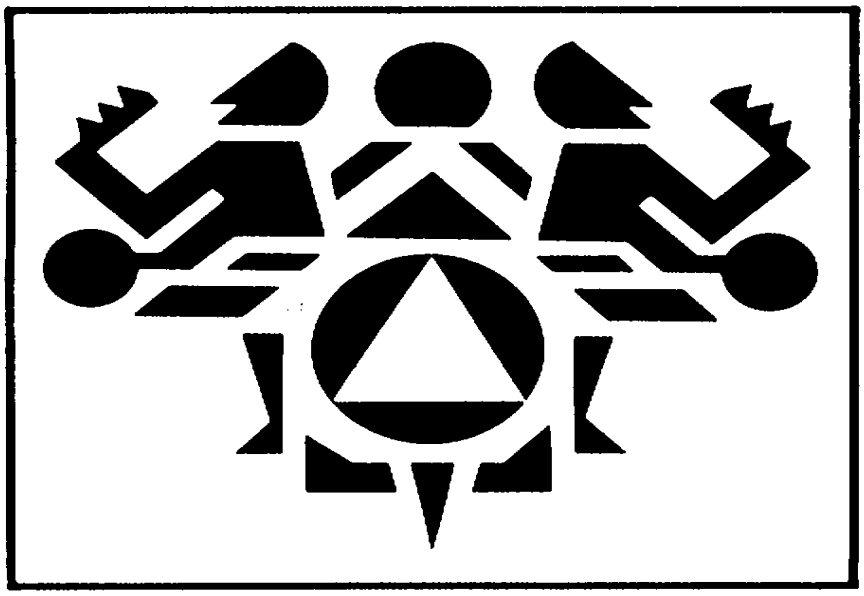
# MINUTES

# NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD



## QUARTERLY BOARD MEETING

## JULY 15-18, 2019

THUNDER VALLEY RESORT
LINCOLN, CA

# *Summary of Minutes*

| Issue | Summary | Action | Follow-Up |
|---|---|---|---|
| **TUESDAY JULY 16, 2019** | | | |
| | | | |
| **PORTLAND IHS AREA DIRECTOR REPORT**<br>**DEAN SEYLER:** | **Portland Area P.L. 93-638 ISDEAA Orientation**<br>❖ July 23 – 24<br>❖ 8:00AM to 4:30PM<br>❖ Embassy Suites by Portland Airport<br>❖ Questions? Call Rena Macy (503) 414-7792 or e-mail at rena.macy@ihs.gov<br><br>**Area Staff Changes**<br>❖ CAPT Thomas Weiser, MD – Acting CMO<br>❖ CAPT Marcus Martinez, Director, Office of Environmental Health and Engineering<br>❖ Ashley Tuomi – Director, Office of Clinical Support<br>❖ CDR Roney Won – Acting Area Diabetes Consultant<br>❖ Currently Advertising for:<br>❖ Area Chief Medical Officer<br>❖ CEOs at Wellpinit and Warm Springs Service Units<br>❖ Clinical Directors at Ft. Hall and Warm Springs Service Units<br>❖ Area Diabetes Consultant<br><br>**Tribal Leader Letters**<br>❖ July 5, 2019 – Tribal Leaders invited to provide updates to Facilities Master Plan<br>❖ July 3, 2019 – New appointments and updates to the IHS senior leadership team.<br>❖ June 21, 2019 – Consultation and Confer session on the Opioid Grant Program | | |

# *Summary of Minutes*

- June 7, 2019 – Deadline extended on CHAP comment period
- May 24, 2019 – Update on IHS Sanitation Deficiency System
- May 15, 2019 – PRC Tribal Consultation results
- May 8, 2019 – Initiate Tribal Consultation on draft CHAP Policy
- April 23, 2019 – FY19 Small Ambulatory Program
- www.ihs.gov/newsroom/triballeaderletter/

**Portland Area IHS FY 2022 Budget Formulation Meeting**

- Thursday, November 14, 2019
- Embassy Suites Portland Airport
- **Tribal Representatives for Portland**
  - Andrew Joseph, The Confederated Tribes of the Colville Reservation
  - Steve Kutz, Cowlitz Indian Tribe
- **Technical Support Team**
  - CAPT Arnett, PAIHS, Executive Officer
  - Nichole Swanberg, PAIHS, Director, Division of Financial Management
  - Joe Finkbonner, NPAIHB, Executive Director
  - Laura Platero, NPAIHB, Policy Analyst

**FY18 Catastrophic Health Emergency Fund**

- **Status as of June 25, 2019**
  - 79 total cases
  - 53 amendments
  - $3,277,045.00 in reimbursements
  - $66,291.49 pending reimbursements
  - 98% Reimbursed
  - **FY18 CHEF Balance: $ 582,067.00**

# *Summary of Minutes*

**FY19 Catastrophic Health Emergency Fund**

- **Status as of June 25, 2019**
  - 21 total cases
  - 2 amendments
  - $547,964.00 in reimbursements
  - $35,765.82 pending reimbursement
  - 93% reimbursed to date

**CHEF Online Tool**

- Fully automated paperless process for identifying, documenting and submitting CHEF cases for reimbursement.
- Implemented for Federal PRC Programs on May 1, 2019
- Tribal programs have the option to opt-in/opt-out
- Area Office is currently onboarding interested Tribal sites. If your site is interested, please contact:
  - Peggy Ollgaard, Director, Division of Business Operations
  - (503) 414-5598
  - Peggy.Ollgaard@ihs.gov

**<u>Office of Environmental Health & Engineering (OEH&E)</u>**

**Staffing Highlights:**

- CAPT Marcus Martinez, P.E., OEH&E Director Effective August 1.
- Jeffrey Esteban is an Environmental Engineer for the Olympic District Office, Effective June 23.
- Samantha Handrock Transferred to Yakama Field Office June 9. She is the New

Environmental Engineer.
- Scotty Riddle is the New Project Accountant for OEHE, Effective April 14.

