Health News & Notes

Northwest Portland Area Indian Health Board

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Policy

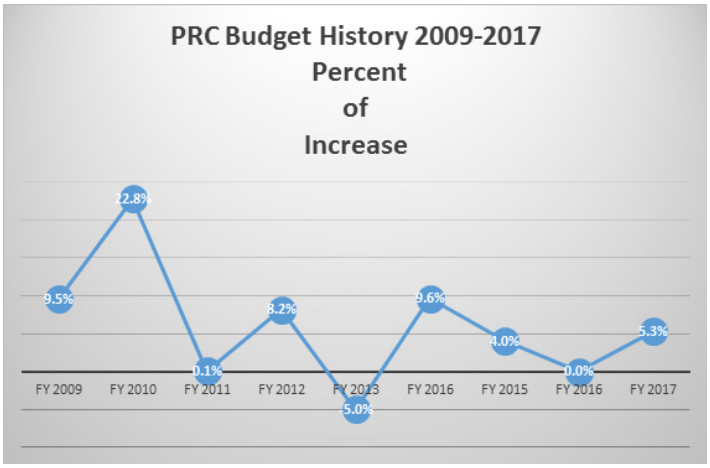
FY 2017 BUDGET ANALYSIS

By Ed Fox

The Purchased and Referred Care Roller-Coaster

Just when you started to get used to calling CHS, Contract Health Services, by its new name, Purchased and Referred Care, "PRC," the Congress and the President strike a budget deal that freezes PRC funding. As the NPAIHB Analysis of the FY 2017 IHS Budget notes there have been some very good years for CHS/PRC during the Obama Administration, but FY 2016 turned out to be one of the worst. CHS has become PRC, a Permanent Roller Coaster.

The President requests a 5.3% increase for FY 2017, an amount sufficient to maintain the purchasing power program of the program this year, but does nothing to restore the lost purchasing power of the FY 2016, current year, budget. Health Programs that were unable to fund all recommended health procedures last year will run out of funding even sooner this year. The table below depicts the ups and downs of PRC funding since FY 2009.



The FY 2017 Budget

The table below (on page 8) depicts a very reasonable FY 2017 Budget Request from the President. The year to year increases for the health services account (7.7% increase) over 2016 are overall sufficient to cover inflation, but in some line items less than needed to cover the cost of inflation, staffing new facilities and population growth. In response to tribal concerns there is a welcome emphasis, followed by significant funding for mental health and substance abuse disorder services.

Contract Support costs will once again be fully funded and a reasonable estimate ($800 million) is given in the budget subject to modification based on new and expanded contracting activity. Once again the goal of a mandatory funding formula is presented, but not yet in place for Contract Support Costs.

IN THIS ISSUE:

IMPACTS ON 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 five of those issues: a recent federal court decision requiring IHS to fully fund leases under the ISDEAA; Contract Support Costs appropriations and policy developments; a new CMS policy on 100% FMAP recovery; proposed changes to IHS's Catastrophic Health Emergency Fund policy; and IHS's new Medicare Like Rate regulations.

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 clinic facility in Kivalina, Alaska. The IHS had declined 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 the regulatory criteria were discretionary, and that it was free to limit the lease compensation to clinic funding amounts already available to Maniilaq through its ISDEAA funding agreement.

Judge Bates closely reviewed the statutory and regulatory language and found that they were ambiguous. Applying the Indian law principle of interpretation that ambiguities in statutes or regulations benefitting Indian tribes must be resolved in favor of the tribes—a generally applicable rule that is also specifically codified in the ISDEAA and its implementing regulations—Judge Bates ruled that Maniilaq Association's interpretation of the regulations was reasonable and that the court must therefore defer to it. Judge Bates ordered the IHS to negotiate with Maniilaq over proper lease compensation consistent with his order and opinion. It remains to be seen whether the IHS will seek to appeal the ruling, but if the ruling stands it will have significant implications for tribes and tribal organizations seeking to enter into fully compensated Section 105(l) leases for tribally owned facilities used to carry out ISDEAA contracts and compacts throughout the country.

IMPACTS ON TRIBAL HEALTH PROGRAMS

Contract Support Costs Appropriations and Policy Development Updates

CSC Appropriations. The Administration has released its FY 2017 Budget Request, in which it proposes to 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 protects tribal program budgets by ensuring full funding of CSC while protecting program funding.

Policy Developments. The IHS, through its tribal-federal CSC Workgroup, is revising 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 will initiate consultation on its new draft CSC policy on April 8, 2016, when the agency will issue a "Dear Tribal Leader" letter along with the policy and exhibits, which include the CSC calculation spreadsheet and standards for review and approval of CSC requests. A 60-day comment period will run until June 8, 2016. IHS will then collect and collate the comments. The Workgroup will convene 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 by July or early August.

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.

New CMS 100% FMAP Policy

The Centers for Medicare & Medicaid Services (CMS) recently announced important revisions to its policy governing when 100% Federal Medical Assistance Percentage (FMAP) is available to States for services furnished to Medicaid-eligible American Indians and Alaska Natives (AI/ANs). CMS previously interpreted the governing statutory language—which states that the federal government will pay 100% FMAP for services "received through" the IHS or a Tribal health facility, to exclude services provided by outside non-IHS/Tribal providers. In a

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IMPACTS ON TRIBAL HEALTH PROGRAMS

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State Health Official (SHO) letter released on February 26, 2016, however, CMS announced that it will consider services by non-IHS/Tribal providers as "received through" an IHS or Tribal facility (and therefore eligible for 100% FMAP) "when an IHS/Tribal facility practitioner requests the service, for his or her patient, from a non-IHS/Tribal provider (outside of the IHS/Tribal facility), who is also a Medicaid provider, in accordance with a care coordination agreement."

