Health News & Notes

Northwest Portland Area Indian Health Board

Indian Leadership for Indian Health

A Publication of the Northwest Portland Area Indian Health Board

August 2016

THE NATIONAL TRIBAL BEHAVIORAL HEALTH AGENDA

A Federal/Tribal Collaboration to Improve Health and Wellbeing

"We continue to address the impacts of alcohol and other drugs, youth suicides, domestic violence and the list continues. However, now is the time to address the source of these symptoms—historical and intergenerational trauma."—**Tribal leader, White House Tribal Nations Conference, 2014**

The story of American Indians and Alaska Natives is one of resiliency and survival. However, threats such as social injustice over multiple generations continue to have enduring consequences for tribal communities and contribute to behavioral health problems—mental and substance use disorders—being experienced today.

These problems are reflected in high rates of interpersonal violence, depressive symptoms (depression and unresolved grief and loss), substance use (alcohol and illicit drugs), and suicide. Root causes and resulting behavioral health issues also impact other areas that contribute to well-being, such as overall health, education, employment, child welfare, and engagement with the justice system, which create an urgent need for tribes, federal agencies, and other interested parties to work together more effectively.

DEVELOPMENT OF THE AGENDA

The idea for what has become the National Tribal Behavioral Health Agenda (TBHA) was brought forward by concerned and engaged tribal leaders. To bring the idea to fruition, the Substance Abuse and Mental Health Services Administration, Indian Health Service, and National Indian Health Board shared information and facilitated discussions and meetings with hundreds of tribal leaders, tribal health administrators, tribal members, advocates for American Indian and Alaska Native health, Native youth, and federal agencies.

Input was received through facilitated sessions that were held independently or during other scheduled tribal and federal gatherings and meetings. Because it was important to garner federal input in the process, the U.S. Department of Health and Human Services also hosted the Federal Interagency Forum to discuss current programming that might align with the TBHA. Federal Interagency Forum discussions demonstrated a synergy between tribal and federal input and showed that opportunity exists for greater collaboration.

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Impacts on Native Health

ISSUES IMPACTING TRIBAL HEALTH PROGRAMS

By Geoffrey D. Strommer, Partner
Hobbs, Straus, Dean & Walker

A number of developments on important issues impacting tribal health programs have occurred over the past few months. This article briefly discusses several of those issues: the status of the FY 2017 IHS budget; opioid abuse legislation and funding in FY 2017 bills; an update on a recent federal court decision requiring IHS to fully fund leases under the ISDEAA; Contract Support Costs appropriations and policy developments; IHS consultation on proposed changes to IHS's Catastrophic Health Emergency Fund policy; and IHS's new circular on purchase of health insurance by tribes, tribal organizations and urban Indian organizations.

Status of FY 2017 IHS Budget

We expect that Congress will enact in September a FY 2017 Continuing Resolution (CR) of at least several months duration to fund the Indian Health Service and other federal agencies. CRs for the most part fund programs at their previous year's level and conditions, thus thwarting or delaying any gains that may have been proposed in pending appropriations bills. Hopefully the CR will not be of a long duration and Congress will negotiate "regular" FY 2017 appropriations bills based on the recommendations already made by the House and Senate appropriations committees. We need, therefore, to pay attention to the recommendations of these Committees and weigh in on them. One likely scenario is that a CR would run into December and then an omnibus appropriations bill will be enacted for the rest of the fiscal year There are a number of differences between the House and Senate Committee-approved Interior, Environment and Related Act appropriations bills regarding the IHS including:

- House proposes $271 million over FY 2016 and $108 million below the Administration's request; Senate proposes $186 million over FY 2016 and $191 million below the request.
- House has $84.5 million more than the Senate and includes considerably more funding for built in costs than does the Senate.
- Purchased/Referred Care: Senate $914.1 million (level funding); House $960.8 million. House Report instructs IHS to allocate the increase above FY 2016 according to formula reserved for program increases only.

ISSUES IMPACTING TRIBAL HEALTH PROGRAMS

- Behavioral health Initiative (under Mental Health): Senate $25 million; House -0-
- Youth Initiative (under Alcohol and Substance Abuse): Senate $16.8 million; House -0-
- Small Ambulatory Health Care Facilities: Senate $10 million; House -0-
- New and Replacement Quarters: Senate -0-; House $12 million
- Accreditation Emergencies: Senate -0-; House $6 million
- Creation of a Prescription Drug Monitoring Program on a Multi-state Basis – House $1 million; Senate -0-

With regard to Committee report language:

- Advance Appropriations: The Senate asks for a GAO report and evaluation on the use of advance appropriations for healthcare programs across the Federal government, and their applications to the Indian Health Service
- Population Growth Funding Distribution: the House questions the distribution of population-growth funds, saying it does not reflect places where caseloads are growing and asks the IHS to consider an alternate method of distribution.
- Report on Full Funding for IHCIA: the House directs IHS to provide a plan of what would be required to fully fund the IHCIA.

Key matters on which the House and Senate Committees have the same provisions are:

- Contract Support Costs – CSC would be maintained as a separate account and provide an indefinite appropriations ("such sums as may be necessary"). The estimate of CSC needs for FY 2017 is $800 million. The bills do not contain the proviso that was the FY 2016 appropriations act that could be used to deny CSC carryover from one year to the next.
- Contract Support Costs for Domestic Violence, Zero Suicide Initiative Substance Abuse and Suicide Prevention. The bills do not continue the bill language from FY 2016 of "Notwithstanding any other provision of law" which IHS apparently used to deny CSC for these grants.
- Volunteer Dentists/Credentialing. Both Committees are interested in IHS establishing a pilot project for a centralized credentialing system for volunteer dentists, similar to what the DOD and the VA have. The House Report directs the IHS to consult with those agencies and private organizations to develop this pilot project. The

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Senate Report language is softer, asking the IHS to consult with those agencies, private organizations and state dental organizations and work to establish a pilot program.

Opioid Abuse Legislation Enacted into Law / Opioid Funding in FY 2017 Bills

On July 22, 2016 President Obama signed into law S. 524, the Comprehensive Addiction and Recovery Act of 2016 (CARA). CARA is designed to address a wide range of issues regarding the prevention and treatment of opioid abuse. While the legislation was approved by the House and Senate on near-unanimous votes, the two parties had strong disagreements with regard to funding. While congressional Democrats and the President advocated for emergency mandatory funding to address the opioid crisis, CARA authorizes, but does not appropriate, such funds. The President, in signing the bill, noted it takes "modest steps" and called for more funding for addiction treatment.