**Transitions in Division of Sanitation Facilities Construction (SFC):**

CAPT Mathew J. Martinson, SFC Director transferred to EPA
- Served as the Director, Division of Sanitation Facilities Construction for Over 6½ Years.
- As of July 1, Branch Chief at EPA Region 10 in Seattle, Overseeing Drinking Water, Infrastructure and Clean Water Act Permitting.

CDR Craig Haugland, P.E., will Serve as Acting Director Until the Position is Filled on a Permanent Basis.
- Project Engineer from the Port Angeles Field Office.
- 30-years Engineering and Project Management Experience

**Office of Environmental Health & Engineering (OEH&E)**

**Staffing Highlights (continued):**
- ***Acting Division Director for Sanitation Facilities Construction***
  - *CDR Craig Haugland, P.E., Acting Director, craig.haugland@ihs.gov*
- ***Spokane District and Fort Hall Field Office (Eastern Washington, Idaho)***
  - *CDR Steve Sauer, P.E., BCEE, District Engineer, steve.sauer@ihs.gov*
- ***Olympic District (Washington, West of the Cascade Mountains)***
  - *CDR Roger Hargrove, P.E., District Engineer, roger.hargrove@ihs.gov*
- ***Oregon District (Oregon Tribes + Yakama Field Office)***
  - *LT Derek Hancey, P.E., Supervisory Environmental Engineer, derek.hancey@ihs.gov*
- ***District Utility Consultant (Area-wide coverage)***
  - *CDR Ben Chadwick, P.E., District Engineer (Utility Consulting) - Arrives July 22nd*

# *Summary of Minutes*

**FY 19 Facilities Appropriation Update**

- Backlog of Essential Maintenance, Alteration, and Repair (BEMAR)
  - $1.7M is Reserved for Tribal Facilities
  - Only Previously Reported Facility Deficiencies Are Eligible
  - DHFE Sent Request for Additional Info to THD's on Tribal Priorities, Due June 28th
  - PAFAC Assist with Prioritization; Final Fund Allocation by End of the FY
- Small Ambulatory Program (SAP)
  - Applications Were Due June 28th
  - $2.0M Max Award
  - Timeline for Award Determination Not Yet Established, Applicants will be Notified
- Joint Venture Construction Program
  - New Announcement Under Consideration in Near Future, Nothing Official
  - If Interested, Focus on Getting Projects "Shovel Ready" (Site, Funding, Preliminary Design)

CMO Updates:

- Recent Special General Memos
  - SGM 19-01 Assuring Access to Medication Assisted Treatment for Opioid Use Disorder
  - SGM 19-02 Hepatitis C Universal Screening and Treatment
- Other
  - Circular 19-03 Wait Times for Primary Care Visits in IHS Direct Care Facilities

# *Summary of Minutes*

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|---|---|---|---|
| | Medical Epidemiologist Updates<br>❖ Immunizations<br>❖ State-led Tribal Immunization Summits<br>❖ Updates to RPMS<br>❖ Measles<br>❖ Highest number of cases in 1 year since measles declared eliminated in the US in 2000<br>❖ Recent outbreaks in WA, OR and 1st cases in ID in 20 yrs.<br>❖ No Tribal communities or facilities involved so far | | |
| **NPAIHB EXECUTIVE DIRECTOR REPORT, JOE FINKBONNER:** | ***Personnel***<br>**Interns & Temps:**<br>• Chandra Wilson (Klamath Modoc)<br>• Rowan Lutz (Lummi Nation)<br>• Josephine Lutz (Lummi Nation)<br>• Anna Feroglia (Lakota Sioux)<br>• Chiarra Bettega (Round valley Indian Tribes)<br><br>**Recognition:**<br>• **Dr. Tom Becker 20 Years ~ plaque will be given in October**<br><br>***Meetings***<br>**APRIL**<br>• PHAB Executive Committee Meeting, Washington, DC (4/24 – 4/26)<br>**MAY**<br>• 2019 Portland Area Dental Meeting, Portland, OR (4/15 – 4/16)<br>• ATNI, Spokane, WA (5/20 – 5/21) | | |

| | | | |
|---|---|---|---|
| | • Vacation<br>***Upcoming Meetings***<br>**AUGUST**<br>• Region 10 Opioid Summit, Vancouver, WA (8/6 – 8/9)<br>• Nike Native Fitness, Nike HQ (8/15 – 8/16)<br><br>**SEPTEMBER**<br>• NIHB National Tribal Health Conference, Temecula, CA (9/16 – 9/19)<br>• Arcora Foundation Board Retreat, Skamania, WA (9/19 – 9/21)<br>• Washington Governor's Centennial Accord, TBD (9/24 – 9/25)<br>• Dancing in the Square Downtown Portland, OR (9/27)<br><br>**OCTOBER**<br>• NPAIHB Staff Retreat, Sun River, OR (10/1 – 10/3)<br>• ATNI, Suquamish, WA (10/7 – 10/10)<br>• NPAIHB QBM, Pendleton, OR (10/22 – 10/24)<br><br>**HONORING of Andy Joseph, Jr. time as NPAIHB Chairman, blanket presented.** | | |
| **NATIONAL AND REGIONAL COMMITTEE UPDATES** | **National and Regional Committees**<br>• U.S. Department of Health and Human Services (HHS)<br>• Indian Health Service (IHS)<br>• Substance Abuse Mental Health Services Administration (SAMHSA)<br>• Centers for Disease Control and Prevention (CDC)<br>• Centers for Medicare and Medicaid Services (CMS)<br>• National Institutes of Health (NIH) | | |