In order to extend 100% FMAP to services provided by urban Indian organizations, IHS and Tribal health facilities may enter into care coordination agreements with urban Indian organizations as they would with any other outside provider. In all cases, the care coordination agreement must require the IHS or Tribal health facility to retain responsibility for the patient's care and medical records.

The CMS FMAP policy governs reimbursements to States, not Tribes, for Medicaid expenditures. However, the expanded policy offers new incentives for States to work in cooperation with Tribes on Medicaid policy matters of significance to Tribes, since it is the Tribal health programs that must enter into care coordination agreements in order to qualify their referred services for the 100% federal match. Accordingly, CMS has recommended that States consult with Tribes to determine how the policy can benefit both state and tribal interests.

Proposed Changes to IHS Catastrophic Health Emergency Fund Regulations

The IHS recently 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. Many tribes are in the process of submitting comments on the proposed rules, or have done so already. The comment period has been extended to May 10, 2016.

The IHS proposes some significant departures from its current practices for being able to obtain CHEF assistance for PRC expenditures. For example, the IHS is proposing not to pay CHEF for a catastrophic claim that exceeds the CHEF threshold if the patient is eligible for "alternate resources," which the IHS proposes to define to include tribal self-insurance. However, the addition of tribal alternate sources of payment is inconsistent with the underlying statutory authority in the Indian Health Care Improvement Act, and the IHS has never before treated tribal health plans as alternate resources, either for CHEF or for the underlying PRC program. 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.

Some of these issues could have been avoided or mitigated had IHS conducted formal tribal consultation before releasing the proposed CHEF rules. Many tribes are asking IHS to suspend any further action on the proposed CHEF regulations until the IHS conducts meaningful consultation with tribes and tribal organizations. At the Tribal Self-Governance Advisory Committee meeting on March 29, Principal Deputy Director Mary Smith said IHS would consider pulling the rule, conducting consultation, then re-issuing the proposed rule once IHS receives a formal request to do so.

IHS Issues Final Rule Extending Medicare Like Rates to Non-Hospital Providers

On Monday, March 21, 2016, the IHS issued a final rule extending Medicare-Like Rates to non-hospital based services. IHS's existing Medicare-Like Rates regulations at 42 C.F.R. part 136, provide that hospital based providers must accept payment from Purchased/Referred Care programs at Medicare-Like Rates or risk losing their right to participate in the Medicare program. The new IHS rule would extend Medicare-Like Rates to

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THE STATE OF PUBLIC HEALTH
PUBLIC HEALTH 101

By Joe Finkbonner
NPAIHB Executive Director

In a recent editorial in the American Journal of Public Health (April 2016, Vol 106, No. 4) DeSalvo and O'Carroll write of the transformation of public health from 1.0 to what is currently needed 3.0. They describe public health 1.0 as the era of the establishment of antibiotics and vaccines that increased life expectancy and quality. Furthermore, they describe that our current era of public health would be described as 2.0 beginning with the release of the Institute of Medicine (IOM) report *The Future of Public Health*.

Public Health 3.0 is not only the transformation of how we perform but it also requires us to re-examine what our respective roles should be and who we involve in the overall capacity of public health systems. It calls for public health directors to be health strategists for the community and engage policy makers, schools, transportation, and business leaders.

The transformation to Public Health 3.0 requires that we use tools, like accreditation, which puts emphasis on quality improvement and the ACA that requires nonprofit hospitals to perform community health assessments to develop and strengthen partnerships that more broadly examine the deteminants of health. Use those partnerships to strengthen our workforce, education systems, road safety, etc.

I have included the following information from the HealthyPeople.gov website on this very topic – Public Health 3.0 to more fully elucidate the details.

> *Public Health 3.0 is a major upgrade in public health practice to emphasize cross-sectoral environmental, policy, and systems-level actions that directly affect the social determinants of health and advance health equity. It represents a challenge to business leaders, community leaders, state lawmakers, and Federal policymakers to incorporate health into all areas of governance.*
>
> *The Public Health 3.0 initiative is led by the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Health (OASH) and builds on the work of Healthy People 2020, which encourages collaborations across communities and sectors.*

Why We Need Public Health 3.0

Despite public health's increasing focus on how environments impact health, our ZIP codes remain a more accurate determinant of health than our genetic codes. As a society, we have a collective responsibility to create conditions that allow all members of our communities to make healthy choices. And yet public health initiatives often exist in silos, resulting in missed opportunities to leverage the critical knowledge of communities to improve health at the local level.

Public Health 3.0 calls for us to boldly expand public health to address all aspects of life that promote health and well-being, including:

- *Economic development*
- *Education*
- *Transportation*
- *Food*
- *Environment*
- *Housing*
- *Safe neighborhoods*

How to Achieve Public Health 3.0

To make Public Health 3.0 a reality, we must draw on leadership from both the public and private sectors that impact community health—for example, housing, education, and economic development. Partners from sectors like these must work collaboratively to improve health outcomes and advance health equity. Additionally, we must empower local leaders to be the chief health strategists in their communities.

The opportunities presented by this new vision of public health are extensive. By increasing stakeholders and working to foster creativity and innovation across sectors, we can make lasting gains in public health across our Nation's increasingly diverse communities.

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FEDERAL CHANGES TO ESSENTIAL COMMUNITY PROVIDER LIST COULD HAVE LARGE IMPACT ON INDIAN HEALTH CARE PROVIDERS

By Doneg McDonough
NPAIHB Consultant

The federal Department of Health and Human Services (HHS) this year has made changes to how it will determine which health care providers, including Indian health care providers (IHCPs), will receive the essential community provider (ECP) protections under the Affordable Care Act (ACA), and these modifications could have a significant impact on IHCPs in Oregon, as well as other states. In addition, HHS modified its policy on which states are subject to the HHS ECP protections.