While CARA contains tribal eligibility for a number of competitive grant programs there is no tribal-specific allocation of funds. When the Senate first considered its opioid legislation an amendment was filed to provide for a tribal allocation but the amendment did not receive a vote on the Senate floor.

Below is information on selected sections of CARA:

Pain Management Task Force. Section 101 requires the establishment of a large Pain Management Best Practices Inter-Agency Task Force which would include representatives of HHS and relevant HHS agencies (i.e, the Indian Health Service) and experts in the field of minority health. The Task Force is to study whether there are gaps or inconsistencies among federal agencies in their pain management best practices and to propose recommendations regarding the same. CARA specifically provides that the Task Forces does not have rulemaking authority.

Section 107. Improving Access to Overdose Treatment. HHS may provide information to health care facilities of the Indian Health Service on "best practices for prescribing or co-prescribing a drug or device approved or cleared under the Federal Food, Drug and Cosmetic Act for emergency treatment of known or suspected opioid overdose…". It also authorizes $5 million for Federally Qualified Health Centers and others from FY 2017 through 2021 for expansion of access to drugs or devices for emergency treatment of opioid overdose.

Section 201. Comprehensive Opioid Abuse Grant Program. The CARA authorizes $103 million in each of fiscal years 2017 through 2021 for a new Department of Justice (DOJ) program to distribute funds that "equitably address the needs of underserved populations, including rural and tribal communities; and focuses on communities that have been disproportionately impacted by opioid abuse…"

The Attorney General is authorized to make grants to Indian tribes and state and local governments to provide services primarily relating to opioid abuse; developing, implementing, or expanding a treatment alternative to incarceration programs; training criminal justice agency personnel on substance use disorders and co-occurring mental illness and substance use disorders; the development of a mental health court; the development of a drug court; the development of a veterans treatment court program; creating programs focused on parents whose incarceration could result in their children entering the child welfare system; and the development of community-based substance use diversion programs sponsored by a law enforcement agency.

Section 202. First Responder Training. CARA codifies an existing program whereby HHS provides grants to tribes, tribal organizations and others that will allow "first responders and other key community sectors to administer a drug or device approved or cleared under the Federal Food, Drug and Cosmetic Act for emergency treatment of known or suspected opioid overdose." Funds are also to be used for training and for the establishment of protocols. CARA authorizes $12 million annually for this program for each of fiscal years 2017 through 2021.

IMPACTS ON TRIBAL HEALTH PROGRAMS

Section 301. Evidence-Based Prescription Opioid and Heroin Treatment and Interventions Demonstration. CARA codifies an existing Substance Abuse and Mental Health Services Administration program for grants for tribes, tribal organizations and others to expand the availability of medication-assisted treatment and other clinically-appropriate services. Funds are for to be awarded in areas where there high rate or rapid increase in the use of heroin or other opioids. CARA authorizes $25 million in each of fiscal years 2017 through 2012 for this program.

We note that the Comprehensive Addiction and Recovery Act addresses many other issues which are not necessarily designed as grant programs. The Conference Report on CARA is available here: https://www.congress.gov/114/crpt/hrpt669/CRPT-114hrpt669.pdf

Opioid Funding in Pending FY 2017Appropriations Bills. While we expect Congress to enact in September a Continuing Resolution to provide funds for at least a portion of FY 2017, the work that the Appropriations Committees already done on FY 2017 bills will set the stage for negotiations for an omnibus appropriations bill. The House and Senate Committees have made recommendations for substantial funding addressing opioid matters. The House bill would provide $500 million to SAMHSA in discretionary funds "to create a network of grants to states, localities, territories and Indian tribes to develop integrated opioid response initiatives focusing on prevention, education, treatment and recovery services." The Senate bill would provide $261 million in discretionary opioid-related funding. Discretionary opioid funding in HHS for FY 2016 was $135 million.

The House DOJ appropriations bill would provide $103 million under Office of Justice Programs for the new program authorized in Section 201 of CARA; the Senate bill does not propose this funding. Other opioid-related funding is found in the Drug Enforcement Administration and the Bureau of Prisons accounts.

Court Requires Full Funding for ISDEAA Lease

On March 22, 2016, Judge John D. Bates of the United States District Court for the District of Columbia issued a memorandum opinion and order in Maniilaq Association v. Burwell, No. 15-152 (D.D.C.), ordering IHS to negotiate lease compensation under Section 105(l) of the Indian Self-Determination and Education Assistance Act (ISDEAA) and implementing regulations for a proposed lease of Maniilaq Association's health clinic facility in Kivalina, Alaska. The IHS had rejected the lease proposal on the grounds that the compensation requested by Maniilaq Association exceeded the amount to which Maniilaq was entitled under the ISDEAA, even though Maniilaq's proposed compensation was based on specific criteria set out in the Section 105(l) implementing regulations. The IHS argued that those regulatory criteria are discretionary, and that the IHS was free to limit Maniilaq's lease compensation to clinic funding amounts already available to Maniilaq through its ISDEAA funding agreement for a different leasing program.

Judge Bates ruled in March that the statutory and regulatory language was ambiguous with respect to compensation, and that the ambiguity must be resolved in favor of Maniilaq under the Indian law principle of interpretation that ambiguities in statutes or regulations benefitting Indian tribes must be resolved in favor tribal interests (a generally applicable rule that is also specifically codified in the ISDEAA and its implementing regulations). Judge Bates retained jurisdiction over the case and ordered the IHS to negotiate with Maniilaq over proper lease compensation consistent with his order and opinion. On July 14, 2016, the parties filed a joint status report and proposed final order notifying Judge Bates that they had agreed on a compensation amount and lease terms. On July 27, 2016, Judge Bates issued a final order requiring the IHS to enter into the lease and ordering the IHS to pay Maniilaq $470,187.65 as required by the lease. The final negotiated annual compensation amount represents nearly an 825% increase as compared with the amount that Maniilaq received for FY 2015 and FY 2016 for the Kivalina clinic through its Annual Funding Agreement.