# *Summary of Minutes*

**HHS Secretary's Tribal Advisory Committee (STAC)**

- Primary purpose of HHS Secretary's Tribal Advisory Committee (STAC) is to seek consensus, exchange views, share information, provide advice and/or recommendations; or facilitate any other interaction related to intergovernmental responsibilities or administration of HHS programs, including those that arise explicitly or implicitly under statute, regulation or Executive Order.
- Portland Area Representatives:
  - Ron Allen, Jamestown S'Klallam (Primary)
  - Gail Hatcher, Klamath (Alternate)
- Meetings:
  - Last meeting: HHS Updates May 7-11 in Scottsdale, Arizona
  - **Next meeting: September 12-13 in Washington, D.C.**

The last STAC meeting was hosted by Gila River in AZ May 7-11 in Scottsdale. Klamath Vice Chairwoman Gail Hatcher attended STAC meeting.

Deputy Secretary Hargan talked about recruiting issues in Indian country and the success of the CHAP program. He visited the program in Alaska.

- Councilwoman Hatcher let Secretary Hargan know about the CHAP work in our area and that HHS/IHS must find a way to work with areas that are ready for CHAP expansion.
- Secretary Hargan was also asked about Advance Appropriations for IHS. He said his hands are tied on it and that's up to Congress.
- Secretary Hargan was also asked about ACA litigation. He said that if courts determine that the ACA unconstitutional, and ICHIA impacted, he will reach out to tribes.

For CMS- Chris Traylor said that he CMS cannot provide a national AI/AN exemption on work requirements.

# *Summary of Minutes*

- STAC members also brought up the opposition to Medicaid block grants to him.
- He will take back tribes' comments about tribal sovereignty and opposition to block grants.
- [Unfortunately, Mr. Traylor left the administration at the end of May].

For IHS-RADM Weahkee provided an update on several items.

- Councilwoman Hatcher recommended that IHS work with Congress to change SDPI to allow tribal shares. He acknowledged that this recommendation is consistent with behavioral health recommendations.
- Councilwoman Hatcher also asked about FY 2021-2025 SDPI funding and requested budget changes related contractors hired by IHS for administration, evaluation and data support.
- He stated that he would take this back to Dr. Bullock.
- Tribes should be able to compete at the national level going out to vendors especially if TECs able to do the work.

The next STAC meeting will be held September 12-13, 2019 in Washington, D.C.

- There are national at large position openings on the STAC – 3 National at large delegate positions are open; and 1 alternate position. The deadline is July 26.

**IHS Tribal Leader Diabetes Committee (TLDC)**

- The IHS Director established the Tribal Leaders Diabetes Committee (TLDC) in 1998 to assist in developing a successful partnership between IHS and Tribal diabetes programs and in deciding the process for distribution of resources from the Balanced Budget Act of 1997 Special Diabetes Program for Indians (SDPI).
- Portland Area Representatives:
  - Cassandra Sellards-Reck, Cowlitz (Primary)
  - Sharon Stanphill, Cow Creek (Alternate)

# *Summary of Minutes*

- Conference calls-Third Wednesday of every month 1-2pm PST.
- Last meeting: June 18-19 in Billings, Montana.
- **Next meeting: August 7-9 in Oklahoma City, Oklahoma**

- Portland Area Representatives Cassie Sellerds-Reck and Sharon Stanphill attended the meeting and Sarah attended as the Technical Advisor.
- The TLDC developed questions to be submitted to IHS to recommend for inclusion in a Dear Tribal Leader Letter for consultation with tribes regarding the SDPI FY 2021-2015 grant cycle.
- We are handing out the questions.

**IHS Budget Formulation Workgroup**

- IHS organized the Budget Formulation Workgroup to assist the agency in formulating upcoming fiscal year budgets. Develops program priorities, policies, budget recommendations by ensuring active participation of tribal governments and tribal organizations in the formulation of the IHS budget request and annual performance plan.
- Portland Area Representatives:
  - Workgroup Co-Chair, Andy Joseph, Jr., Colville
  - Steve Kutz, Cowlitz Tribe
- FY 2021 National Budget Formulation Meeting:
  - Last national meeting: June 27-28 in Reno, Nevada
  - **Portland Area Meeting: November 14 in Portland, Oregon.**
  - **Next national meeting: February 13-14, 2020 in Washington, D.C.**

- National Tribal Budget Formulation Workgroup (NTBFW) met on June 27-28 in Reno, Nevada. Andy. was able to attend the meeting for Portland Area.

- Workgroup decided to request full funding now (not 12 year phased in funding).
  - An analysis will be conducted to determine what that amount is.
  - Workgroup would like to have a consistent message as to what full funding. We say IHS funded at half the level of need and also say full funding is at $37 billion. Workgroup decided that a consistent message is needed.
- Recommendation for FY 2022 will be based on NTBFW request for FY 2021, plus 30%.
- Portland Area Budget Formulation Meeting is November 14, 2019 in Portland, Oregon- location TBD.

**IHS PRC Workgroup**

- The charge of the IHS Director's Workgroup is to provide recommendations to the Director on strategies to improve the agency's PRC programs. Reviews input received to improve PRC program, evaluates the existing formula for distributing PRC funds, and recommends improvements in the way PRC operations are conducted within the IHS and Indian Health System.
- Portland Area Representatives:
  - Andy Joseph, Jr., Colville (Primary)
  - John Stephens, Swinomish (Alternate)
- Meetings:
  - Last meeting: May 16-17, 2019 in Phoenix, Arizona
  - **Next meeting: October 15-17 in Washington, D.C**

Recommendations from October PRC Workgroup:

- As to CHEF data- ORAP will provide an update on number of CHEF cases and reimbursements by Area to the group.
- As to Balance billing – IHS will reach out to the Office of CLAS and weigh in on the

issues of balance billing to include citations in the congressional bills being discussed currently that include PRC.