The general ECP provisions in the ACA apply to all states, but it has been only in Federally-Facilitated Marketplace (FFM) states that the specific HHS ECP contracting regulations apply. As such, these HHS ECP requirements have not applied to Oregon, Idaho, or Washington, which are State-Based Marketplace (SBM) states. Now, HHS has extended the ECP requirements to IHCPs in states, such as Oregon, that operate SBMs on the Federal Platform (SBM-FPs).[1] Under this new policy, these ECP requirements do not automatically apply to Idaho and Washington, which are SBM states, but they do apply to Oregon, which is an SBM-FP state.[2]

Under a new policy, IHCPs and other providers must submit a petition to obtain placement on or remain on the annual list of ECPs maintained by HHS (HHS ECP List) for the 2018 benefit year.[3] Being placed on or remaining on the HHS ECP List is important, as this action helps ensure the right of IHCPs located in a qualified health plan (QHP) service area to receive a contract offer from the QHP. Again, in the past, this right under federal regulations to receive a contract offer has applied only to IHCPs in FFM states. Now, HHS has extended it to IHCPs in states, such as Oregon, that operate SBM-FPs.

Actions IHCPs Should Consider for 2018

Under the new policy, IHCPs and other providers that want to obtain placement on the 2018 HHS ECP List or update information in a current entry must submit a petition,[4] following the steps outlined in the table below. Although the provider submission window for updates and corrections for the 2017 HHS ECP List closed on January 15, 2016, the ECP petition process remains open throughout 2016 for providers to update and correct their data for future plan year lists.

Steps for Submitting the ECP Petition for the 2018 Benefit Year

1. Access the electronic petition at https://data.healthcare.gov/cciio/ecp_petition Begin answering the questions, filling in all required data fields and scrolling over the "i" buttons for additional instructions (when available).
2. Answer questions about you (the submitter) in the "About You" section.
3. Indicate under "Requested Action" whether your facility wishes to obtain placement on, change its data on, or remove itself from the HHS ECP List in the "Requested Action" section.
4. Find your facility (if your facility currently appears on the HHS ECP List) by clicking on the "Check to see if you are on the list" button in the "Requested Action" section (a searchable database will open) and note your row number (you will need this later to complete the petition / question 17).
5. Complete the "Eligibility," "Site Information, Organization Information," and "Point of Contact"

[1] This Marketplace model, newly established in the HHS Notice of Benefit and Payment Parameters for 2017, will enable State-Based Marketplaces (SBMs) to execute certain processes using the federal eligibility enrollment infrastructure. SBM-FPs and HHS will have to enter into a federal platform agreement that will define a set of mutual obligations, including the set of federal services upon which the SBM-FP agrees to rely. Under this model, certain requirements previously only applicable to QHPs offered on FFMs, including ECP standards, will apply to QHPs offered on SBM-FPs.

[2] The State of Washington and the State of Idaho have the authority to impose these requirements as well, if either chooses to do so. Because non-FFM states might choose to use the HHS ECP List to identify IHCPs and other ECPs in their state, it is recommended that IHCPs in non-FFM states also register on the HHS ECP List.

[3] This requirement will apply in 2018; CCIIO relaxed this requirement for 2017. The 2017 HHS ECP List includes available ECPs based on data maintained by HHS and other federal agencies, as well as provider data that HHS received directly from providers through the ECP petition process for the 2017 plan year.

[4] Because of the addition of several new data fields for the HHS ECP List for 2017, all ECPs must submit a revised entry to provide missing required information (IHCPs and other ECPs seeking placement on the list for the first time also must submit the petition).

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FEDERAL CHANGES TO ESSENTIAL COMMUNITY... CONTINUED

sections.

6. After completing the petition, click the "Preview your Petition before Submitting" button.
7. Fix validation errors (if any) found in the petition (indicated in red).
8. Submit your finalized petition.

Actions IHCPs Should Consider for 2017

Though the provider petition submission window has closed for the 2017 benefit year, IHCPs that do not appear on the 2017 HHS ECP List still can engage QHP issuers directly to secure a contract offer, as long as IHCPs submit a petition through the process identified above by no later than August 22, 2016. IHCPs also should update their entries on the HHS ECP List on an ongoing basis. For example, it is important to maintain the contact information in an entry on the HHS ECP List to allow QHP issuers to contact IHCPs and make contract offers.

Additional Information

Link to a Fact Sheet on the 2017 ECP List:
https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Description-and-Purpose-of-HHS-List-of-ECPs-for-PY-2017.pdf

Link to ECP Petition Instructions:
http://tribalselfgov.org/wp/wp-content/uploads/2015/12/ECP-Provider-Petition-Instructions-12-09-15.pdf

Link to FAQs on the ECP Petition:
https://data.healthcare.gov/dataset/ECP-Petition-FAQs-12-07-15/igr2-dm75

Contact for Assistance with Submitting the ECP Petition:
EssentialCommunityProviders@cms.hhs.gov

Doneg McDonough leads the health care consulting firm Health System Analytics and advises clients on maximizing opportunities under the Affordable Care Act (ACA) and the Indian Health Care Improvement Act (IHCIA). Doneg serves as a technical advisor to the Tribal Self-Governance Advisory Committee, as well as the Centers for Medicare and Medicaid Services Tribal Technical Advisory Group

FETAL ALCOHOL SPECTRM DISORDERS

By Suzie Kuerschner and Jacqueline Left Hand Bull

Understanding of Fetal Alcohol Spectrum Disorders (FASD) continues to grow, and development of positive approaches to accommodate and integrate those with FASDs, whether mild or severe, into community life also continues to grow. The following may be helpful information.