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THRIVING FOR THE FUTURE: A NEW WAVE OF NATIVE HEALTH PROFESSIONALS ON THE RISE

By Celena McCray, THRIVE Suicide Prevention Project Coordinator

Approximately 65 Native youth representing 21 federally-recognized tribes, traveled to Portland, Oregon to attend the 6th Annual THRIVE Youth Conference on June 27th-July 1st, 2016. The conference is open to youth nationwide, and offers the opportunity to participate in one of four interactive workshops that teach about healthy lifestyles. Topics discussed include the signs of suicide, exploring healthy ways to deal with stress, and how to channel challenging life events into positive outcomes, such as creating song lyrics, digital stories, being a leader in the community, or diving into science and academics.

This year's conference theme was *THRIVING* for the Future. Our aim was to empower youth to proactively think about their future and explore community assets that strengthen their nations.

The five-day agenda was comprised of guest speakers, four workshop sessions from science and medical health fields, leadership, digital storytelling, and song writing. Each session incorporated American Indian/ Alaska Native culture, traditional learning strategies, and skill-building activities that educate youth about healthy decision-making.

This was the second year for the *Science of Healthy Lifestyles* workshop. This session was organized and led by staff at the Oregon Health and Science University (OHSU). Youth met with Native professionals working in health and science fields; among them were Dr. Amanda Bruegl (Oneida/Stockbridge-Munsee tribes) and Dr. Erik Brodt (Chippewa/Anishinaabe). These doctors presented on the ***We Are Healers*** program which provided youth information on how to pursue higher education in the medical field. Participants also explored the amazing technology of the OHSU Simulation Center, learned how translational research impacts physical and mental health in humans, and met scientists and health professionals at all stages of their careers. By the end of the week several youth were inspired and now plan to go to medical school.

We R Native brought in a new class of ambassadors! Twelve Native youth from the Northwest vicinity received hands-on leadership training and had the opportunity to create a social media campaign targeting alcohol and drug abuse. The campaign will be revealed over *We R Native's* social media outlets in late summer. Youth learned about the different resources *We R Native* offers and how they can utilize those resources to create positive changes in their communities. With former youth ambassadors assisting the *We R Native* workshop facilitator's, inspiration and engagement by the youth was easy to come by. We are very excited to see the amazing work this new cohort has in store.

In another workshop, youth promoted social change and action by sharing their stories through digital media and the art of *digital storytelling*. Facilitator Joe Law (Klamath/ Siletz/Northern Cheyenne), and a team of facilitators assisted students with the creation of powerful stories that ranged from, college aspirations to how one's community can influence lives in positive ways. To some, digital storytelling can be very therapeutic and very educational. One teen participant wrote "I would like to make more videos to share with my tribe on things like our youth group, opportunities in our community, and teach others." To view these stories, you can find it on our *We R Native YouTube* channel.
Direct link: https://www.youtube.com/watch?v=zOhMZZWPWNA&list=PLvLfi7yZ2zQGs3iIyCYb040u1xyDjsGx9

The final workshop was Beats Lyrics Leaders (BLL), led by J. Ross Parrelli and a group of incredible mentors. BLL offered a hands-on approach to learning, as they taught each participant the ins and outs of beat making, lyric/song writing, and recording. Students left with a sense of purpose, belonging, understanding, and pride for one's culture. This family-like environment taught goal setting, empowerment, confidence, skill development, public speaking, creative writing, and how to strengthen their communities.

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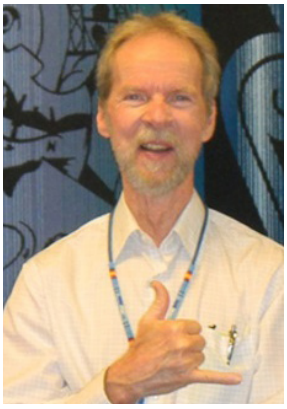
NW NATIVE AMERICAN RESEARCH CENTERS FOR HEALTH (NW NARCH) FELLOW HIGHLIGHTS



By Dr. Tom Becker
NW NARCH & Cancer Project Director

Greetings,
The NW Native American Research Centers for Health (NW NARCH) Fellowship Program is very proud of all of our graduates and we wanted to share a snapshot of some of our groundbreaking Native professionals. This program is designed to assist full-time students pursuing their research-related degrees and the goal is to increase the number of American Indian/Alaska Native (AI/AN) health professionals who are committed and prepared with the biomedical or social service research skills needed to conduct successful research projects.

The program is funded by the Indian Health Service (IHS) and the National Institutes of Health (NIH) and The Northwest Portland Area Indian Health Board (NPAIHB) administers the grant and is able to provide a limited number of scholarships and fellowships to support research career development and ensure graduates in the field by providing financial assistance, mentorship, and culturally relevant training.

For more information, please contact Dr. Tom Becker, NW NARCH Director at tbecker@npaihb.org or Tanya Firemoon, NW NARCH Program Assistant at tfiremoon@npaihb.org.

Jacob Davis,
(Turtle Mountain Band of Chippewa), NW NARCH Fellow Masters of Public Health with a specialization in American Indian Public Health (first graduate in the nation with an AI specific MPH degree)

How did I learn about the NW NARCH Fellowship?
I was fortunate enough to have received scholarships to attend the NARCH Summer Training Institute's in 2010 through 2012. My participation within this institute provided me the opportunity to develop a professional relationship with the Northwest Portland Area Indian Health Board which led to me applying for the NW NARCH Fellowship.

Why did I choose my specific degree?
The reason I chose the American Indian Masters of Public Health degree is because it offered me the opportunity to learn about American Indian specific public health components. North Dakota State University was the first in the nation to offer this AI specific curriculum that seemed to align with my professional aspirations while allowing me to learn from nationally known AI professionals such as Dr. Donald Warne.

After graduating, what are my career goals and/or educational goals?
Since the completion of my degree in the spring of 2015 I have been focusing on the development of a consultant business that takes a holistic approach to working with tribal entities in regards to public health. I am currently working as a consultant for Prevent Child Abuse North Dakota which allows me to assist two of the five tribes within the state as a Tribal Data Liaison.

How did the NW NARCH fellowship help in furthering my education?
Prior to applying for the NW NARCH Fellowship I was working full time within an academic setting as a Project Coordinator. Receiving the fellowship allowed me to leave my position so that I could dedicate my time towards completing my degree in two years. The fellowship provided not only financial support but mentorship which I know helped me fully engage within my program.

