



Northwest Portland Area
Indian Health Board

Indian Leadership for Indian Health

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Indian Health Appropriation Update



Jim Roberts,
Policy Analyst, NPAIHB

As we wind down 2015 fiscal year everyone is wondering what will happen for Indian health appropriations in FY 2016. On September 30, 2015, the Congress passed a Continuing

Resolution (CR) bill to that will continue to keep the government programs and services running through December 11, 2015. The 2016 CR maintains the spending caps put into place by the Budget Control Act of 2013. This federal funding will continue for the length of the continuing resolution, or until Congress approves the appropriations for FY 2016. Congress is claiming this to be a “clean” CR in that it does not contain any controversial provisions or riders. Prior to the pending CR, Congress must agree on spending bills for the remainder of the fiscal year. At odds for Congress are finding an agreement to lift spending caps that are set in the Budget Control Act (BCA) and an agreement on raising the debt ceiling. If Congress does not find a compromise around these two issues it is very likely that the appropriations could be subject to another

The States of South Dakota and Alaska have submitted proposals asking the Centers for Medicare & Medicaid Services (CMS) to expand their current policy on 100% Federal Medical Assistance Percentage (FMAP) to Contract Health Services (now call Purchased & Referred Care; CHS/PRC). FMAP is the rate used to determine the matching funds between the federal and state governments in the Medicaid program. 100% FMAP would require the federal government to pay an entire amount and the states would not have to provide matching funds. CMS has conducted two All Tribes Calls and held a consultation session the National Indian Health Board’s Annual Conference. During these consultation sessions CMS explained that Alaska has requested 100% FMAP for emergency and non-emergency medical transport and transportation-related expenditures as well as for services provided through CHS/PRC referrals; and that South Dakota has requested 100% FMAP for telehealth services, specialty services provided through collaborative arrangements, and services provided by community health representatives.

CMS has issued a variety of interpretations of this rule over the years, which has caused some confusion and even litigation as to its breadth and scope. CMS’ current interpretation allows 100% FMAP reimbursement for (1) all services provided to IHS beneficiaries enrolled in Medicaid within an IHS or tribally-operated facility by an IHS or tribal employee; (2) services provided by outside providers within the “four walls” of an IHS or tribally-operated facility through arrangements or contracts with those outside providers; and (3) services provided beyond the “four walls” of an IHS or tribally-

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a c r o s s -
t h e - b o a r d
sequestration.
Legislation
(H.R. 3063
and S. 1497)
has been
introduced to
exempt the
IHS and BIA
appropriations
from being
sequestered
under the BCA.
**CMS Revisiting
100% FMAP
Rule**

continued on page 10

CHRONIC DISEASES

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CHAIRMAN'S NOTE



Andy C. Joseph Jr.
*Colville Tribal Council, HHS Chair, NIHB Exec.
Committee Member, NPAIHB Chair*

I want to thank our sister health board, the California Rural Area Indian Health Board (CRIHB) for once again hosting our 14th biennium meeting. It's hard to believe that our organizations have been meeting for over 28 years now on health issues that are important to us as contract health dependent areas. I always enjoy attending the Joint CRIHB/NPAIHB board meetings and this year's format was a welcome change. The breakout workshops held on Tuesday and Wednesday were very informative and then the transition to the regular joint meeting on Thursday and Friday made the entire week a worthwhile event of Indian health information.

Following our joint meeting I've had several meetings that I participated in to represent our Tribes. On July 23rd, we reconvened the All Tribes meeting for the first time in over five years. The All Tribes meeting is a long standing tradition for Portland Area Tribes to discuss important IHS budget and financing operations with the IHS Portland Area Office. I am glad we have figured out a way to continue these meetings because it gives us a mechanism to develop our priorities with the Area Office and to be transparent about the IHS Portland Area Office resources and Tribal shares.

In August I attended the Direct Service Tribes Advisory Committee's (DSTAC) national meeting held in Flagstaff, Arizona. The agenda included updates about direct service tribes contracting issues, the Affordable Care Act and tribal sponsorship, the Veterans Administration's reimbursement agreements with Tribes, the Whitehouse Generation-I initiative, and closed with an IHS listening session. This was a very good conference this year and we provided the Portland priorities whenever the opportunity presented itself.

September was a very busy month for me and the staff of the Board. I attended the Board's Nike Native Fitness XII (12) event in Beaverton, the Affiliated Tribes of Northwest Indians (ATNI) Annual Conference in Spokane, and also attended the National Indian Health Board's Annual Consumer Conference in Washington, D.C.. I am always impressed with the Nike Native Fitness events and the quality of training and education sessions to promote fitness in our Tribal communities. This event is well attended with many native health and fitness instructors

CHAIRMAN'S NOTE

from across Indian Country and promotes the Boards programs.

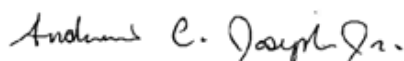
This year's ATNI event included several general assembly sessions about the Boards work in health policy. We discussed the exemptions for Tribal governments to comply with the ACA's employer requirements to provide insurance and exemption from Cadillac tax that could have an effect on Tribes. I am happy to also report that I was elected to the ATNI Executive Board as the third Vice-President. My new role with ATNI, I will help to elevate health issues with the Executive Board.

I was very pleased with our Board's participation at the NIHB Annual Conference in Washington DC. The rest of Indian Country was able to see and hear firsthand about the important work at our Board. I was very proud to see the promising potential of our up and coming staff like Celena McCray and Christina Peters, along with our seasoned veterans like Stephanie Craig Rushing and Jim Roberts. There were at least 6-7 presentations where our health board was represented on the NIHB agenda, which I am happy to report is a reflection of the high expectations that our Board has for our organization.