- When a person with a possible FASD:
  - Please consider calmness is important in:
    - » Environment (light, sight & sensory)
    - » Voice (loudness, modulation)
    - » Affect (demeanor)
  - They will benefit from:
    - » Concrete, on-part direction
    - » Positive mapping & reinforcement

- Fetal Alcohol Spectrum Disorder may produce anxiety and/or sensory issues that require adaptive approaches when guiding to prevent, or responding to, injury
  - Some helpful steps:
    - » Introduce yourself with a smile.
    - » Offer reassurance using an open and calm approach.
    - » Establish rapport and relationship using a friendly affect.
    - » Communicate assessment of situation/injury and "what is going to happen" one part at a time:
      - Reassure with each part and introduce some physical steps for self regulation (such as breathing)
      - Repeat, using same words and sequence.

  - Avoid:
    - » Over communicating and/or lengthy explanations.
    - » Words or body language that may convey judgement.

FY 2017 BUDGET ANALYSIS

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Preventive Health Services are increased by an average of 6.6% again responsive to the priorities of tribal leadership. The Urban Health Program receives a 7.6% budget increase in 2017 and is likewise responsive to the budget formulation workgroups call for increased funding for Urban Indian Health Programs.

New Facilities construction funding increases by 26%, but continues to ignore the needs of Portland Area Tribes for funding for small ambulatory facilities.

Table No. 1: Indian Health Service Budget - Three Years
Comparison of FY 2015, 2016, and President's FY 2017
(Dollars in Thousands)

Sub Sub Activity	Final Budget FY 2015	Final Budget FY 2016	Change Over FY 2015	Percent Change	President's FY 2017 Budget	Change Over FY 2016	Percent Change
SERVICES:							
Hospitals & Health Clinics	$ 1,836,789	$ 1,857,225	$ 20,436	1.1%	$ 1,979,998	$ 122,773	6.6%
Dental Services	$ 173,982	$ 178,286	$ 4,304	2.5%	$ 186,829	$ 8,543	4.8%
Mental Health	$ 81,145	$ 82,100	$ 955	1.2%	$ 111,143	$ 29,043	35.4%
Alcohol & Substance Abuse	$ 190,981	$ 205,305	$ 14,324	7.5%	$ 233,286	$ 27,981	13.6%
Purchase and Referred Care	$ 914,139	$ 914,139	$ -	0.0%	$ 962,331	$ 48,192	5.3%
Total, Clinical Services	$ 3,197,036	*$ 3,237,055*	*$ 40,019*	1.3%	*$ 3,473,587*	*$ 236,532*	7.3%
PREVENTIVE HEALTH:	$ -						
Public Health Nursing	$ 75,640	$ 76,623	$ 983	1.3%	$ 82,040	$ 5,417	7.1%
Health Education	$ 18,026	$ 18,255	$ 229	1.3%	$ 19,545	$ 1,290	7.1%
Comm. Health Reps	$ 58,469	$ 58,906	$ 437	0.7%	$ 62,428	$ 3,522	6.0%
Immunization AK	$ 1,826	$ 1,950	$ 124	6.8%	$ 2,062	$ 112	5.7%
Total, Preventative Health	$ 153,961	*$ 155,734*	*$ 1,773*	*1.2%*	*$ 166,075*	*$ 10,341*	6.6%
OTHER SERVICES:	$ -						
Urban Health	$ 43,604	$ 44,741	$ 1,137	2.6%	$ 48,157	$ 3,416	7.6%
Indian Health Professions	$ 48,342	48,342	$ -	0.0%	$ 49,345	$ 1,003	2.1%
Tribal Management	$ 2,442	2,442	$ -	0.0%	$ 2,488	$ 46	1.9%
Direct Operation	$ 68,065	72,338	$ 4,273	6.3%	$ 69,620	$ (2,718)	-3.8%
Self Governance	$ 5,727	5,735	$ 8	0.1%	$ 5,837	$ 102	1.8%
Total Other Services	$ 168,180	$ 173,598	$ 5,418	3.2%	$ 175,447	$ 1,849	1.1%
Services Total without CSC	$ 3,519,177	$ 3,566,387	$ 47,210	1.3%	$ 3,815,109	$ 248,722	7.0%
Contract Support Costs	$ 662,970	717,970	$ 55,000	8.3%	$ 800,000	$ 82,030	11.4%
TOTAL, SERVICES including CSC	$ 4,182,147	$ 4,284,357	$ 102,210	2.4%	$ 4,615,109	$ 330,752	7.7%
FACILITIES:	$ -						
Maintenance & Improvement	$ 53,614	$ 73,614	$ 20,000	37.3%	$ 76,981	$ 3,367	4.6%
Sanitation Facilities Construction	$ 79,423	99,423	$ 20,000	25.2%	$ 103,036	$ 3,613	3.6%
Hlth Care Facilities Construction	$ 85,048	105,048	$ 20,000	23.5%	$ 132,377	$ 27,329	26.0%
Facil. & Envir. Hlth Supp	$ 219,612	222,610	$ 2,998	1.4%	$ 233,858	$ 11,248	5.1%
Equipment	$ 22,537	22,537	$ -	0.0%	$ 23,654	$ 1,117	5.0%
Total, Facilities	$ 460,234	*$ 523,232*	*$ 62,998*	*13.7%*	*$ 569,906*	*$ 46,674*	8.9%
TOTAL, IHS	$ 4,642,381	$ 4,807,589	$ 165,208	3.6%	$ 5,185,015	$ 377,426	7.9%

WELLNESS TIME ESCALATES ACTIVITY

By Don Head
WTDP
Project Specialist

It's pretty hard to work at the Board without becoming healthier. We work in the public health field, of course, so we have access to a lot of information about chronic diseases affecting the communities and tribes that we serve. We are also encouraged to live healthier with policies enacted by the Board that serve to improve our quality of life, for instance, allowing newborn infants in the office for their first six months of life, or assisting employees with tobacco cessation by subsidizing $100/year in cessation medications.