What would you share with others who are seeking financial assistance?
This is an opportunity that could change your life and allow your educational goals to be your primary focus. The support the administration provides is not limited to financial and also assists with professional development and mentorship. The organizational values are rooted in American Indian culture and helps motivate students through these beliefs.

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MOVING TOWARDS A TRIBALLY-BASED COMMUNITY HEALTH WORKFORCE: IHS RELEASES DRAFT POLICY STATEMENT CREATING A NATIONAL COMMUNITY HEALTH AIDE PROGRAM

By Pamela Johnson
Native Dental Therapy Initiative Project Specialist

On June 1, 2016, the Indian Health Service (IHS) released a Dear Tribal Leader Letter and a policy statement titled, "Creating a National Indian Health Service Community Health Aide Program." Their goal is to see community health aides utilized to the fullest extent permissible in IHS and tribally run hospitals and clinics.

Because of our commitment to tribally-informed healthcare delivery systems, and our robust work supporting Dental Health Aide Therapy programs in the Portland Area, the Northwest Portland Area Indian Health Board is excited about the possibility of expanding care to tribal members in the Portland Area through the CHAP program. We see this as the crucial first step of a longer process to improve the health care delivery system in tribal communities all over the country. This is an opportunity to expand the capacity of our health care work force and create an accessible entry point for our young people and tribal members into the health professions.

What is CHAP?

Community health aide programs (CHAP) are not new to the Indian health system. Alaska has had a CHAP program for over 60 years. CHAP services have proven to be a sustainable, effective, and culturally acceptable method for delivering health care. Although community health aides have been used within the Indian health system, the potential for a national expansion of community health aide services is significant, especially considering the poor recruitment and retention of providers at IHS facilities. The Alaska CHAP program includes Community Health Aides (CHA/Ps)Behavioral Health Aides (BHA/Ps) and Dental Health Aides (DHA/Ts). The CHAP program provides needed health, oral health, and behavioral health services while also emphasizing wellness and healthy choices.

Benefits of a CHAP program

The current healthcare delivery system is failing tribal communities in many ways. Not only is access often a challenge due to expense and location, but there is a significant lack of AI/AN providers. The Alaska CHAP program:

- Provides routine, preventive , and emergent care;
- Respects the knowledge and resources in the tribal community and grows providers from that source. Community Health Aides are selected by their communities to receive training;
- Trains AI/AN community members who speak the native languages and can provide culturally appropriate care;
- Breaks down barriers to care and barriers to training;
- Creates an accessible entry point for AI/AN people wishing to become health care providers;
- Utilizes a training program that emphasizes not just skill and proficiency but also ensure Aides could receive training with a minimal time away from communities and families.
- Brings care to communities;
- Fosters a team approach to delivering health care services.
- Enables members of the team to function at a higher capacity.

NPAIHB's letter supporting the CHAP expansion offered the following recommendations:

- Support draft policy that includes the expansion of all three disciplines of the Community Health Aide Program providers;
- Amend IHCIA to allow for the expansion of DHATs

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WELLNESS TIME ESCALATES ACTIVITY

By Monika Damron
(Hualapai/Navajo)
IDEA-NW Biostatistician

Last September two of my coworkers and I got the idea of starting a Hood to Coast team here at the Northwest Portland Area Indian Health Board (NPAIHB). Hood to Coast is a 198 mile relay race that starts at Timberline Lodge on Mt. Hood and ends on the coast in Seaside, OR. Each team consists of 12 runners and each runner runs 3 legs. By the end of the race, each runner will have run anywhere from 13 to 19 miles total. I had haphazardly joined a Hood to Coast team for the 2015 race and found it to be challenging, rewarding and just plain fun. In the month after the race, I had recounted my experience to the my colleagues and to my surprise I sparked their interests! They declared they wanted in.

However, to start a Hood to Coast team we'd have to enter a lottery system. Every year 2,800 teams from all 50 states and over 38 countries will apply to run Hood to Coast and only 1,050 will get in. First priority is given to teams who have run before and to teams who have applied before but were rejected. This would be our first bid into the Hood to Coast relays and by all mean the odds were against us. Furthermore, although the race occurs at the end of August, we would not only have to make our bid by the first week of October, but also submit a check of $1,670 for registration fees. At this time we were a team of three and October was only two weeks away. But somehow, we convinced two more colleagues to join us, and as a team of five we pulled it together in time to submit our bid for the 2016 Hood to Coast relays.

WE GOT IN!

After the excitement of beating the odds wore off worry set in. How were we going convince seven more people, plus a few alternates, to run 13-19 miles each for a race that lasts about two days with no promise of sleep? I personally had a moment of "This is crazy. What were we thinking? We are crazy." However, as it happens, NPAIHB is as much as an advocate for good health and wellness in the workplace as it is in the communities we serve so we had a platform to speak from. NPAIHB members began to take interest in all aspects of the race. There were those who stepped up to be runners and then there were those who stepped up to be volunteers. As we recruited, one thing we knew for sure was that our team would NOT be about becoming expert runners, but would be about the joy of being physically active and healthy – walk the talk! Thus, team HANDS was formed i.e. Healthy Active Natives Doing Something.

In addition to training for this race, team HANDS has also been fundraising in order to pay for the initial registration fee, food, travel, lodging, and race gear such as shirts, reflective vests, flashlights, and flashers. In our efforts to fundraise we have hosted numerous luncheons, have had donations from Columbia sportswear, as well as pop can recycling, QBM auctions, and selling small treats and snacks. Currently we have raised $2,000 and are halfway to our goal of $4,000. We hope team HANDS will continue to race each year, therefore any extra money we raise will go towards the 2017 HANDS Hood to Coast

Go Fund Me page: https://www.gofundme.com/2uz4nauk

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Collectively, the input sessions allowed participants to share information on behavioral health and related priorities, the nature of behavioral health service delivery, significant successes and challenges, and considerations for advancing behavioral health among American Indian and Alaska Native people and communities. Across discussions, tribal leaders and representatives agreed to the importance of the TBHA, its foundational elements, and considerations for the development of the TBHA. From the discussions emerged a series of overlapping opportunities and priorities that serve as the framework for the National TBHA.