- There was a discussion on a no show policy for patients. IHS will look at the legality of paying for no shows or patients being financial responsible for no shows. Possible draft policy being considered, e.g., 3 no shows; escrow payments, extenuating circumstances such as travel. IHS may look at correlation between CHRs and no shows related to PRC.
- As to GAO, Workgroup to formally write a thank you to the GAO and invite the GAO to the next meeting if held in Rockville. All PRC issues were closed out with GAO.
- As to CHEF proposed rule, IHS will find a path forward to move the CHEF regulation forward.
- As to CHEF tool, IHS involved in ongoing maintenance of CHEF online tool.

Agenda items for next meeting:
Formula change- future PRC agenda item (CRIHB's proposal).
GAO
Other issues to be identified
Best practice on the workflow process of care coordination as done by the Rapid City.
Are there any issues that our Area representatives need to raise at the October PRC Workgroup meeting?

**IHS CSC Workgroup**

- The CSC Workgroup meets to further the federal government's administration of CSC within the IHS. The agency is in active participation with Tribes, has developed a comprehensive CSC policy to implement the statutory provisions of ISDA.
- Portland Area Representative:
  - Tribal Co-Chair, Andy Joseph, Jr., Colville

# *Summary of Minutes*

- Meetings:
  - Last meeting: April 23, 2018 12:00pm-1:30pm in Albuquerque, NM
  - **Next meeting: August or September 2019**

**IHS DSTAC**

- IHS Director established the Direct Service Tribes Advisory Committee (DSTAC) to address health service delivery issues and concerns important to direct service tribes. The work of the Committee is specifically aimed at the areas of trust, data and budget.
- Portland Area Representatives:
  - Janice Clements, Warm Springs (Primary)
  - Greg Abrahamson, Spokane (Alternate)
- Meetings:
  - Last meetings: May 29-30 in Rapid City, South Dakota
  - **Next meeting: July 29-31 in Albuquerque, New Mexico**

**IHS TSGAC**

- At the recommendation of self-governance tribes, representatives from the self-governance tribes and Indian Health Service staff developing guidelines for establishment of the Tribal Self-Governance Advisory Committee (TSGAC). Provides information, education, advocacy, and policy guidance for implementation of self-governance for implementation of self-governance within the Indian Health Service.
- Portland Area Representatives:
  - Ron Allen, Jamestown S'Klallam (Primary)
  - Tyson Johnston, Quinault (Alternate)

# *Summary of Minutes*

- Meetings:
  - Last meeting: April 24-25, 2019 in Washington D.C.
  - **TSGAC strategy session: September 10-11, 2019 in Washington, D.C.**
  - **Next meeting: July 17-18, 2019 in Washington, D.C.**

**IHS IHCIF Workgroup**

- Indian Health Care Improvement Fund (IHCIF) Workgroup was established in anticipation of a FY 2018 IHCIF appropriation to assess the impact of past allocations to address inequities, effects of the current health care environment, and make recommendations that will be sent out for tribal consultation.
- Portland Area Representatives:
  - Gail Hatcher, Klamath (Primary)
  - Steve Kutz, Cowlitz (Alternate)
- Meetings:
  - Last meeting: February 12-13, 2019 in Crystal City, VA.
  - **Next meeting: In person meetings completed; conference call(s) to be scheduled to review draft report.**

**IHS CHAP TAG**

- The Community Health Aide Program (CHAP) Tribal Advisory Group (TAG) will provide subject matter expertise, program information, innovative solutions, and advice to the Indian Health Service (IHS) to establish a national CHAP.
- Portland Area Representatives:
  - John Stephens, Swinomish (Primary)

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| | – Andy Joseph, Jr., Colville (Alternate)<br>• Meetings:<br>– Last meeting: April 3, 2019 at the Self Governance Conference in Acme, MI.<br>– **Next meeting: Summer, 2019**<br><br>**IHS NTAC**<br>• The National Tribal Advisory Committee (NTAC) on Behavioral Health acts as an advisory body to the Division of Behavioral Health and to the Director of the Indian Health Service, with the aim of providing guidance and recommendations on programmatic issues that affect the delivery of behavioral health care for American Indian and Alaska Natives.<br>• Portland Area Representatives:<br>– Cassandra Sellards Reck, Cowlitz (Primary)<br>– Cheryl Sanders, Lummi (Alternate)<br>• Last meeting: March 13-14, 2019 in Alpine, CA<br>• **Next meeting: August 27 or August 28, 2019 in Rockville, MD (proposed)**<br><br>**IHS FAAB**<br>• Facilities Advisory Appropriation Board (FAAB) is charged with evaluating existing facilities' policies, procedures, and guidelines for recommending changes, if necessary. Participates in the development and evaluation of any proposed new policies, procedures, and guidelines of facilities construction priorities.<br>• Portland Area Representatives:<br>– Tim Ballew, Lummi (Primary)<br>– Andy Joseph, Jr., Colville (Alternate)<br>• Meetings: | | |