The policy most directly affecting my health consists of the Wellness policy, which allows us to take 30 minutes each day to engage in activity, and to get us out of our chairs and away from our desks. Examples include yoga, walking or running, craft circles, deck-of-cards workouts, and my favorite, cycling. I map out routes that take me across bridges, up hills, and throughout the downtown area. The rides are short, 30 minutes in length, and usually coincide with lunch.

Cycling just to ride is fun, but it becomes easier to jump in the saddle when you have a goal. In 2013 my goal was to complete Reach the Beach. Reach the Beach is a fundraising effort that benefits the American Lung Association (ALA). As a former smoker for nineteen years, I appreciate this organization and what it accomplishes. I have not smoked for over four years, and part of that is due to the Board's cessation policy. My bicycle also plays a big role, since smoking and cycling are fairly mutually exclusive activities. Riders are supported with rest stops, water stations, and a lunch break through 104 miles, from Beaverton (just south of Portland) to Pacific City. In 2013, I joined Chris Sanford (Network Administrator) and David Stephens (Multimedia Project Specialist) in riding the entire 104-mile course. I was a little concerned, since I had never ridden a century (a ride of at least 100 miles), but my friends' advice pretty much boiled down to "keep pedaling." I was also able to take time to train using the Board's Wellness policy, and I started riding my bicycle to work to take advantage of this.

In 2014, Chris and I finished the Portland Century, in the blistering heat of August, throughout Portland and Vancouver. In 2015, I once more rode the 104-miles in Reach the Beach, and this time Nicole Smith (Biostatistician) joined Chris, David, and me. Next month, on May 21, 2016, Nicole and I will have two more staff joining us in riding Reach the Beach. Monika Damron (IDEA NW Biostatistician) and Nanette Yandell (WEAVE Project Director) both will be riding the 104-mile course, while Nicole and I are opting for the 80-mile course, and the extra hour of sleep. It's been great that more Board staff are interested in riding bicycles; having friends to ride with helps with the motivation to finish.

Board employees are a healthy and active bunch, and part of it is the support we receive from the Board, through its policies that engender wellness and improved quality of life. It also helps that Board staff are generally very supportive of each other. The environment of encouragement we have in the workplace has prompted some of the Board staff to enter the annual Hood-to-Coast Relay scheduled for August 26-27, 2016. This is a 198-mile running

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2016 – 2020 OREGON YOUTH SUICIDE INTERVENTION AND PREVENTION PLAN

By Ann D. Kirkwood,
Oregon Health Authority Suicide Intervention Coordinator

The Oregon Health Authority has released a new Youth Suicide Intervention and Prevention Plan to guide the state in addressing Oregon's high youth suicide rate. Modeled after the National Strategy for Suicide Prevention, the state's document addresses key priorities and best practice interventions for suicide prevention and customizes national approaches for use in Oregon.

ORS 418.704 requires preparation of an Oregon Youth Suicide Intervention and Prevention Plan in 2015, with updates a minimum of every five years. The enabling legislation enacted in 2014 (HB 4124) also requires that an annual report be submitted to the Legislature. HB 4124 established a position of youth suicide intervention and prevention coordinator in the Oregon Health Authority Health Systems Division (formerly Addictions and Mental Health), to help stakeholders prepare the plan and submit the annual reports.

Starting on December 1, 2014, the coordinator worked with staff in the Health Systems Division and Public Health Division and groups of diverse stakeholders to write the plan. Approximately 100 subject matter experts were recruited from across disciplines, including youth and families, and from all geographic areas for a steering committee and seven work groups to prepare the plan between March and November 2015.

The plan includes approximately 80 specific action items under four general themes: Healthy and empowered individuals, families and communities; Clinical and community preventive services; Treatment and support services; and Surveillance, research and evaluation. Below are example action items under each category:

Healthy and empowered individuals, families and communities

- Develop an Oregon Alliance to Prevent Suicide of public and private partners to establish priorities and a public policy agenda to guide implementation of the plan over five years, including recommendations for providing suicide risk assessment and crisis counseling as essential health benefits.
- Develop materials to promote mental health literacy and system understanding among parents and youth.
- Establish a work group involving youth to prepare a plan for use of social media.

Clinical and community preventive services

- Supplement trauma-informed care with suicide prevention strategies.
- Analyze suicide risk assessments used in medical and behavioral health care settings and disseminate best practice assessment tools.
- Train medical and behavioral health providers in assessing, managing and treating individuals at risk for suicide or self-harm.
- Expand the Oregon Pediatric Society's trainings for primary care physicians on depression and substance use screening.
- Disseminate best practice guidelines on recommended activities after a suicide (postvention) to schools and a wide range of community members, and provide technical assistance to those communities/individuals.
- Establish information-sharing protocols at the local and state levels in forming postvention activities (2015 SB 561).

Treatment and support services

- Establish programs to follow up with youth and families after release from emergency departments to ensure safety and warm handoffs to outpatient care.
- Provide discharge planning at release from emergency departments.
- Develop guidelines on use of peer and family supports in suicide intervention and treatment.