Finally, this past week I attended the National Congress of American Indians (NCAI) in San Diego, California along with other members of our staff. Our work at NCAI continues to promote the health policy priorities and issues that are important for our Portland Area Tribes. Our staff works during the Northwest Caucus and the Health Committee meetings to make sure our views and interests are represented. This year's elections resulted in Brian Cladoosby, Swinomish Tribal Chairman, being re-elected to a second term as the NCAI President. Chair Ron Allen from the Jamestown S'Klallam Tribe was also elected to serve as the Treasurer for NCAI.

Looking to our work ahead, we have to prepare our new legislative agenda for the next session of this 114th Congress. We also have our upcoming FY 2018 Portland Area IHS budget formulation session, and need to begin for the next appropriations cycle by preparing our Annual Budget Analysis for FY 2017. As you can see, just as our work begins to wind down for the holiday season, we must also begin our work for next year. I want to wish you all a very happy holiday season as we go into that time of the year!

Whi Leem lem (Thank You)
Euuhootkn (Badger)



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Northwest Projects

Ryan Swafford, Preventing Sexual Assault Project
Manager
Christina Peters, Oral Health Project Director
Pam Johnson, Oral Health Project Specialist

iSTAYHEALTHY: LIVING WITH HIV/AIDS: A PARTNERSHIP BETWEEN CHEROKEE NATION AND THE NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD'S TRIBAL EPIDEMIOLOGY CENTER

By David Stephens, RN, Stephanie Craig Rushing, PhD, Jorge Mera, MD and Jessica Leston, MPH

The use of mobile phone apps is widespread, but their use for HIV care self-management is only in its infancy. In order to better understand the effects of adding smartphone technology to current treatment therapy for American Indian and Alaska Native (AI/AN) people living with HIV/AIDS (PLWHA), the Northwest Indian Health Board's Project Red Talon sought to answer key questions that may contribute to improved care and diagnostics for AI/AN PLWHA through the use of the iStayHealthy App.



New Ways to Manage HIV Care

There are a wide variety of options for HIV prevention and disease self-management. Historically, emphasis has been placed on interventions that required individuals to meet in person with specialists, in a group or one-on-one setting. However, new technologies are challenging and strengthening the traditional healthcare paradigm. The proliferation of internet users, social networking sites, and mobile technology has allowed HIV prevention and care specialists to branch out and explore new ways to reach individuals, spread information, raise awareness, change behaviors, and most importantly, engage consumers in their own health and care.

The iStayHealth App Project

iStayHealthy is an iPhone/iPad app for people living with HIV. The application is free to download and use. The application provides people living with HIV a tool that helps them manage their treatment, by allowing the user to:

- Record and review essential blood results (CD4/ Viral Load)
- Record and manage current medication

(anti-retroviral as well as non-HIV specific meds)

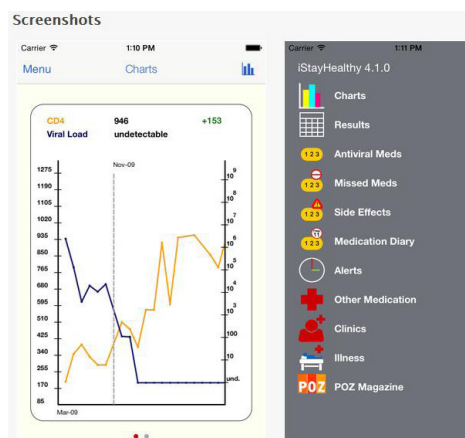
- Set medication reminders helping users taking their medications regularly and on time
- Learn about side effects of medications
- Send reports to a medical provider of their choice
- Store results of medical visits, and personal health statistics
- Track their symptoms of HIV treatment so they can share and discuss with their health care team
- Access a glossary explaining HIV-relevant terms

For this project, the research team gave 9 AI/AN PLWHA patients an iPhone loaded with the iStayHealthy App. Individuals provided feedback via phone interviews on whether they found the App easy to use, helpful for tracking symptoms, helpful for remembering to take medications on schedule, and useful for sending reports to their case manager or physician.

The pilot project was completed in early 2015, and the results were positive. Overall, 7 of the 9 participants responded to our followed-up calls on a routine basis (1-4 times in month 1, and 2-5 times in months 2-6). On a scale of 1-5 (with 1 being very satisfied and 5 being not satisfied), all participants expressed high satisfaction with their smartphones (average = 1) and with the iStayHealthy App (average = 2). We also found that:

- **Most participants were using their smartphones daily for their HIV care.** "After I started reading all this stuff on there, I have more information available

to me. Before I was only using my internet at work, and I did not really want to use it at work for looking up HIV stuff. I think it's a lot of help, because I don't want to



iSTAYHEALTHY: LIVING WITH HIV/AIDS Cont..

pull that info up on a computer at work.”