# *Summary of Minutes*

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| | – Last meeting: March 19-20, 2019 in Rockville, MD; last call on April 10, 2019.<br>– **Next meeting: August 13-14 in Rockville, MD**<br><br>**CDC TAC**<br>• CDC Tribal Advisory Committee (TAC) advises CDC/ATSDR on policy issues and broad strategies that may significantly affect AI/AN communities. Assists CDC/ATSDR in fulfilling its mission to promote health and quality of life by preventing and controlling disease, injury, and disability through established and ongoing relationships and consultation sessions.<br>• Portland Area Representatives:<br>– Steve Kutz, Cowlitz (Primary)<br>– Cassandra Sellard-Recks, Cowlitz (Alternate)<br>• Meetings:<br>– Last meeting: February 4-5, 2019 in Atlanta, GA<br>– **Next meeting and Tribal Consultation: August 13-14, 2019 in Cherokee, NC**<br><br>**SAMHSA TTAC**<br>• SAMHSA formed the Tribal Technical Advisory Group (TTAC) in recognition of 2008 Presidential Executive Orders and Memorandum of Tribal Consultation to enhance the government-to-government relationship to honor the federal trust responsibility and obligations to tribes and AI/AN.<br>• Portland Area Representative:<br>– Jeremiah Julius, Lummi (primary)<br>– Nickolaus Lewis, Lummi (alternate)<br>• National At-Large Representative:<br>– Andrew Joseph, Jr., Colville | | |

# *Summary of Minutes*

- Meetings:
  - Last meeting: March 13-14, 2019 in Alpine, CA
  - **Next meeting-virtual: July 30-31 (3 hrs per day)**

**CMS TTAG**

- The CMS Tribal Technical Advisory Group (TTAG) serves as an advisory body to CMS. Provides expertise on policies, guidelines, and programmatic issues affecting the delivery of health care for AI/AN served by Titles XVIII, XIX, and XXI of the Social Security Act or any other health care program funded (in whole or in part) by CMS.
- Portland Area Representatives:
  - John Stephens, Swinomish (Primary)
  - Nickolaus Lewis, Lummi (Alternate)
- Meetings:
  - Last meeting: February 20-21 in Washington D.C.
  - Last conference call: April 10, 2019
  - **Next meeting: July 24-25, 2019 in Washington D.C.**

**MMPC**

- The Medicare, Medicaid and Health Reform Policy Committee (MMPC) is a standing committee of the National Indian Health Board. The committee is chaired by a member of the NIHB Board of Directors. The primary purpose of the MMPC is to provide technical support to the CMS TTAG.
- Membership in MMPC is open to individuals authorized to represent a tribe, tribal organization, urban Indian program, or IHS.
- Meetings:
  - Last meetings: February 19, 2019 in Washington D.C.
  - Last conference call: May 7, 2019

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| | – **Next meeting: July 23, 2019 in Washington D.C.**<br><br>**NIH TAC**<br>• The National Institutes of Health (NIH) Tribal Advisory Committee (TAC) is advisory to the NIH, and provides a forum for meetings between elected Tribal officials (or their designated representatives) and NIH officials to exchange views, share information, and seek advice concerning intergovernmental responsibilities related to the implementation and administration of NIH programs.<br>• Portland Area Representatives:<br>– Robyn Sigo, Suquamish (Primary)<br>– Jeromy Sylvan, Port Gamble S'Klallam (Alternate)<br>• Meetings<br>– Last meeting: March 21-22, 2019 in Bethesda, MD<br>– Consultation: June 24, 2019 in Reno, NV<br>– **Next meeting: August 19-23 2019 in Fairbanks, AK**<br><br>**Other Meetings**<br>• IHS Information Systems Advisory Committee (ISAC)<br>• IHS Catastrophic Health Emergency Fund (CHEF) Workgroup<br>• IHS Health Promotion/Disease Prevention Policy Advisory Committee (HP/DP)<br>• Portland Area Fund Distribution Workgroup (FDWG)<br>• Portland Area Facilities Advisory Committee (PAFAC) | | |
| **LEGISLATIVE UPDATE, LAURA PLATERO,** | **Report Overview**<br>1. Hot Topics<br>2. Legislation | | |

# *Summary of Minutes*

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| **GOVERNMENTAL AFFAIRS/POLICY DIRECTOR AND SARAH SULLIVIAN, HEALTH POLICY ANAYLST:** | 3. Future IHS Appropriations & Budget Formulation<br>4. New & Pending Federal Policies<br>5. Litigation<br>6. Upcoming National/Regional Meetings<br><br>**Hot Topics**<br>• *Texas v. United States* - Threat to the ACA/IHCIA<br>• House Appropriations for IHS and HHS<br>• SDPI Reauthorization and Funding<br>• Lower Health Care Costs/Surprise Billing<br>• CMS Work Requirements<br><br>**Legislation**<br>**FY 2020 Labor HHS Education Appropriations**<br>• On 6/19/19, House passed four-bill FY 2020 appropriations package (226 to 203)<br>– HHS: $99.4 billion (+$8.9 billion above FY 2019 enacted level)<br>• NIH: $41.1 billion (+2 billion)<br>• CDC: $8.3 billion (+$938 million)<br>• SAMHSA: $5.9 billion (+129 million)<br>• HRSA: $7.6 billion (+$485 million)<br>• CMS: $4 billion (+$315 million)<br>• ACF: $27.9 billion (+$4.7 billion)<br>• ACL: $2.3 billion (+$180 million)<br>• Office of the Secretary: $550 million (+$5 million) | | |

- Senate Bill Status: Not released; testimony submitted

**FY 2020 House Labor HHS Education Appropriations- Indian programs**

- CDC:
  - Good Health and Wellness in Indian Country- $21m (level)
- SAMHSA:
  - Tribal Opioid Response Grants-$50m (level)
  - Medication Assisted Treatment Grants for Tribes-$10m (level)
  - AI/AN Zero Suicide Program-$2.2m
  - AI/AN Suicide Prevention-$2.9m
- ACL:
  - Native American Nutrition and Supportive Services-$37.2m (+$3m)
  - Native American Caregiver Support Services-$12m (+$2m)
- HRSA
  - NHSC Loan Repayment Program to individuals who work for I/T/Us-$15m