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WASHINGTON'S NEW STATE SUICIDE PREVENTION PLAN: WHAT YOU NEED TO KNOW

By Karyn Brownson,
State Suicide Prevention Plan Project Manager

On January 6, the Washington State Department of Health released its new suicide prevention plan. This plan expands and updates Washington's past suicide prevention plan for youth ages 10 to 24, which was originally written in the mid-1990s. In 2014, the Washington State Legislature passed House Bill 2315, requiring the Department of Health to lead development of a suicide prevention plan covering all age groups. Because suicide is a public health problem that affects everybody, the department asked community members statewide to be involved in crafting a new and useful prevention plan See:
http://www.doh.wa.gov/Portals/1/Documents/Pubs/631-058-SuicidePrevPlan.pdf

The plan was developed over the course of a year and a half by the Department of Health, with significant contributions from a large steering committee and a statewide group of stakeholders who participated in listening sessions, contributed personal stories, provided expert consultation and reviewed drafts. More than 250 stakeholders were integral in developing the plan, including tribal members from all over the state.

The final plan has something for everyone. There are resources for readers in crisis. General suicide awareness information is included, as is information about the connection between suicide and adverse childhood experiences (ACEs) and historical trauma. Readers can also learn about risk and protective factors and strategies to prevent suicide. The chapter on data shows the effect of suicide in Washington and what geographic locations or people are disproportionately affected. And the body of the plan contains prevention goals and recommendations for systems including education, unemployment, health care, journalism, corrections, government, child welfare and more.

The plan's recommendations are organized around the four Strategic Directions laid out in the National Strategy for Suicide Prevention. See:
http://actionallianceforsuicideprevention.org/nssp

Together, these four pockets of work help us prevent suicide before risk arises, structure comprehensive suicide prevention initiatives in our communities, provide accessible and appropriate treatment for behavioral health problems and suicide risk, and design programs that are informed by data and evaluated for effectiveness.

Because identifying and supporting people at immediate risk of suicide is truly urgent, it is often the focus of suicide prevention work. This plan takes a broader view by including upstream prevention – what we can do to prevent suicide before risk appears. We make recommendations for changing the public conversation to reduce stigma about suicide and mental illness, building connectedness in our communities, nurturing social and emotional health starting in early childhood, and building the belief that everyone plays a role in supporting behavioral health and preventing suicide. While the plan also includes recommendations for prevention programs and clinical services, the message was loud and clear from our colleagues and stakeholders that upstream prevention is essential to reducing suicide and healing the wounds it leaves in our communities.

Writing the plan was only the first step. Putting it into action will require an even bigger community effort, and we all have a role to play. The Department of Health is working with the Governor's Office to coordinate a group to work on system-level implementation of the plan, and we look forward to working with partners from the tribes on this new endeavor. We are also putting together a statewide speakers' bureau made up of people who are passionate about suicide prevention and want to bring awareness about the state plan to their workplace or community.

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OREGON YOUTH SUICIDE INTERVENTION AND PREVENTION...

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- Collaborate to identify ways stakeholders can implement laws pertaining to confidentiality of information (including HIPAA and 2015 HB2948) to promote information-sharing across systems (physical and mental health, substance use treatment and schools) and with families and families of choice.
- Encourage integration of behavioral health and primary care.

Surveillance, research and evaluation

- Establish an OHA Evaluation Committee to identify measures and sources of data to gauge progress on suicide prevention and intervention initiatives and monitor implementation of the plan.
- Compare Oregon's youth suicide rates and prevention activities with other states ranked the highest and lowest for youth suicide.

Also included are action items related to a grant-funded suicide prevention project administered by the Public Health Division that is currently underway. Through congressional funding to Oregon from the Garrett Lee Smith Memorial Act, the Caring Connections Initiative builds on existing public/private partnerships and health system transformation efforts on youth suicide prevention in Oregon.

Copies of the full plan are available online at:
www.tinyurl.com/hr94228

For information about the plan or to obtain a hard copy, email Ann D. Kirkwood, Oregon Health Authority Suicide Intervention Coordinator, at:
ann.d.kirkwood@state.or.us
or call 503-947-5540.

IMPACTS ON TRIBAL HEALTH PROGRAMS

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non-hospital providers, but does not make compliance with the rule a Medicare condition of participation. The rule is binding on IHS and urban facilities, but optional for tribal facilities.

Under the new rule, the IHS and tribal facilities that choose to opt-in must pay either a rate they have negotiated with the provider or the lowest of (1) the applicable Medicare rate; (2) an amount negotiated by a repricing agent; or (3) an amount no higher than the provider's most favored customer rate. The rule also allows IHS, Tribal and urban facilities to pay a higher rate if they determine that rate is fair and reasonable. This flexibility was included in the final rule in response to tribal concerns that because the new rule is not binding on the providers like it is for hospital based services, that providers may simply refuse to see tribal patients if the rate is too low. The final rule is effective May 20, 2016.

...WHAT YOU NEED TO KNOW.

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Appendix E of the document is an action planning tool any group of people can use for local plan implementation. If you have an idea for a suicide prevention project in your workplace or community, this tool can guide you through the planning process to make it reality. We know many outstanding suicide prevention projects are operating all over the state. If there is a project you would like to see highlighted on the Department of Health's website, please email the project location and contact information to suicidepreventionplan@doh.wa.gov.

To be part of the implementation efforts of the state plan, please email the Department of Health at suicidepreventionplan@doh.wa.gov. We appreciate the opportunity to partner with you on this urgent public health issue.

WASHINGTON STATE SUICIDE PREVENTION TRAINING REQUIREMENTS FOR HEALTH PROFESSIONALS

By Karyn Brownson,
State Suicide Prevention Plan Project Manager with the Washington State Department of Health

Many people who die by suicide see a primary care provider in the months before their death. A series of bills requiring suicide prevention training for health professionals have passed the Washington State Legislature since 2012. Each bill has added to or changed the requirements, and many people are unclear on what is required. We at the Department of Health hope this will answer your questions.

WHO NEEDS TO TAKE THIS TRAINING? IS MY PROFESSION INCLUDED?