FOUNDATIONAL ELEMENTS

The TBHA is not a strategic plan—it is a guiding blueprint that identifies priorities to assist in strengthening policies and programs, aligning disparate resources, and facilitating collaboration. The TBHA framework is organized around five foundational elements that provide both content and direction and six cross-cutting considerations (Native youth, identity, culture, self-sufficiency, data, and Tribal leadership). Underlying each of the five foundational elements are priority areas that reflect recurring issues raised by tribal leaders and tribal members. The following is a brief description of the foundational elements and related priorities.

FOUNDATIONAL ELEMENT 1: HISTORICAL AND INTERGENERATIONAL TRAUMA

The focus is on clarifying the sources of the trauma to create a common understanding of how the past contributes to the present in order to support efforts that promote and support healing. Priorities include:

- Supporting systems for individuals, families, and communities affected by traumatic events that support the collective group to heal
- Supporting community connectedness as a strong protective factor against many behavioral health issues, including suicide, depression, and substance use
- Breaking the cycle of trauma

FOUNDATIONAL ELEMENT 2: SOCIOECOLOGICAL APPROACH

The focus is to address influencing factors (i.e., peers and social networks, family, other community members, governing structures, economic systems, culture and history, etc.) that impact health. Priorities include:

- Sustaining environmental resources that are part of the tribal a way of life and a source of traditional foods and medicines
- Building reliable infrastructure to address unemployment, improve housing opportunities, support the health workforce, and other infrastructural needs
- Supporting healthy families and kinship as a vital source of strength

FOUNDATIONAL ELEMENT 3: PREVENTION AND RECOVERY SUPPORT

The intent is to advance health delivery models that emphasize early identification of community health issues and provide ongoing, comprehensive support for sustained recovery. Priorities include:

- Programming that meets community needs and incorporates traditional American Indian and Alaska Native worldviews that promote health and healing
- Supporting community mobilization and engagement that reflects ownership of their issues and works to develop an appropriate local response

FOUNDATIONAL ELEMENT 4: BEHAVIORAL HEALTH SYSTEMS AND SUPPORT

The focus is on improving coordination, linkages, and access to high-quality behavioral health services. Priorities include:

- Workforce development to address staffing shortages, improve access to providers, and ensure cultural competency in service delivery
- Mechanisms to address insufficient funding, continuity of funding, and alignment of funding with tribal priorities, values, or traditional practices
- Tribally directed programs that reflect individual tribal priorities, culture, and traditions
- Youth-based programming focused on culture as a strong protective factor, prevention, and education on behavioral health to reduce stigma around treatment
- Scope of programming to support continuum of

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care for tribal members in their communities
- Law enforcement and justice programs that operate in collaboration with behavioral health programs

FOUNDATIONAL ELEMENT 5: NATIONAL AWARENESS (NA) AND VISIBILITY

The intent is to increase visibility while ensuring that tribal governments have the ability to direct shared messages that strengthen a tribe's public and behavioral health response and readiness. Priorities include:

- Tribal capacity building on ways to best communicate challenges and successes in their communities
- Tribally directed communication strategies on how best to exchange information and communicate in a timely and effective manner
- Partner capacity building on working with tribal communities to effectively engage and drive change

NEXT STEPS

In the near future, a draft of the TBHA will be shared with tribal leaders for additional input. This is an important opportunity to ensure the continuation of tribal voices in creating a collaborative tribal and federal course for improving behavioral health. Collaboration with tribes is the power of the TBHA.

CHAP Tribal Consultations

Telephone Consultation:
October 4, 2016 at 12pm-1:30pm PST
Call in number: 1-888-955-8942
Passcode: 9659843

In Person Consultations:
September 19, 2016 from 1:00pm-2:30pm at NIHB's Annual Consumer Conference in Scottsdale, Arizona

October 9, 2016 from 2:15pm-3:30pm at NCAI's Annual Convention in Phoenix, Arizona.

MOVING TOWARDS A TRIBALLY-BASED COMMUNITY HEALTH WORKFORCE:

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in the lower 48 without requirements for state by state authorization;
- Regional Federal CHAP Certification Boards Should Be Explored;
- National Convening and Workgroup Should Be Established for CHAP Expansion;
- IHS Must Foster an Internal Culture that Supports Mid-Level Providers to Ensure the Success of an Expansion.

Our comment letter, a background on CHAP, Dear Tribal Leader Letter and Policy Statement can all be found on our website: www.npaihb.org/policy or by contacting Laura Platero, Policy Director, at lplatero@npaihb.org.

Even if you are not considering including providers from the CHAP program in your health care delivery system, your support of the CHAP expansion is still vital! It will allow tribes that want CHAP providers to train and employ them. Tribes have stood together and spoken with one voice on the right and responsibility that tribes, as sovereign nations, have to identify the needs of their people and determine and deliver the systems of health, education, and welfare that will best serve their people.

We urge you to submit your written comments or to participate in upcoming telephonic and in person consultations. The dates/times of the telephonic and in person consultations are provided on the IHS website: https://www.ihs.gov/newsroom/triballeaderletters/ and in the text box to the left.

(NW NARCH)
FELLOW HIGHLIGHTS

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Dr. Vernon Grant,
(Blackfeet Nation),
NW NARCH Fellow PhD

How did I learn about the NW NARCH Fellowship?
I received an email announcement my first year as a doctoral student. The announcement had been out for a while and NPAIHB had one spot to fill. I immediately called Dr. Becker and we had a great conversation. He said that because only one spot remained, he needed all my materials as soon as possible. I scrambled that night getting everything together and sent it to him the very next day. I called a few days later and Dr. Becker told me over the phone that my application was selected!

Why did I choose my specific degree?
Through graduate school I began learning about how obesity impacts Indian populations. I was subsequently studying the physiological mechanisms associated with obesity and the development of diabetes and other chronic diseases. I wanted to have an impact with my education and study in a field where I could address obesity and at the same time share my vision of creating opportunities for a physically active Indian country.

After graduating, what are my career goals and/or educational goals?
I am currently a postdoctoral fellow in the Department of Family Medicine and Community Health at the University of Wisconsin. I have one year of funding left. This summer I will be writing a K01 NIH grant that will fund me for the next 5 years and maintain my trajectory toward becoming an independently funded researcher. My career goal is to obtain an R01 funded research project and eventually establish a center that is focused on physical activity, nutrition, and sleep research in Indian Country.