- **Most participants were using the iStayHealthy App 3-6 times a week for their HIV care.** “It’s always been good, I pay more attention to bloodwork, specifically the CD4” and the “App helps remind me to take medicine. Helps with reminders for doctor appointments and keeping track of my viral load.”
- **The App opened communication between patients and their provider/care team.** “Yes, he actually sat down with me for like an hour and explained everything to me. And it is going to help with diabetes and I emailed him through the iStayHealthy App, and I have the nurses. I also have their contact information...so I can call them directly from the App.”
- **Most people in the project were already adherent to their medications, but they did use the App to track and see CD-4 trends, which they had not been able to do before.** “It has made me more aware, more aware of my condition & CD4 levels. Able to keep track of all my meds, and don’t have to carry around all those bottles around to appointments” and “I go to the doctor on the 9th, and I’ll put the results (CD4) in the phone and able to look up stuff in a split second, if a doctor says something I don’t understand.”
- **Even people who had been living with HIV for years learned new things in the App’s resource center.** “I program my labs after each doctors visit. I read the articles on POZ too. I also got sick with a respiratory virus and I used the phone to look up my medications.”
- **People started downloading other health Apps for fitness and health maintenance and had recommendations to improve the App.** “I downloaded a diabetes tracker and a workout steps tracker” and “Add a vaccination tracker, cause doctors always ask, and they always don’t know. Create something where you can free text to write in vaccinations.”

everyday clinical medicine, particularly the cost of the smartphones and data service. App use and user satisfaction were both detrimentally impacted by interruptions in service over the course of the pilot due to data plan limitations and overages. Updates and changes to the iStayHealthy App itself was another factor that influenced satisfaction with the App. Interestingly, project participants never brought up concerns over privacy of their health information or HIV status (all phones were passcode protected).

The iStayHealthy App is designed to empower PLWHA to continue leading fulfilling and healthy lives. Through this pilot, the team learned that patients used the smartphones and Apps to improve *all* aspects of their health. Participants voiced a desire to build meaningful connections with their care team, and when given a new way to learn and communicate, they developed new disease management skills. This project demonstrated that new technologies can assist in building patient knowledge of health and disease, provide needed resources to patients, involve patients in medication adherence, and help patients and providers assess health at and between clinic visits. Additional research is now needed to determine the extent to which smartphones and apps can improve medication adherence, disease management and healthy empowerment for all AI/AN people living with HIV/AIDS.

This project and article was approved by the Cherokee Nation IRB. For more information on the project, please contact Jessica Leston, jleston@npaihb.org or 907-244-3888.

During the pilot, the research team identified several barriers to integrating smartphone and app use to

PACIFIC NW TRIBES BRINGING DENTAL CARE INTO THE 21ST CENTURY



Pam Johnson
Oral Health Project Specialist

It is well documented that American Indians and Alaska Natives (AI/AN) carry a disproportionate burden of oral disease. Oral health is essential to overall health, and we cannot have healthy communities without access to reliable, high quality, affordable dental care.

This month the Northwest Portland Area Indian Health Board (NPAIHB) submitted to the Oregon Health Authority (OHA) an application for a dental pilot project that would study using dental health aide therapists to assist dental teams serving Oregon Tribes in expanding care to more people. This is the first pilot application submitted under Oregon's pilot authority, and if approved, would be the first time such providers worked in the state.

The pilot replicates the highly successful Alaska Native [Dental Health Aide Therapy \(DHAT\)](#) program. DHATs are midlevel providers who deliver preventive and routine but much-needed restorative care—such as filling cavities, placing temporary crowns, and extracting loose teeth. DHATs have been practicing successfully in Alaska for a decade and have expanded much-needed oral health care to 40,000 people. On May 29, 2015, the Alaska DHAT program was recognized by the Indian Health Service for its innovative public health and clinical strategies to provide quality dental care in Tribal communities.

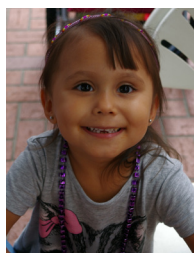
Under the pilot, Tribes in Oregon will recruit, train and

employ DHATs from their communities to expand care in their communities. A student from the Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians has already started her training this past July in [Alaska's Dental Health Aide Therapist](#) program, and the Coquille Indian Tribe is planning to recruit and send a student next year.

In Washington State, the Swinomish Indian Tribal Community is also proceeding with introducing a DHAT to the dental team. Because there is no authorizing legislation in Washington for pilots or licensing DHATs, the Swinomish Senate adopted its own Dental Health Provider Licensing Code. This code establishes a Dental Health Provider Licensing Board and defines qualifications and standards for not only licensing Tribal Dental Health Aide Therapists, but also Tribal Dentists and Hygienists. The Swinomish have also sent a student to receive DHAT training in Alaska.

For more information check out the Oral Health Project page on our website: http://www.npaihb.org/programs/oral_health_project or contact

Pam Johnson, Oral Health Project Specialist, pjohnson@npaihb.org, 206-755-4309



HERITAGE UNIVERSITY'S SUICIDE PREVENTION PROGRAM



***Mattie Tomeo-Palmanteer,
BSW, Colville Confederated
Tribes & Yakama Nation***

Heritage University's Suicide Prevention Program provided tribal outreach on the Yakama Nation Reservation on June

18 and 19, 2015. Victoria Burns, Brittany Nash, and I supported the children and youth activities as well as providing child care to parents who were involved in the speaker sessions. My speaker presentation included two engaging activities for families: a life experience awareness activity and a trauma characteristics activity.

The best part about volunteering at the Yakama Nation Behavioral Health Program's Mental Health Camp (in my opinion) was working with the childcare, arts and crafts, and sports activities. Laura George-Day provided a number of craft activities to choose from and Josephine Buck provided a variety of sport games to play. We appreciate all of their assistance.