You need to take this training if you are licensed by the state of Washington in one of the professions below. If you are in one of these professions but not licensed by the state of Washington, these requirements don't apply to you. However, this training should be useful for health professionals whether it is required or not.

Six hours of training on suicide assessment, treatment and management at least once every six years:

- Marriage and family therapists
- Psychologists
- Social worker associates—advanced or social
- worker associates—independent clinical
- Advanced social workers or independent
- clinical social workers
- Mental health counselors

Six hours of training on suicide assessment, treatment and management one time:

- Naturopaths
- Physician assistants
- Licensed practical nurses, registered nurses, advanced registered nurse practitioners (certified registered nurse anesthetists are exempt)
- Osteopathic physicians and surgeons, other than a holder of a postgraduate osteopathic medicine and surgery license
- Physicians, other than a resident holding a limited license
- Osteopathic physician assistants
- Person holding a retired active license for one of these professions

Three hours of training on suicide screening and referral every six years:

- Advisers or counselors
- Chemical dependency professionals
- Occupational therapy practitioners

Three hours of training on suicide screening and referral one time:

- Chiropractors
- Physical therapists or physical therapist assistants

WHAT TRAINING CAN I TAKE TO MEET THE REQUIREMENT NOW?

If you are a physician (MD), there is a specific list of trainings you can take for this requirement, effective now. Please contact Mike Farrell at Michael.farrell@doh.wa.gov for more information.

If you are not a physician, from now until July 1, 2017, you need only to take a training that includes content on suicide assessment, treatment and management (for six-hour trainings) or suicide screening and referral (for three-hour trainings). *For training after July 1, 2017, see below.*

A model list of current trainings in line with those basic content requirements is on the Department of Health's website here: http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/SuicidePrevention/TrainingPrograms.

Until July 1, 2017, you may take trainings on the list, or other trainings that meet the basic requirements. The current list is a good starting place for people who are not sure what their training options are.

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WASHINGTON STATE SUICIDE PREVENTION

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WHEN AND HOW WILL THIS REQUIREMENT CHANGE?

As required by House Bill 1424, the Department of Health is working on rulemaking to set minimum standards for trainings to be on a final approved training list. After July 1, 2017, health professionals can get credit only for trainings on that list.

WHAT WILL THAT FINAL LIST LOOK LIKE? HOW CAN I GET A TRAINING APPROVED AND ADDED?

The Department of Health is developing a process for trainings to be submitted, reviewed and added to the final approved list. That list will be built between June 30, 2016 and July 1, 2017. Trainings on the current list will not be automatically approved.

If you plan to submit a training for approval, please follow the rulemaking process and ensure your training meets the minimum standards. For more information, see:
http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/SuicidePrevention or email suicidepreventionce@doh.wa.gov.

WELLNESS TIME ESCALATES ACTIVITY

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relay that starts at Timberline Lodge and ends at Seaside, OR. This fundraising effort benefits the Providence Cancer Center. Runners are assigned different legs, and are expected to run the entire 198 miles throughout the night and into the next day. Their team name accurately reflects the culture and lifestyle of the Board staff: Team HANDS, or *Healthy Active Natives Doing Something.*

Team HANDS

Monika Damron
Erik Kakuska
Antoinette Aguirre
Nora Alexander
Celena McCray
Ryan Sealy
Birdie Wermy
Stephanie Craig-Rushing
David Stephens

THE STATE OF PUBLIC HEALTH

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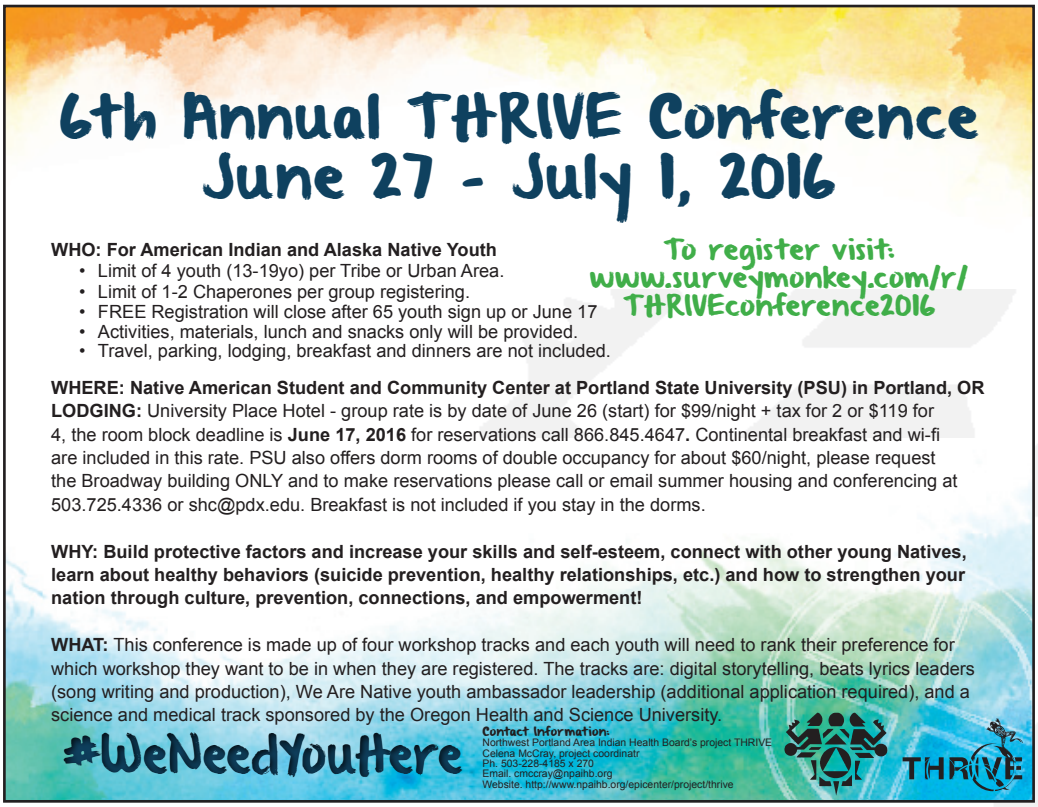
How OASH Is Implementing Public Health 3.0

Throughout 2016, OASH will host regional listening sessions with community leaders from the private and public sectors to learn more about opportunities to improve and modernize public health. Following the listening sessions, OASH will issue a national framework for this new era of public health.