**FY 2020 Interior IHS Appropriations Summary**

- National Tribal Budget Formulation Workgroup recommended over $7 billion for IHS for FY 2020 (36% increase over FY 2017 enacted level).
- President Released Budget on 3/11/19
  - $82.6m increase above FY 2019 for services and facilities (1.7%) or $115 m (2%) increase overall above 2019 enacted level
- House Bill Status:
  - On 6/25/19, House passed Interior appropriations bill (with 4 others).
    - $6.3 billion or $537m above FY 2019 enacted level
- Senate Bill Status: Not released; testimony submitted

# *Summary of Minutes*

**Other Directives in House Bill**

- 105(l) Leases:
  - Report required within 90 days on treatment of 105(l) leases like CSC and estimated costs in current and next fiscal year.
- Electronic Health Records (EHR):
  - Must provide notice at least 90 days before funds are obligated or expended by IHS; and directive to look at VA system.
- VA MOU:
  - Urges IHS to look at performance measures related to MOUs.
- Electronic Dental Records (EDR):
  - Directs IHS to include EDR in its assessment.

**Advanced Appropriations Bills for BIA/BIE/IHS and IHS only**

- **S. 229 & H.R. 1122 – Advanced Appropriations for BIA and BIE at DOI and IHS at HHS.**
  - Senate Bill introduced by Sen. Tom Udall (D-NM) on 1/25/19.
  - House Bill introduced by Rep. Betty McCollum (D-MN-4) on 2/8/19.
  - **Status**: Both referred to respective House and Senate Committees.
- **H.R. 1135 –Advanced Appropriations for IHS.**
  - House Bill introduced by Rep. Don Young (R-AK- At Large) on 2/8/19; referred to Committees.
  - Senate Bill anticipated to be introduced.
  - **Status**: In House Committees.

**Special Diabetes Program for Indians Reauthorization**
**SDPI expires September, 2019. Several bills to reauthorize:**

# *Summary of Minutes*

- **H.R. 2328- Community Health Investment, Modernization, and Excellence Act of** 2019 (Rep. Tom O'Halleran (D-AZ)-4 years at $150m)
  - **Status: 7/11/19- House E&C Health Markup**
- **H.R. 2668 – Special Diabetes Program Reauthorization Act of 2019** (Rep. Diana DeGette (D-CO)-5 years at $200m)
  - Status: 6/4/19- House E&C Health Subcommittee Hearing
- **H.R. 2680 – Special Diabetes Programs for Indians Reauthorization Act of 2019** (Rep. Tom O'Halleran (D-AZ)- 5 years at $200m)
  - Status: 6/4/19-House E&C Health Subcommittee Hearing
- **H.R. 2700 – Lowering Prescription Drug Costs and Extending Community Health Centers and Other Health Priorities Act** (Rep. Michael Burgess (R-TX)- 1 year extension at $150m)
  - Status: 6/26/19- In Committees
- **S. 192 - Community and Public Health Programs Extensions Act**) (Sen. Lamar Alexander (R-TN) – 5 years at $150m)
  - **Status: 1/18/19- In HELP Committee**
- **S. 1895- Lowering Health Care Costs** Act (Sen. Lamar Alexander (R-TN) – 5 years at $150m)
  - Status: 7/8/19- Placed on Senate Leg Calendar

**Indian Health Professions Bills**

- **H.R. 3340- Tribal Healthcare Careers Act**
  - Introduced by Jimmy Gomez (D-CA) on 6/19/19
  - Provides a set-aside of funds for Indian populations under the health profession opportunity grant program under Section 2008 of the Social Security Act.

- **Status**: Referred to Ways & Means

- **H.R. 3343- Technical Assistance for Health Grants Act**
  - Introduced by Daniel Kildee (D-MI) on 6/19/19
  - Provides for technical assistance under health profession opportunity grant program under section 2008 of Social Security Act.
  - **Status**: Referred to Ways & Means

**Other Indian Specific Health & DOI Bills**

- **Pay Our Doctors Act (H.R. 195)**
  - **Status**: In Committee
- **Native American Suicide Prevention Act of 2019 (S. 467 & H.R. 1191)**
  - **Status:** In House and Senate Committees
- **Assessment of the Indian Health Service Act (S. 498)**
  - **Status:** In Committee
- **Urban Indian Health Parity Act (S. 1180/H.R. 2316)**
  - **Status:** In House and Senate Committees
- **PROGRESS for Indian Tribes Act (S. 209 & H.R. 2031)**
  - **Status**: Passed Senate on 6/17/19; In House Committee

**Opioid Bills**

- **Comprehensive Addiction Resources Emergency Act of 2019 (CARE) (S. 1365 & H.R. 2569)**
  - Provides emergency assistance to states, territories**, tribal nations**, and local areas affected by the opioid epidemic, and financial assistance, for the development, organization, coordination and operation of more effective and efficient systems for the delivery of essential services to individuals with

substance use disorder and their families.
  - **S. 1365**- Introduced by Sen. Elizabeth Warren (D-MA) on 5/8/19.
    - **Status**: In HELP Committee
  - **H.R. 2569**- Introduced by Rep. Elijah Cummings (D-MD) on 5/8/19.
    - **Status**: 5/13/19-Referred to Indigenous Peoples of the United States Subcommittee (Natural Resources)
- **Examining Opioid Treatment Infrastructure Act of 2019 (H.R. 1303)**
  - **Status**: In Committee