A young man named Theodore and his mother worked together on a small headdress and watching them interact impressed me. The young boy was thrilled to have his mother's full attention and guidance; he was literally shining with joy. The next day we gave the children a chance to get up and speak about their favorite activity from the camp and why they enjoyed it. He was the first to stand up and say he enjoyed making his headdress. Even though we had a slip and slide, swimming, water balloons, coloring, sidewalk chalk, volleyball, badminton, and soccer he valued the time crafting with his mother the best.

The Northwest Portland Area Indian Health Board's Western Tribal Diabetes Prevention, WeRNative, and Sexual Assault Prevention Programs donated t-shirts, water bottles, and sports bags as incentives to reward the participation from the children, youth, and their parents. Parents were encouraged to keep attending activities throughout the summer and continue

building on the intellectual, physical, emotional and spiritual growth of their children. When questions were asked about the presentations given throughout the two days, they were quick to answer each question. Questions included:

- What is PTSD?
- What is Historical trauma?
- What is a Co-Occurring disorder?
- What are signs of depression?
- What suicide prevention tools do you know of?
- What can you do if someone is suicidal?
- Who can you call?

Agatha, a lady that is well known for baking homemade bread said "if I had someone in my home that was suicidal I would run to the neighbors, if they weren't home I would go on to the next neighbor, and on and on until I found someone to help." I like that approach because on this reservation not everyone has a home phone or cell phone.

At Heritage University we are in the process of developing a student suicide crisis response plan and we have adopted the approach from the National Suicide Strategic Plan that "no door is a wrong door". I would like to encourage our tribal communities to join in and practice the "no door is a wrong door" approach too.

The Heritage University prevention project is supported by the Northwest Portland Area Indian Health Board THRIVE Project's

*Garett Lee Smith
Youth Suicide
Prevention
Program"*



FACTORS ASSOCIATED WITH EARLY SEXUAL EXPERIENCE AMONG AI/AN YOUTH: BASELINE FINDINGS FROM THE *NATIVE IT'S YOUR GAME* PROJECT



In August, a study carried out in partnership with staff at the Northwest Portland Area Indian Health Board was published in the *Journal of Adolescent Health*, which examined the risk and protective factors associated with early sexual activity among American Indian and Alaska Native (AI/AN) youth.

As part of the project, the research team surveyed 537 AI/AN youth 12 to 14 years old from 27 study sites in Alaska, Arizona, and the Pacific Northwest. Among the youth surveyed, 6.5% were sexually experienced. Youth who were older in the age range, who had more knowledge about HIV/STIs, and those who had experienced dating violence victimization in the past year were more likely to be sexually experienced.

AI/AN youth were less likely to be sexually active if they had lower intentions to have sex in the next year, avoided risky situations (like parties with alcohol, or spending time alone with friends of the opposite sex), did not use alcohol, experienced parental monitoring, and believed their friends had similar beliefs about sex.

This information is helping the research team design more effective sexual health interventions for AI/AN middle school youth. Parents can help their children avoid risky situations by supervising or monitoring their friendships and whereabouts. As health educators, providing tools or resources that enhance parents' ability to monitor and communicate with their child about their behavior may help delay sexual initiation among AI/AN youth. Similarly, integrating substance use prevention activities into sexual health programs may further delay sexual activity.

Additional analyses from the study team will be available soon, which will determine the efficacy of the Native It's Your Game intervention in improving the sexual health of AI/AN youth.

Study co-investigators include: Christine M. Markham, Ph.D., Stephanie Craig Rushing, Ph.D., M.P.H., Cornelia Jessen, M.A., Travis L. Lane, Gwenda Gorman, Amanda Gaston, M.A.T., Taija Koogee Revels, Jennifer Torres, M.P.H., Jennifer Williamson, Elizabeth R. Baumler, Ph.D., Robert C. Addy, Ph.D., Melissa F. Peskin, Ph.D., and Ross Shegog, Ph.D.

The complete article is available from Stephanie Craig Rushing (at scraig@npaihb.org) or from the *Journal of Adolescent Health*.

VACCINES AND AUTISM A CONVERSATION



*Capt. Thomas M Weiser,
MD, MPH
Medical Epidemiologist*

Doc, I need your help. I'm worried about my granddaughter. She was just born and her parents decided

they didn't want to vaccinate her. When I was little, my sister got whooping cough. She was so sick, we took her to the hospital but they said there was nothing they could do. They wouldn't let me see her because I might get sick, too. She was just three years old. I will never forget the last time I saw her. Since I was the oldest child, I always felt that I should have been able to do something for her. I can't bear the thought of that happening to my granddaughter. What can I say to my son and his wife to convince them that they should get every vaccination the clinic has to protect little Kayla?

I am so sorry to hear about your sister. Even though it was so long ago, I can see that it was such a hard time. You are right, getting your granddaughter all the recommended vaccines is really important to keeping her healthy. You know, over the last 60 years, a lot of vaccines have been developed. And part of the problem we face is that they have been so successful. Smallpox has been eradicated, polio has been eradicated from this half of the world and almost from the whole world. Measles, mumps, rubella, diphtheria, whooping cough- these diseases are so rare that many doctors have never seen a case of these diseases. And it's because we have had such strong vaccination programs that these diseases have practically disappeared. Parents worry about side-effects, they worry that there are too many shots. What is your son most worried about with vaccines?

He says he read on the internet that vaccines cause autism. My sixteen year old nephew has autism, it is so hard for him and my sister's family- he has to go to special schools, and my sister worries about his future. What is the truth about vaccines and autism,

should they skip vaccinations because of this?