How did the NW NARCH fellowship help in furthering my education?
NARCH was my primary source of funding throughout graduate school. This funding literally kept me in school and is one of the primary factors that helped me graduate. I cannot stress enough the importance of obtaining this type of funding – NARCH allowed me to focus on my education without being forced to work. This would have drastically changed my focus and potentially increased the duration of time I spent working on my dissertation. Instead, I was able to focus on my coursework and doctoral research simultaneously and graduate in the time frame that I had originally planned. Since earning my doctorate, I have heard stories about how individuals spend a decade working on their doctorate because they need to work full-time are being pulled in too many different directions. Research and dissertation writing was my job that could have only been accomplished with NARCH funding.

What would you share with others who are seeking financial assistance?
This process begins in the classroom – I can't stress that enough. Undergraduates typically fail to see the importance of a high GPA. Many funding mechanisms heavily weigh GPA as a marker of success and a different applicant will be selected over you if they have a higher GPA. In addition, many scholarships and funding mechanisms require a letter of recommendation – professors cannot say anything good about you if you do poorly in their class.

Funding is everywhere, but one must be diligent and relentless. In addition, one cannot be discouraged if their application is rejected. You can't get them all, but as Wayne Gretsky stated, "you miss 100% of the shots you don't take." Be persistent and take failure with a grain of salt. Pick up the phone and call! It is amazing how much information and ground one can cover with a simple conversation versus numerous email exchanges.

Finally, secure enough funding that school can be your job – the only way to do that is to apply, apply, and apply some more. When you get rejected (and you will), apply again.

THRIVING FOR THE FUTURE:

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Click here to hear their lyrics and incredible beats. (Direct link: https://soundcloud.com/beatslyricsleaders)

Each day the conference hosted guest speakers and/or health educators to teach the youth about healthy lifestyles. The first guest speakers included National Geographic Education Fellow and Explorer, Jon Waterhouse (S'Skallam/Chippewa/Cree), and his wife Mary Marshall, author and photojournalist. Through their unique experiences and world travel, they gave powerful testimony on never giving up on your dreams. Showing amazing photography, their presentation was not only captivating, but really gave a clear message that you can achieve your goals if you really put in the time and effort. Another speaker who traveled all the way from Washington D.C. was program coordinator Teddy McCullough (Coyote Valley Band of Pomo Indians) from the Center for Native American Youth at the Aspen Institute. Mr. McCullough provided updates on the Generation Indigenous (Gen-I) initiative and many Native youth opportunities coming up over the next few months. Lastly, Native health educators from across the country stopped by after lunch each day and taught the youth about healthy-decision making with the *Native STAND* (Students Together Against Negative Decisions) curriculum.

Funding for this conference was made possible (in part) by grant number SM61780 from SAMHSA and a Methamphetamine & Suicide Prevention Initiative (MSPI) grant awarded by the Indian Health Service (IHS). The views expressed in written conference materials or publication and by speakers and moderators do not necessarily reflect the views, opinions, or policies of CMHS, SAMHSA, or HHS; nor does mention of trade names, commercial 36 practices, or organizations imply endorsement by the U.S. Government. .

Thank you to all the facilitators, presenters, and staff that took the time to invest in these talented youth and really create yet another successful conference! Don't' forget to SAVE-THE-DATE for next year's conference which will be held June 26-30, 2017 in Portland, OR.

WELLNESS TIME ESCALATES ACTIVITY

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team. Additional donations can be given to our Go Fund Me page: https://www.gofundme.com/2uz4nauk

After months of preparation, Hood to Coast is finally around the corner, the official dates are August 26th-27th. Our team, consisting of 11 NPAIHB members and 1 NPAIHB nephew, has risen to the challenge of training for this race. Together we have done group runs, cross-fit type work outs, and Frisbee days. Apart we are pursuing activities such as running 5k or 10k races, cycling up to 80 mile races, and hiking long distances such as summiting Mt. St. Helens.

NPAIHB members who are not running have volunteered to be drivers, food suppliers, directors of traffic and runners on race day as well as offering up their homes to runners to relax, eat and shower before they run their next leg. For me, Hood to Coast is more than just a run. It's a bonding experience. Runners and volunteers alike, you walk away feeling like "Wow I did that" or more likely "Wow WE did that."

IMPACTS ON TRIBAL HEALTH PROGRAMS

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The IHS has 60 days from the date of the final order to file a notice of appeal. If the ruling stands or is affirmed on appeal, it will have significant implications for tribes and tribal organizations throughout the country seeking to enter into fully compensated Section 105(l) leases for tribally owned or leased facilities used to carry out ISDEAA contracts and compacts with both the BIA and the IHS.

Contract Support Costs Appropriations and Policy Development Updates

CSC Appropriations. In June 2016, the House and Senate Appropriations Committees each approved their versions of the FY 2017 Interior, Environment and Related Agencies Appropriations bills[1]. Both bills would continue the FY 2016 enacted policy of appropriating an indefinite amount—"such sums as may be necessary"—to separate accounts in both the Indian Health Service (IHS) and Bureau of Indian Affairs (BIA) discretionary budgets. Though this approach is not permanent and does not classify CSC as mandatory funding, it is a positive step that ensures full funding of CSC while protecting program funding. Both bills also removed a harmful provision from the FY 2016 appropriations act that appeared to penalize tribes for carrying forward unspent CSC from one year to the next. At this point it appears that a Continuing Resolution will be needed, to run from October 1 past the November election and probably into next year. At that point Congress will likely take up a multi-agency omnibus bill. Hopefully the CSC language from the Interior bills will remain unchanged.

Policy Developments. The IHS, through its tribal-federal CSC Workgroup, has revised its CSC policy to implement Congress's full-funding mandate. (The old policy's primary purpose was to allocate insufficient funding during the "shortfall" era when Congress capped CSC appropriations each year.) IHS conducted a consultation process; the comment period ended on June 8, 2016. IHS is collecting and collating the comments. The Workgroup will convene on September 15-16 in Washington, DC, to review the comments and make final recommendations on the policy and exhibits. IHS will then run them through a final approval process and it expects to finalize them before the end of the year.