**Other Health Bills**

- **Lower Health Care Costs Act (S. 1895)-**Sen. Alexander Lamar (R-TN)
  - Purpose is to lower health care costs, extend community health centers and SDPI
    - **Status:** 7/8/19: Placed on Senate Legislative Calendar
- **Aligning 42 CFR Part 2 with HIPAA**
  - **Protecting Jessica Grub's Legacy Act (S. 1012)**-Sen. Joe Manchin (D-WV)
    - **Status**: 4/3/19-In HELP Committee
  - **Overdose Prevention and Patient Safety Act (H.R. 2062)**-Rep. Earl Blumenauer (D-OR)
    - **Status**: 4/3/19-In E&C Committee
- **PrEP Assistance Program Act (H.R. 1643) & PrEP Coverage Access and Coverage Act (S. 1926)**
  - **Status:** In House and Senate Committees

**Veterans' Bills**

- **Tribal HUD-VASH Act of 2019 (S. 257)**

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| | – **Status**: 6/27/19-Passed Senate; Referred to House Committee on Financial Services<br>• **Veterans Improved Access and Care Act of 2019 (S. 450)**<br>– **Status**: 5/22/19-Senate VA Hearings<br>• **Department of Veterans Affairs Tribal Advisory Committee Act of 2019 (S. 524 & H.R. 2791)**<br>– **Status**: 5/22/19-Senate VA Hearings; 5/16/19-Referred to House Committee on VA Affairs<br>• **Commander John Scott Veterans Mental Health Improvement Act of 2019 (S. 785)**<br>– **Status**: 5/22/19-Senate VA Hearings<br>• **Tribal Veterans Health Care Enhancement Act (S. 1001)**<br>– **Status**: 5/22/19-Senate VA Hearings<br><br>**DV & Missing AI/AN Bills**<br>• **Violence Against Women's Act of 2019 (H.R. 1585)**<br>– **Status:** 4/4/19-Passed House; 4/10/19-Placed on Senate Legislative Calendar<br>• **Not Invisible Act (S. 982 & H.R. 2438)**<br>– **Status:** 6/19/19- SCIA; 5/10/19-Referred to Indigenous Peoples of the U.S. Subcommittee<br>• **Studying the Missing and Murdered Indian Crisis Act of 2019 (S. 336)**<br>– **Status:** 2/5/19- SCIA<br><br>**Future IHS Appropriations & Budget Formulation**<br>**FY 2021 IHS Budget Formulation**<br>• National Tribal Budget Formulation Workgroup met on March 14-15, 2019 in Washington D.C. and recommended full funding for IHS at $37.61 billion to be phased | | |

in over 12 years.

- For FY 2021, a total of $9.1 billion for IHS is requested. Includes:
  - $257 m for full funding of current services
  - $413 m for binding fiscal obligations
  - $2.7 b for program increases (46% above FY 2019 enacted level)
  - And more!
- Other recommendations for IHS:
  - Support preservation of Medicaid, IHCIA and Indian-specific provisions of the ACA.
  - Fund critical infrastructure investments (Health IT/HCFC)
  - Exempt Tribes from Sequestration
  - Support Advance Appropriations
  - Allow federally-operated health facilities and IHS headquarters to use federal dollars efficiently and adjust programmatic funds flexibly across accounts at the local level
  - Support funding of tribes outside of grants based system.
  - Permanently authorize SDPI and increase funding to $200 m per year plus annual inflationary increases.
  - Take a adequate steps to fully address 105(l) leasing obligations and work proactively with Congress to ensure its full payment as an indefinite appropriation.
- Available at: https://www.nihb.org/legislative/budget_formulation.php

**FY 2022 IHS Budget Formulation**

- National Tribal Budget Formulation Workgroup (NTBFW) met on June 27-28 in Reno, Nevada.

- Workgroup decided to request full funding now (not 12 year phased in funding).
  - An analysis will be conducted to determine what that amount is.
- Recommendation for FY 2022 will be based on NTBFW request for FY 2021, plus 30%.
- Portland Area Budget Formulation Meeting for FY 2022 is November 14, 2019 in Portland, Oregon- location TBD.

**New & Pending Federal Policies**
**Executive Orders**

- **Improving Price and Quality Transparency in American Health Care to Put Patients First**-Issued 6/24/19
  - Within 60 days, HHS Secretary must issue a proposal to require hospitals to post standard charge information
  - Within 90 days, Secretaries of HHS, Treasury and Labor to issue a proposal to require providers, issuers and plans to facilitate access to information that tells patients about expected out-of-pocket costs before they receive care
- **Evaluating and Improving the Utility of Federal Advisory Committees**
  - Directs agencies to terminate at least 1/3 of its current committees established under 9(a)(2) of FACA, including other committees.
  - Agencies must send OMB a list of all their advisory committees and recommendations on which ones to eliminate by August 1.
  - OMB has one month to take recommendations to President
  - **We understand that no tribal advisory committees will be impacted at IHS or HHS (per IHS leadership)**