Dan (concerned parent), there is so much information on the internet, it is hard to know what to believe. But let me tell you this, no vaccine causes autism. I am going to say that again - **No vaccine causes autism!** There was a researcher in England who published an article trying to say that the measles vaccine caused autism, but he finally admitted that he lied. The journal made a statement that the article was false and retracted the paper saying the information should no longer be used. But people have started to believe celebrities, like Jenny McCarthy and others, who are not scientists and haven't carefully studied the science behind vaccines, instead of listening to doctors and scientists who are really trying to help children stay healthy.

Doc, I believe what you said, but how can I convince my son and his wife that vaccines are safe?

Well, it sounds like your son is trying to do the best thing for his daughter, and maybe the best thing is to show him some other information from the internet, information from sites that are committed to telling the truth about the benefits of vaccines.

www.immunize.org

<http://www.cdc.gov/vaccines/parents/index.html>

There are also resources available about autism and, in fact, top autism researchers have now released a statement that they agree there is no data to support a connection between vaccines and autism. They wrote:

A decade ago most researchers agreed that we needed to study vaccines in relation to autism. We had to reconcile the fact that the number of vaccines children were receiving was increasing, and at the same time, the number of children who were being diagnosed with autism also was on the rise. Fortunately this was a question that could be studied – and answered – by science. We looked at children who received vaccines and those who didn't, or who received them on a different, slower schedule. There was no difference in their neurological outcomes. Multiple studies have been completed which investigated

VACCINES AND AUTISM- A CONVERSATION Cont...

the measles, mumps and rubella vaccination in relation to autism. Researchers have also studied thimerosal, a mercury-based preservative, to see if it had any relation to autism. The results of studies are very clear; the data show no relationship between vaccines and autism.

Cite:

<http://www.autismsciencefoundation.org/autismandvaccines.html>

You know, Dan, there might be something else you can do. It looks like you are due for some vaccines yourself.

Me? I thought vaccines were just for babies.

Well it looks like it's been a while since you had a tetanus shot. The new version of the tetanus shot also protects against diphtheria and pertussis or whooping cough. Especially if your granddaughter has not been vaccinated, it is important that you protect her by getting vaccinated yourself.

Well, okay Doc, can we do that today?

Sure, but that's not all. You should have gotten the shingles vaccine a couple years ago. And now that you turned 65, you are due for the pneumococcal shot that prevents pneumonia.

Three shots? Is that all, Doc?

Well, we're also getting into flu season, Dan, and you're in luck - we just got our flu vaccine in last week.

Doc, are you sure it's okay to get all four shots at the same time? Shouldn't I come back next week?

Dan, it's really important to help keep you healthy and to protect your granddaughter, especially from the flu and whooping cough.

OK, Doc, I'm ready.

continued from cover page...

INDIAN HEALTH APPROPRIATION UPDATE Cont...

operated facility through contractual arrangements with outside providers so long as the service is billed by the IHS or tribally-operated facility itself.

While the statute makes the 100% FMAP rule apply to any service "received through" an IHS or tribally-operated facility, the current CMS's current interpretation does not cover CHS/PRC services. Portland Area Tribes have gone on record that this should include CHS/PRC services, as they are received only through referrals in connection with IHS or tribally-operated facilities. The CHS/PRC system is an integral part of the care IHS beneficiaries receive through IHS and tribally-operated facilities. Recognizing that economies of scale often do not allow IHS or tribally-operated facilities to provide care themselves, the purchased/referred care system extends their reach to allow beneficiaries to receive care through IHS and tribally-operated facilities through a purchased/referred care referral.

HRSA Issues Guidance on 340B Drug Program

The Health Resources and Services Administration (HRSA) has published a notice of proposed guidance. The Guidance proposes significant changes regarding when individuals are eligible for 340B drug pricing. The most important element about the Guidance is that it could change who is considered to be eligible by Indian programs. The current HRSA guidance provides that an individual may be considered a patient for 340B purposes so long as: (1) the covered entity has an established relationship with the patient, such that it maintains the patient's health records; (2) the patient receives care from an employee of the covered entity or "under contractual or other arrangements (e.g., referral for consultation)" such that the covered entity maintains responsibility for the care; and (3) the scope of services is consistent with the scope of federal funding or FQHC look-alike status provided to the entity.

The 340B program is limited to "covered entities." Covered entities are prohibited under section 340B(a)(5)(B) from reselling or transferring a drug to a person who is not a "patient" of the covered entity. This section does not, however, define patient. The criteria for determining who is a patient of a tribal health program

continued from cover page...

INDIAN HEALTH APPROPRIATION UPDATE Cont...

are established under Indian Self-Determination and Education Assistance Act (ISDEAA) agreements and statutes and regulations governing eligibility for Indian health services.

The new Guidance sets new requirements that, when applied together, will significantly curtail access to 340B pricing for tribal health programs. First, whether an individual is considered a patient for 340B purposes is to be evaluated on a prescription-by-prescription basis. Second, for an individual to be considered a patient the prescription must be issued at a tribal facility by an employee or independent contractor of the tribal facility. Tribes and the Board are advocating that HRSA amend its proposed guidance to provide an exception for tribal health programs that clarifies that 340B pricing is available to all individuals that a tribe or tribal organization is authorized to serve under its ISDEAA contract or compact.

IHS Integrated Data Collection System

The IHS has issued a Dear Tribal Leader Letter (DTLL September 23, 2015) about its plan to implement of a new Integrated Data Collection System Data Mart (IDCS-DM). The system is designed to improve the reporting of national clinical measures which are required under the Government Performance and Results Act (GPRA) and the GPRA Modernization Act (GPRAMA).