The policy resulted from intense negotiations, and neither tribal nor federal Workgroup representatives are entirely happy with it. Still, it marks a major step forward, as it will provide for consistency across the IHS Areas and predictability for tribes and IHS negotiators. The policy is quite complex, especially compared with BIA's, and will require time, effort, and training for both tribal and federal staff to understand and apply. The complexity derives in part from Tribes' CSC litigation history with IHS and the desire of both sides to leave as little ambiguity as possible. IHS has promised to conduct training sessions for both agency and tribal personnel who deal with CSC issues.

Proposed Changes to IHS Catastrophic Health Emergency Fund Regulations

On January 26, 2016, the IHS issued proposed regulations that would change how the IHS implements the Catastrophic Health Emergency Fund (CHEF). CHEF is part of the Purchased/Referred Care (PRC) program and is designed to help cover medical costs of disasters and catastrophic illnesses that would otherwise quickly deplete a PRC program's already limited funding.

The proposed regulations, which were issued without prior tribal consultation, propose some significant departures from the IHS's current practices and raise several concerns for Tribes and tribal health programs. For example, the proposed regulations would not permit CHEF reimbursement for a catastrophic claim that would otherwise qualify for reimbursement if the patient is eligible for "alternate resources," which would include tribal self-insurance coverage. The IHS has never before treated tribal health plans as alternate resources, either for CHEF or for the underlying PRC program, and many tribes and tribal organizations

[1] See S. 3068; S. Rept. 114-281; H.R. 5538; H. Rept. 114-632.

objected that to do so would be inconsistent with the underlying statutory authority in the Indian Health Care Improvement Act. The proposed regulations would also grant the IHS significant discretion in how to administer the CHEF program, without providing any criteria or procedures governing how the Area PRC directors are to review CHEF claims, or how the IHS headquarters will determine whether an alternate resource exists.

In response to several requests from tribes asking IHS to suspend any further action on the proposed CHEF regulations until the IHS can conduct meaningful tribal consultation on the issue, the IHS announced on June 1, 2016, that it would engage in tribal consultation before moving forward with the proposed rule. At a recent meeting of the IHS Tribal Self-Governance Advisory Committee, IHS Principal Deputy Director Mary Smith announced that the IHS would hold two in-person consultation sessions (one in conjunction with the National Indian Health Board 2016 National Tribal Health Conference in Scottsdale, Arizona, on September 19, 2016 from 9:00 a.m.-9:50 a.m., and one in conjunction with the National Congress of American Indians Annual Convention and Marketplace in Phoenix, Arizona, on October 9, 2016 from 1:00 p.m. – 2:00 p.m.) as well as two telephone consultation sessions. The telephone consultations will take place on August 16 and October 24. Ms. Smith's Dear Tribal Leader Letter with details on these consultation opportunities is available at:
https://www.ihs.gov/newsroom/triballeaderletters/

IHS Proposes New Circular On Purchase Of Health Insurance By Tribes, Tribal Organizations and Urban Indian Organizations

On July 18, 2016, IHS issued a "Dear Tribal Leader Letter" and a new, draft IHS Circular to address the purchase of health insurance by tribes, tribal organizations (T/TO) and urban Indian organizations under Section 402 of the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1642. Section 402 authorizes the use of certain federal funds (like Medicare and Medicaid reimbursements, and funds made available under the Indian Self-Determination and Education Assistance Act (ISDEAA)) to buy health insurance for eligible beneficiaries. Health benefits coverage can be purchased in any manner, including through the following: a tribally owned and operated health care plan; a State or locally authorized or licensed health care plan; a health insurance provider or managed care organization; a self-insured plan; or a high deductible or health savings account plan. 25 U.S.C. 1642(a). The IHS proposes the draft Circular to provide guidance related to circumstances in which T/TO purchase such health insurance coverage for IHS beneficiaries using-in part or in whole-ISDEAA funding or other IHS appropriated funds.

The IHS Principal Deputy Director, Mary Smith, and other IHS representatives recently discussed the draft Circular with the Tribal Self-Governance Advisory Committee and the IHS has already held one tribal consultation teleconference. Tribal representatives have already voiced several concerns about the proposed Circular, namely that it goes beyond the Section 402 authority and is overly restrictive.

For example, the Circular recommends that language be inserted into ISDEAA contracts, compacts or funding agreements to identify what funds are being used, the amount of funding needed, eligibility criteria and other subjects, but Section 402 does not require that ISDEAA contracts, compacts, or funding agreements be amended for its implementation. As currently drafted, the Circular would also impose Purchased/Referred Care (PRC) program and eligibility rules on tribal insurance programs; limit how T/TOs can use the third party reimbursements they collect; and control some CHEF reimbursements to T/TOs. Of particular concern is language in Section 4 of the Circular, in which IHS seeks to impose limits on tribal self-insurance by treating such insurance as a payer before IHS, even excluding some individuals from being considered eligible for PRC if they have insurance that was purchased by a tribe or tribal organization under Section 402 of the IHCIA.

Of additional concern is that the Circular would apparently keep in place the IHS's previous, controversial