I ask that Tribes and tribal leaders ponder this transformation as you are developing and strengthening your own public health capacity and to engage at one of the listening sessions. Spokane, will be the site of the closest session. I will share more information about the listening sessions as the details develop.

NPAIHB GATHERINGS/ANNOUNCEMENTS



CONGRATULATIONS JIM FRY! 20 YEARS!

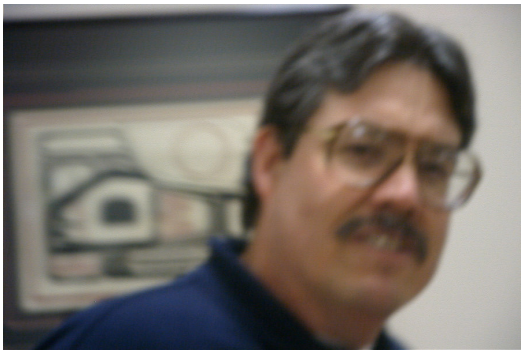
James C. Fry, AAS, BA (Colville Confederated Tribes)

This quarter we have the honor of recognizing Jim Fry for 20 years of service to the tribes of the Northwest through his professional work at NPAIHB.

Jim was raised in Eastern Washington and has resided on reservations there and in Idaho while working for various Native American Tribes. He began work with the Northwest Portland Area Indian Health Board (NPAIHB) in April of 1996. His work began as the Hanford Project Information Specialist, and then at the Northwest Tribal Epidemiology Center (EpiCenter) as the first staff member with the position of Information Systems Specialist. He eventually became the Network Administrator for NPAIHB and Network Specialist for the Circle of Health Project. James holds an AAS degree in Business Computer Programming and a BA degree in Management Information Systems. A valued member of the Management Team, he is currently the Director of Information Services for NPAIHB where he oversees network operations, information technology purchases, and helpdesk functions.

In addition to his commitment to work we appreciate Jim as an active gardener (ask about his hot peppers), involved grandfather, and dedication to his family. We know we can count on Jim for sage advice and a ready sense of humor.

We acknowledge Jim, with our great appreciation for his years of service to the Board. Thank you Jim for your first 20 years!



UPCOMING EVENTS

APRIL

April 19-21
8th Annual OK TEC Public Health Conference
Grand Casino Bloulevard, Shawnee, OK

April 24-29
2016 Self-Governance Annual Consultation Conference
Orlando, FL

April 26
WEAVE - Worksite Wellness webinar 2pm-3pm
Portland, OR

MAY

May 2-4
Fertile Ground II: Growing the Seeds for Native American Health
Minneapolis, MN

May 2-6
Tribal Emergency Preparedness Conference
Spokane, WA

May 12-13
National Council of Urban Indian Health Conference
Alpine, CA

May 17-19
2016 Nurse Leaders in Native Care Conference
Phoenix, AZ

UPCOMING EVENTS

MAY

May 24-25
Northwest Tribal Regional Diabetes Conference
Portland, OR

May 24-26
OR-Epi Conference
Portland, OR

JUNE

June 5-8
26th National Native Health Research Conference
Cherokee, NC

June 13 - July 1
NARCH Summer Institute
Portland, OR

June 15
IHS National Directors Award Ceremony
Bethesda, MD

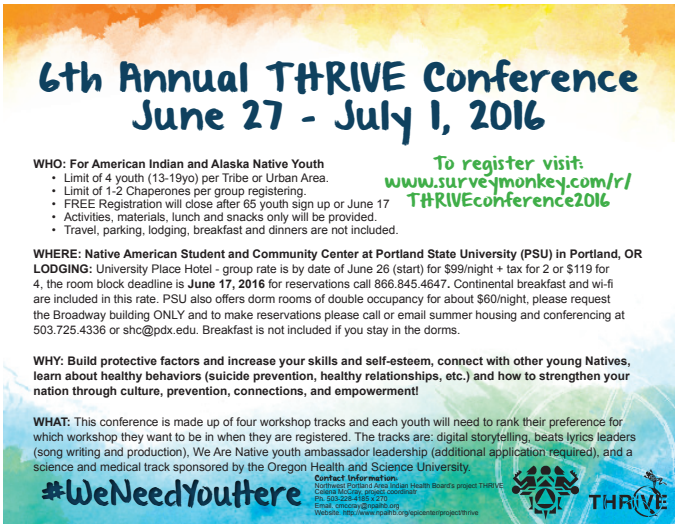
June 27-30
Native Youth Wellness Warrior Camp
Portland, OR

UPCOMING EVENTS

JUNE

June 26 - July 1
NCAI Mid-Year Conference
Spokane, WA

June 27 - July 1
6th Annual THRIVE Conference
Portland, OR



JULY

July 8-9
Native Vetrans Summit IV
Willamina, OR

July 12-15
Integrating Primary and Behavioral Health Care Through the Lens of Prevention
New Orleans, LA

AUGUST

August 8-11
QBM
Omak, WA

August 30-31
Native Fitness XIII
Beaverton, OR

August 30-31
National Tribal Forum Excellence in Community Health
Spokane, WA

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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APRIL 2016 RESOLUTIONS

RESOLUTION #16-02-01
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