IHS explains that it plans to begin the new system in FY 2016. The new IDCS-DM is a system within the National Data Warehouse (NDW) and provides a mechanism for Tribes and Urban health programs that do not use the IHS's Resource and Patient Management System (RPMS) to report GPRA and GPRAMA data. IHS has initiated Tribal Consultation requesting Tribal input about health program needs and interests associated with this new reporting mechanism. IHS explains that historically, a majority of Tribal health programs have used the RPMS to report health information. However as Tribes have moved to non-RPMS systems, Tribal participation has decreased to report GPRA and GPRAMA performance data. IHS has requested that Area Directors to consult with Tribes on the IDCS DM implementation by October 31.

TRIBES AND UNITED STATES SETTLE CLASS ACTION SUIT FOR \$940 MILLION

CLASS COUNSEL'S PRESS RELEASE

September 17, 2015

FOR IMMEDIATE RELEASE

TRIBES AND UNITED STATES SETTLE CLASS ACTION SUIT FOR \$940 MILLION

A class of over 640 Indian Tribes and tribal organizations together with the United States today (September 17, 2015) filed a joint motion in Federal District Court in Albuquerque, New Mexico for preliminary approval of a \$940 million settlement of a class action suit against the Government. The class action lawsuit, *Ramah Navajo Chapter v. Jewell*, No. 90-CV-0957 JAP/KBM, seeks damages for underpayments of contract support costs made by the Bureau of Indian Affairs (BIA) under the Indian Self-Determination and Education Assistance Act of 1975 (ISDA). The Ramah Navajo Chapter brought the suit in 1990, and was later joined by the Oglala Sioux Tribe and the Pueblo of Zuni as Class Representatives. The Class is represented by Class Counsel Michael P. Gross and Co-Class Counsel C. Bryant Rogers and Lloyd Miller.

Under the ISDA, Indian Tribes can choose to take over federal programs such as law enforcement, courts, land management, and job training that the BIA would otherwise provide itself for a tribal community. Doing so allows Tribes to provide services that are more responsive to tribal needs, policies and objectives. About one-half of the BIA's programs are now administered by Tribes and tribal organizations under the ISDA.

To ensure that Tribes have the necessary resources to operate these federal programs, the ISDA requires that the BIA pay the Tribes' contract support costs (CSC), which are essentially administrative overhead costs. However, the BIA has historically underpaid CSC requirements. This has typically forced Tribes to divert program money to cover the overhead and thereby reduced program funding to the disadvantage of tribal members.

In 1994, Congress began capping total annual appropriations for CSC payments at levels that did not

TRIBES AND UNITED STATES SETTLE CLASS ACTION SUIT

Cont...

provide enough funding for the BIA to pay all tribal contractors' CSC needs. The government argued that these appropriation caps limited the Tribes' rights to pursue damages for the underpayments. In 2012, the Supreme Court rejected this argument, and held the government liable for the underpayments. The current settlement was negotiated in the wake of that decision, and covers the 20 years when the caps were in effect, 1994 through 2013.

The proposed settlement, if approved, will be the fourth and final settlement in the lawsuit. The first and second settlements were monetary settlements that covered years prior to 1994 and totaled \$113 million. The third settlement in 2008 reformed the system for computing CSC requirements. The current settlement for an additional \$940 million will immediately provide much needed funding to Indian nations. In addition, the Supreme Court victory in this case has already resulted in Congress removing all caps on CSC appropriations starting last year. As a result, since 2014 annual CSC payments to Tribes and tribal organizations have been boosted by over \$200 million dollars. In addition, the Supreme Court victory has led to hundreds of individual settlements of CSC claims against the U.S. Indian Health Service totaling several hundred million dollars. The hearing on the Joint Motion for Preliminary Approval is expected to be held at the United States Courthouse, 421 Gold Avenue, SW, Albuquerque, New Mexico 87103, on September 23, 2015, at 11:00 a.m., Honorable James A. Parker presiding.

The Indian Self-Determination policy was first proposed by President Richard M. Nixon in a Message to Congress on Indian Affairs in July 1970. He was concerned that the then existing policy of forced termination of Federal recognition of tribes deemed "ready to become full Americans" had caused tremendous hardship, violated Indian treaties, and breached moral obligations of long standing to America's first inhabitants. A bipartisan group of Senators spear-headed by Senator Henry "Scoop" Jackson of Washington accepted the President's call, introducing the legislation that was eventually enacted as Public Law 93-638.

Self-determination has generally been regarded as the most successful Indian policy in United States history. It reversed the disastrous policy of forced termination and recognized that Tribes were much more qualified to design and operate programs for the benefit of their members than a federal bureaucracy. But before today, the Act had not reached its full potential because, without full funding of contract support costs, contracted programs could not be operated at the same level as those run by the agencies. The Class's Supreme Court victory paved the way for full CSC funding for the future and this settlement ensures that past damages for the underfunding are compensated. Together, they represent important landmarks leading the way to fulfillment of the full promise of the ISDA.

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TRIBES AND UNITED STATES SETTLE CLASS ACTION SUIT Cont...

Ramah Navajo Chapter, Oglala Sioux Tribe & Pueblo of Zuni v. Jewell Class Counsel Question and Answer Fact Sheet (Sept. 17, 2015)

What is the background to the new settlement?

The Ramah litigation is a class action lawsuit against the BIA over unpaid contract support costs. Two earlier settlements in the case generally dealt with unpaid contract support costs between the years 1989 and 1993. A third settlement in 2008 made adjustments to the system for negotiating indirect cost rates. Earlier settlements left unresolved claims over unpaid contract support costs suffered during the period 1994 to the present.