IMPACTS ON TRIBAL HEALTH PROGRAMS

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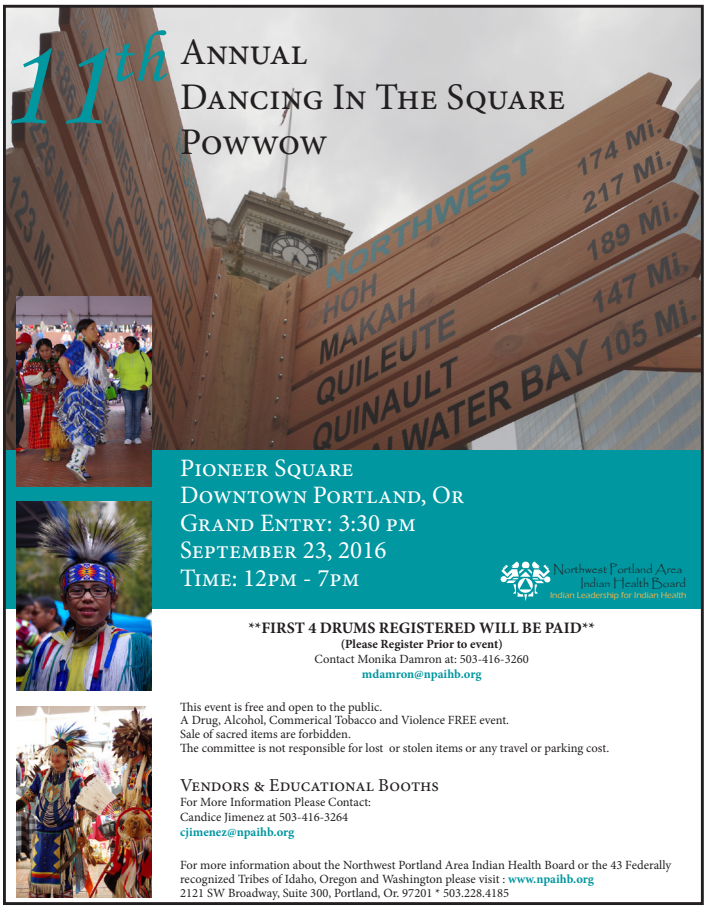
interpretation of Section 402 as set forth in a Dear Tribal Leader Letter in October, 2013. In that letter, IHS had said that "financial need is the only factor permitted by statute on which to base coverage decisions." (emphasis added). Numerous tribes and tribal organizations spoke out against the IHS's position in the October 2013 letter as being incorrect as a matter of law and not supported by the statute; the statute was intended to clarify that tribes are free to sponsor health insurance coverage for some but not all of their beneficiaries, on the basis of factors that include financial need, but not limited to financial need.

On the positive side, Section 5 of the draft Circular represents what appears to be a beneficial shift in the IHS's previous position regarding tribal self-insurance and the CHEF program. Several months ago, the IHS took a position in draft regulations proposed to govern CHEF and in ongoing litigation in Redding Rancheria v. Burwell, Civ. No. 14-2035 (D.D.C.) that tribal self-insurance programs are alternate resources to CHEF and any PRC program operated by the IHS, tribes or tribal organizations. Section 5 of the Circular departs somewhat from that strict view and says that if: (A) a T/TO has a self-insurance plan; (B) the plan is funded entirely or partially with ISDEAA funding; (C) there is no reinsurance or indemnity; and (D) the plan "is designed to follow PRC eligibility," then the IHS will consider the plan to be eligible for CHEF reimbursements on the same basis as any other PRC program is eligible for CHEF.

While this is a positive step in the right direction for some tribal self-insurance plans, tribal self-insurance should not be considered an alternate resource to CHEF or PRC absent specific agreement by the tribe or tribal organization. Additionally, the Circular should not exclude tribal self-insurance plans that involve reinsurance or indemnity, since Section 402 specifically authorizes tribes and tribal organizations to use funding to purchase coverage through a self-insured plan and says that such funds may be used for the expenses of operating the plan, "including administration and insurance to limit the financial risks to the entity offering the plan."

Therefore, while some of the other provisions in the draft Circular may be beneficial to T/TO or could be redeveloped to support T/TO and urban Indian organizations in their purchase of insurance coverage, much of the Circular seeks to impose restrictions that may not be appropriate or warranted under applicable law. IHS is seeking written comments on the draft Circular via email at consultation@ihs.gov, and such comments are currently due on October 31, 2016. (Note: the original due date was August 17, 2016, but that was extended by the IHS in a July 29, 2016 Dear Tribal Leader Letter). IHS will also host two in-person consultation sessions: (1) at the National Indian Health Board Annual Consumer Conference in Scottsdale, Arizona on September 19, 2016 from 11:00am to 11:50am; and (2) during the National Congress of American Indians 73rd Annual Convention in Phoenix, Arizona on October 9, 2016 from 3:45pm to 5:00pm.

NPAIHB GATHERINGS/ANNOUNCEMENTS



SAVE-THE-DATE
7th Annual THRIVE Conference
June 26 - 30, 2017

Registration will open the first week in April 2017!!

WHO: For American Indian and Alaska Native Youth

- Limit of 4 youth (13-19yo) per Tribe or Urban Area.
- Limit of 1-2 Chaperones per group registering.
- Registration is free!

WHERE: Native American Student and Community Center at Portland State University (PSU) in Portland, OR

WHY: Build protective factors and increase your skills and self-esteem, connect with other young Natives, learn about healthy behaviors (suicide prevention, healthy relationships, etc.) and how to strengthen your nation through culture, prevention, connections, and empowerment!

WHAT: This conference is made up of four workshop tracks and each youth will need to rank their preference for which workshop they want to be in when they are registered. Tracks *may* include: art, physical activity & nutrition, digital storytelling, beats lyrics leaders (song writing and production), We Are Native youth ambassador leadership (additional application required), and a science and medical track sponsored by the Oregon Health and Science University.

UPCOMING EVENTS

AUGUST

August 16-18
Native Wellness Institute Healthy Relationships Training of Trainers
Billings, MT

August 16-18
NACA Emerging Native Leaders Summit
Washington, DC

August 18-19
Tribal and State Leaders Health Summit
TBA

August 26-27
Hood to Coast (HTC)
Mt. Hood - Seaside, OR

August 30-31
Native Fitness XIII
Nike World Headquarters, Beaverton, OR

August 31 - Sept. 2
20th National Conference on Child Abuse and Neglect
Washington, DC

August 31 - Sept. 1
13th Annual Direct Service Tribes National Meeting
Rapid City, SD

SEPTEMBER

September 13-15
NICOA Biennial Conference on Aging
Niagara Falls, NY

September 19-22
NIHB Annual Consumer Conference
Scottsdale, AZ

UPCOMING EVENTS

SEPTEMBER

September 23
NPAIHB Annual Powwwow
Pioneer square, Portland, OR

September 26-27
Seeds of native
Washington, DC

OCTOBER

October 9-14
73rd Annual Convention & Marketplace
Phoenix, AZ

October 18-20
NPAIHB Quarterly Board Meeting (Host: Suquamish Tribe)
Port Madison Indian Reservation, WA

NOVEMBER

November 7-9
Tribal Interior Budget Council
Washington, DC

We welcome all comments and Indian health-related news items. Address to:
Health News & Notes/ Attn: Lisa Griggs or by e-mail at lgriggs@npaihb.org
2121 SW Broadway, Suite 300, Portland, OR 97201
Phone: (503) 228-4185 FAX: (503) 228-8182

For more information on upcoming events please visit www.npaihb.org

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