a letter of intent to become a CCO at the request of Oregon Tribes and NARA. This action was taken to preserve the ability of the Board, or its member Tribes and NARA, or a consortium thereof to submit an application to become a CCO. The next due date in the CCO process is to complete a technical application by April 30th; with the final application due on May 14th. It is not likely that the Board or any Oregon Tribe will be able to meet these due dates. A Tribal technical panel met with the OHA on April 6th by conference call and requested a separate application track be established for the Indian health system. It is not known at this time if a separate process for Tribes will be allowed by the OHA. Additional information about CCOs and the application process can be accessed at https://cco.health.oregon.gov/Pages/AboutUs.aspx.

Portland Area Meaningful Use news

Continued from page 15

certified EHR at your facility or are in the process of adopting, implementing, or upgrading to one. The State Medicaid offices will ask for this type of documentation when you attest for an incentive payment. To request an RPMS Vendor Letter go to http://www.ihs.gov/meaningfuluse/index.cfm?module=steps_request_letter

A NEW FACE AT THE BOARD

Congratualtion to Kara & Erik Kakuska and Big Sister Evy with the arrival of Izabella "Iza" Clo born Februrary 23, 2012 at 9 Pounds 1 oz.

THE *TEN RIGHT FIELDERS* NPAIHB SOFTBALL TEAM

Top left: Jim Mears, Damon Hilliard, Lisa Griggs, Erik Kakuska, Eugene Mostofi, Amanda Gaston, Delilah DeWilde
Front row: Mike Feroglia, Don Head, Nicole Smith
(Not Pictured: Elaine Dado, Katie Johnson, Eric Joseph, David Stephens, Galey Morrison and Joe Finkbonner)

Upcoming Events

2nd ANNUAL
THRIVE
CONFERENCE

SAVE THE DATE
Contact: Colbie Caughlan at
ccaughlan@npaihb.org or 503-416-3284

When: June 25 - June 29, 2012

Where: Portland State University Campus in Portland, Oregon

Who: High-school aged Native Youth throughout the U.S.

Registration will be **FREE**!! You will need to register as a group and with 1 chaperone for each 4-5 youth.

Stay tuned for registration information in early 2012. Meals and activities will be paid for by partner's of the conference. *Travel, parking, & lodging will not be covered.*

Possible youth workshop tracks & activities:
- Gathering of Native Americans (GONA)
- Film Production
- Digital Storytelling
- Song writing & production
- Bowling, dancing, and cutural nights

April

April 22-25
30th Annual Protecting Our Children Nation American Indian Conference
Scottsdale, AZ

April 24 - 25, 2012
National Council of Urban Indian Health 2012 Leadership Conference
Arlington, VA

April 25
Native American Youth & Family (NAYA) Health Fair
Portland, OR

April 26-27
National Tribal Advisory Committee (NTAC) Meeting
Rockville, MD

May

May 3 – 4
SPIPA's 6th Annual Medical Update Conference
Shelton, WA

May 6 – 10
2012 Annual Tribal Self-Governance
New Orleans, LA

May 8
Risky Business Training
Bellingham, WA

May 9th
NW Native Adolescent Health Alliance Meeting & Injury Prevention Coalition Meeting
Bellingham, WA

May 9th
WA HCA & AIHC Tribal Workgroup Meeting
Olympia, WA

May 15
Oregon TTWG Meeting
Salem, OR

May 15
Risky Business with iLinc Web Conferencing
NPAIHB Offices, Portland, OR

May 16th
NW Native Adolescent Health Alliance Meeting
NPAIHB Offices, Portland, OR

May 17
Quileute Health Fair
La Push, WA

May 23
12th Annual Tribal Conference "Tribal Needs & Healthcare Reform"
Bow, WA

May 28
Memorial Day

May 30-31
HHS Secretary's Tribal Advisory Committee (STAC) Meeting
Washington, DC

May 30 -31
Annual IHS HIV/AIDS and STI Partners Meeting
Scottsdale, AZ

May 30 – June 1
NIHB Public Health Summit
Tulsa, OK

June

June 4
Oregon TTWG Meeting
Salem, OR

June 6-7
IHS Budget Formulation 2012
Evaluation Meeting
TBA

June 6-7
2012 Accreditation Readiness and Self-Assessment Training
Airway Heights, WA

June 13
WA HCA & AIHC Tribal Workgroup Meeting
Olympia, WA

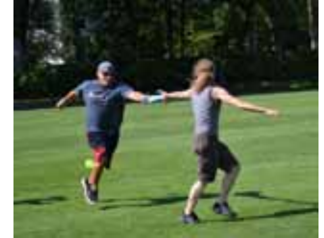
June 17-21
NCAI Mid-Year Conference
Lincoln, NE

June 18 – 21
NPAIHB THD Meeting & Quarterly Board Meeting
Grand Mound, WA

June 25 – 29
2nd Annual National Health Promotion Conference
Portland, OR

June 25 – 28
IHS Behavior Health Conference
Bloomington, MN

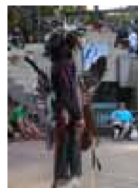
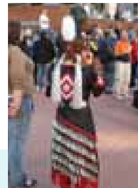
Do you work with Native youth?
Save the Date
August 8th and 9th, 2012



Native Fitness
2012 Focus: Tribal Youth Programs
Nike World Headquarters
Beaverton, OR

In Celebration of National Indian Day; the Northwest Portland Area Indian Health Board Presents:

7Th Annual Dancing In The Square Powwow

September 28th, 2012
Time: 12pm - 7pm
Pioneer Square, Downtown Portland, Or
Grand Entry: 3:30 pm

MC: TBA
Whipman: Ed Goodall
Color Guard: NIVA
Host Drum: Four Directions

FIRST 4 DRUMS REGISTERED WILL BE PAID
(Please Register Proir to event)

This event is FREE and open to the public.
A Drug, Alcohol, Commerical Tobacco and Violence FREE event.
Sales of sacred items are forbidden.
The committee is not responsible for lost or stolen items or any travel or parking cost.

Vendors & Educational Booths
For More Information Please Contact:
Lisa Griggs at 503-416-3269
lgriggs@npaihb.org

For more information about the Northwest Portland Area Indian Health Board or the 43 Federally recognized Tribes of Idaho, Oregon and Washington please visit : www.npaihb.org.
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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD'S JANUARY 2012 RESOLUTIONS

RESOLUTION #12-02-01

INTERVENTIONS FOR HEALTH PROMOTION AND DISEASE PREVENTION IN NATIVE AMERICAN POPULATIONS

RESOLUTION #12-02-02

NATIVE AMERICAN RESEARCH CENTERS FOR HEALTH (NARCH) VII