Why was 1994 a significant year?

Since 1994, Congress has capped the maximum appropriation the BIA could spend on contract support cost payments. As a result, the BIA has long asserted that it could not be held liable for any resulting underpayments.

What happened in the 2012 United States Supreme Court decision?

In 2012, the United States Supreme Court held the government liable for underpayments that occurred in and after 1994. The Court explained that limited agency appropriations did not excuse the BIA's duty to pay each tribal contractor in full.

What does the new settlement do?

The new settlement filed on September 17, 2015 resolves all claims over unpaid contract support costs suffered during the years 1994 through 2013.

Does the new settlement cover 2014 and 2015?

No, the new settlement does not cover 2014 and 2015 because in those years Congress has appropriated sufficient funds for the BIA to fully pay tribal contract support cost requirements.

How much is the settlement amount?

The settlement is \$940,000,000. Future interest on this amount will begin accruing once the federal court enters a final judgment approving the settlement.

What is included and what is excluded from the settlement?

The settlement generally resolves all past claims involving contract support cost underpayments where the underpayment was caused by an agency-wide regulation, policy or practice. But, it does not settle certain claims that are unique to a particular tribal contractor.

The settlement also specifically excludes one category of contract support cost claims: claims for unpaid startup costs or preaward costs.

How will the settlement amount be distributed?

The settlement agreement includes a detailed table showing the share of the settlement to be paid to each Tribe or tribal organization that contracted for some or all of the 20 years covered by the settlement. These pre-assigned shares were calculated by examining the government's records of contract support cost payments, combined with the information the government and the tribal plaintiffs secured in the course of doing a major statistical sampling project. A special Distribution Appendix that is part of the Final Settlement Agreement describes in detail how the percentage shares were computed. Without repeating that discussion here, it would generally be fair to say that the larger the CSC payments that were made to tribal contractors over the years, the larger the share of the settlement that is allocated to those contractors. In addition, the Distribution Appendix provides a minimum payment of \$8,000 for each year that a tribal contractor had a contract with the BIA.

What is the process for securing a share of the settlement?

Each tribal contractor covered by the settlement will receive a Claim Form. The Claim Form will show the Tribe's percentage share of the settlement and the resulting amount computed for that Tribe from the

TRIBES AND UNITED STATES SETTLE CLASS ACTION SUIT Cont...

funds on hand. The Form will be prepared to comply with the Contract Disputes Act, and it will have to be executed by tribal leadership and returned to the Settlement Administrator.

What deductions will be made from the settlement before the settlement amount is distributed?

Deductions will include funds for a "Reserve Account" to deal with unexpected contingencies, the costs of implementing the settlement, and funds covering the attorneys' fees and reimbursable legal expenses to be awarded by the court.

How are attorneys' fees being handled?

As is typical in class action settlements, the case was handled without the payment of any attorneys' fees—that is, it was handled on a "contingent fee" basis. As is also typical in such cases, the attorneys' fees that will now be awarded will be paid out of the overall settlement amount, together with litigation costs. All such amounts are subject to court approval. The settlement agreement states that the tribal attorneys will seek a fee of 8.5% of the settlement amount, and it also states that the government "agree[s] that an 8.5 percent fee is fair and reasonable and support[s]" this fee award. The federal court will need to review and approve the award of fees and the reimbursement of costs. The attorneys in the case are filing a separate application for an award of fees and costs which will be posted on the class website along with all other settlement papers.

Is there any provision for additional compensation to be paid certain Tribes?

Yes, the settlement agreement provides for reimbursing costs incurred by those Tribes that were selected and participated in the sampling process for the time they spent participating in that process. The agreement also provides for enhancing by 20% the shares that would otherwise be computed for the Ramah, Oglala and Zuni Tribes, in recognition of the considerable work these three Tribes did over the years as the representatives of the Class.

Who will supervise the settlement?

The actual distribution of funds will be handled by a company to be selected as the "Settlement Administrator." This company has not yet been selected. The Settlement Administrator's work will be supervised by a Class Monitor. Both the Settlement Administrator and the Class Monitor will be required to report all of their work to the Court.

How does the Treasury Offset Program (TOP) figure into the settlement?

The settlement agreement notes that if a tribal claimant owes money to the United States, the Treasury will apply that debt to reduce that contractor's settlement amount. Any amount left after the offset of the debt will then be released by Treasury for payment to the tribal contractor.

Is there any circumstance under which the settlement could be terminated?

Yes, the settlement could be terminated in one unusual circumstance: if the Court permits at least 15 tribal contractors to opt out of the settlement, and if those 15 tribal contractors' collective share of the settlement exceeds 15% of the total settlement amount. Even if this threshold is not reached, the government will retain any funds that would have been paid to a Tribe that is allowed to opt out of the settlement.

Who can opt out of the settlement?

Most members of the Class previously had two opportunities to opt out of the Ramah class action lawsuit. For this reason, the proposed settlement only confers a right to opt-out of this last settlement on newly-contracting Tribes—that is, tribal contractors that first started contracting with the BIA after March 27, 2002. (Those contractors never before had a chance to consider whether to stay in or opt out of the case.)

What happens now that the settlement agreement has been filed in court?

The federal court will first consider whether to preliminarily approve the proposed settlement. This

TRIBES AND UNITED STATES SETTLE CLASS ACTION SUIT Cont...

could take a few days or a few weeks, and is entirely in the hands of New Mexico Federal Judge Parker. Judge Parker has scheduled a September 23 hearing on the preliminary approval issue. The hearing is open to the public. (*Judge Parker preliminarily approve the settlement on Sept. 30*)

Next, if the settlement is preliminarily approved, a class notice will be sent to all known class members. The notice will also be published in at least one national newspaper focused on providing news to Indian country, on the Class website at <rnccsettlement.com>, and on the BIA's website. The notice will give class members 45 days to review the settlement (as well as the request for attorney fees) and to offer objections or comments.

Once the notice period expires, Judge Parker will hold a hearing to consider whether to give final approval to the settlement and to consider the fee application. Then, Judge Parker will write an opinion and order explaining his decision on both issues and addressing any objections which may have been filed during the class notice period.

If Judge Parker gives final approval to the settlement, the process for transferring the settlement funds from the Treasury to the Class bank account will begin sixty days after the order giving final approval. At that point, the actual distribution process will begin, as one of the first steps, the Settlement Administrator to send claim forms to all class members.

If any class member who objects to the settlement chooses to appeal Judge Parker's approval of the settlement, the whole process could be delayed until resolution of the appeal. Any such appeal could take a year or more.

When is it projected that actual payments will begin?

Even under the most favorable scenario, the process of sending out claims forms and the ensuing distribution of funds will not occur until well into 2016. Once that process is underway, it will likely consume all of 2016 until the very last sums are paid out.

NEW FACES AT THE BOARD



Nanette Star Yandell is the new Project Director and Epidemiologist for the Good Health and Wellness in Indian Country, WEAVE-NW Project, with the Northwest Tribal Epidemiology Center. She joins NPAIHB from the California Rural Indian Health Board where she was the Program Evaluator for their Good Health and Wellness in Indian Country project.

Nanette has 10 years experience working on diverse rural health projects that include: pesticide exposure of agricultural farm workers, nutritional status of pregnant women with HIV, youth suicide rates and their protective factors, and other projects that explored space, place, and health using geographic information systems and epidemiology. She has also worked as the Public Health Policy Coordinator on Health in All Policies across city, county, and tribal communities in Northern California.

She holds a Master of Public Health from George Mason University with a graduate certificate in epidemiology. She also has a BA in sociology and economics from Humboldt State University where she focused on sustainable economic development in rural communities through participatory research and policy change.

Nanette was born in Oregon and considers the Pacific Northwest her home. She is the mother to a wonderful 19-year-old son and a friend to her fabulous 7-year-old Labrador retriever. In time away from NPAIHB, she enjoys practicing yoga, painting, reading, hiking, traveling, and spending time with her family across the Pacific Northwest. She is extremely grateful for the opportunity to be back home and working for Portland Area Tribes.

INDIAN DAY / DANCING IN THE SQUARE POWWOW

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NEW BABY FACES AT THE BOARD

Roberto Edward “Castiel” arrived Sept. 4, 8am weighing 7lbs 2oz, 18 inches long. Congrats Birdie, Alex, April, and Alicia!



Maclin Elizabeth Kim Peters arrived Aug. 18, 12:16pm, weighing 6lbs 12oz. Congrats Christina, Fitz and big sis Katie!



Knox Roe Gaston arrived Jul. 7, 8pm weighing 8lbs 8oz. Congrats Amanda and John!



UPCOMING EVENTS

OCTOBER

October 18-23

National Congress of American Indians (NCAI) 72nd Annual Convention and Marketplace
San Diego, CA

October 24

NARA's 11th Annual BOO BASH
Portland, Oregon

October 26

NPAIHB Tribal Health Director's Meeting
Pendleton, OR

October 27-29

NPAIHB Quarterly Board Meeting
Pendleton, OR



NOVEMBER

November 1-4

143rd American Public Health Association Annual Meeting & Exposition
Chicago, IL

November 6

Tribal Technical Work Group/Your Health Idaho meeting
Boise, ID

November 10

FY 2018 IHS Budget
Portland, OR

November 11

Veterans Day!

November 12

5th Annual Northwest Tribal Opiate Symposium
Auburn, WA

November 17-19

Native American Contractors Association (NACA) 2015 Conference & Expo
Valley Center, CA

UPCOMING EVENTS

DECEMBER

December 7-9

National American Indian Housing Council (NAIHC) Legal Symposium
Las Vegas, NV

December 9 - 10

IHS ISAC Semi-Annual Meeting--Save the Date
Denver, CO

December 10

AIHC Meeting
Sequim, WA

JANUARY 2016!

January 19-21

NPAIHB Quarterly Board Meeting

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



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RESOLUTION #15-04-01

Health Information Technology EHR MU Support Center

RESOLUTION #15-04-02

Funding Equity for All IHS Areas

RESOLUTION #15-04-03

State Grants to Tribal health Programs

RESOLUTION #15-04-04

Facility Master Plans

RESOLUTION #15-04-05

State Exchanges_QHP Contracting

RESOLUTION #15-04-06

MSPI

RESOLUTION #15-04-07

DVPI

RESOLUTION #15-04-08

Dental Grant

RESOLUTION #15-04-09

WTDP SDPI Grant

RESOLUTION #15-04-10

RWJF Data Across Sectors For Health

CALIFORNIA RURAL INDIAN HEALTH BOARD July 2015 RESOLUTIONS

RESOLUTION #315-07-15

Funding Equity for All IHS Areas

RESOLUTION #316-07-15

State Grants to Tribal health Programs

RESOLUTION #317-07-15

Facility Master Plans

RESOLUTION #318-07-15

State Exchanges_QHP Contracting