**Pending Responses from HHS**

- **HHS Office of National Coordinator (ONC) 21st Century Cures Act and CMS**

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| | **Interoperability, Information Blocking and the ONC Health IT Certification Program**; issued 3/4/19; comments due 6/3/19; comments submitted<br>• **HHS Office of HIV/AIDS and Infectious Disease Policy STD Federal Action Plan;** issued 5/3/19; comments due 6/3/19; expected June, 2020<br>• **HHS RFI on National HIV/AIDS Strategy and National Viral Hepatitis Action Plan**; issued 2/8/19; comments submitted; expected June, 2020<br>• **HHS Pain Management Best Practices Inter-Agency Task Force Draft Report on Pain Management Best Practices**; issued 12/31/18<br>• **HHS Tribal Consultation Policy**; DTLL 10/22/18; comments submitted<br>• **HHS Draft Strategy to Reduce Regulatory and Administrative Burden of Health IT and EHRs**; comments submitted<br>• **Disbanding of the OMH AI/AN Health Resource Advisory Committee (HRAC)**<br><br>**CMS Nondiscrimination in Health and Health Education Programs or Activities**<br>• Issued: 6/14/19; comments due 8/13/19<br>• In May 2016, OCR HHS published a final rule (2016 Rule) that sought to codify nondiscrimination requirements and set forth new standards for implementing Section 1557 of the Affordable Care Act (ACA), particularly with respect to the prohibition of discrimination on the basis of sex.<br>• HHS interpreted that Congress did not intend for Section 1557 of the ACA to prohibit discrimination based on gender identity and termination of pregnancy.<br>• Senate Health Committee ranking Democrat Patty Murray (WA) and 30 Democratic Senate colleagues are demanding HHS withdraw its recent proposed rule that scales back the protections under Section 1557.<br>• The Senators want HHS to explain its reasoning for removing protections for transgender individuals, women who have terminated pregnancy and people with | | |

limited English proficiency by July 18th.

**Pending Responses and/or Ongoing Issues with CMS**

- **CMS Medicaid and CHIP Managed Care Proposed Rule** - comments submitted 1/28/19.
- **CMS Work Requirements**
- **CMS Four Walls Limitation- FAQs**
- **CMS Decision on Appeal of Washington DHAT SPA**

**National Institutes of Health**

- Tribal consultation on three initiatives:
  - Tribal Consultation on NIH Intellectual Property Rights in Biomedical Research; comments due 8/22/19.
  - Request for Comments on NIH Draft Policy on Data Sharing Management; DTLL 4/17/19; comments due 8/22/19.
  - Tribal Consultation and Listening Session on the All of Us Research Program; comments/testimony due 8/31/19.
    - Feedback received through the tribal consultation and other public engagement efforts will result in a plan for working with Tribal Nations.
    - More info available at: https://allofus.nih.gov/about/all-us-tribal-engagement

**Recent IHS DTLLs**

- **Invitation to Provide Updated Facility Master Plans and/or Identified Health Care Facility Needs to Local IHS Area Facilities Program Director for Possible Inclusion in the 2021 IHS and Tribal Health Care Facilities Needs Assessment Report to Congress**;

# *Summary of Minutes*

DTLL 7/5/19; data due on 12/31/19

- **Update on New Appointments and Updates to the Indian Health Service Senior Leadership Team**; DTLL 7/3/19
- **Initiation of Tribal Consultation and Urban Confer on Developing IHS Opioid Grant Program to Distribute the FY 2019 Opioid Funding**; DTLL 7/5/19; comments due 8/1/19
    - Related to $10m for Special Behavioral Health Program for Indians FY 2019 appropriation
- **Update on Sanitation Deficiency System-A Guide for Reporting Sanitation Deficiencies for AI/AN Homes and Communities;** DTLL 5/24/19.
    - IHS Facilities Appropriations Advisory Board reviewed comments and provided recommendations
- **Results of Tribal Consultation on the Indian Health Manual Part 2, Chapter 3-PRC**; DTLL on 5/15/19.
    - PRC Workgroup was advised of changes

**Pending IHS Responses**

- **Tribal Consultation on Community Health Aide Program Interim Policy**; DTLL on 5/8/19; comments due 7/8/19; comments submitted.
    - IHS Community Health Aide Program (CHAP) Workgroup to review comments
- **Tribal Consultation on Long and Short Term Options for Meeting ISDEAA 105(l) Requirements**; DTLL on 3/12/19; comments submitted.
    - IHS technical workgroup trying to determine costs
- **Update on the Mechanism to Distribute Behavioral Health Initiative Funding**; DTLL on 12/11/18; comments submitted.
    - IHS National Tribal Advisory Committee (IHS NTAC) provided a

recommendation to RADM Weahkee.

- **Contract Support Costs – Indian Health Manual, Chapter 3 CSC**, rescission of 97/3 split language; DTLL 4/13/18; comments submitted.
  - CSC Workgroup Tribal Chairman, Andy Joseph, Jr., requested an update; IHS close to finalizing a decision & meeting in Aug/Sept

**HRSA UPDATES**

- HRSA Shortage Designation Modernization Project (SDMP) will update existing Auto-HPSA designation scores in August 2019 through an online portal.
- New Auto-HPSA scores will be applicable to the 2020 National Health Service Corp application cycle.
  - Clinics will be able to update their HPSA score in the online portal after the national rollout.
  - Clinics should collect and submit facility-specific data and supplemental data to increase scores in replacement of the ACS data.
  - HRSA and IHS are working to identify data sources to assist in increasing scores for I/T/Us prior to national rollout.
- June 25 Webinar: Auto-HPSA Portal Training for I/T/Us.
  - Webinar recordings available at: https://bhw.hrsa.gov/sdmp
- Apply for the NHSC Rural Community Loan Repayment Program Grant Application through July 18

**VA Updates**

- VA DTLL: Requests comments on implementation of VA MISSION Act; DTLL on 4/16/19; Comments submitted 6/10/19.
- VA and White House launched a Veteran Suicide Prevention Task Force to create a

roadmap to empower veterans and end the national tragedy of suicide (PREVENTS Executive Order)
  - Inclusion of a community integration and collaboration proposal, a national research strategy and an implementation strategy.
- VA extends Agent Orange presumption to Blue Water Navy Veterans who served offshore of the Republic of Vietnam between 1962 and 1975 to be eligible for disability compensation benefits.

**Litigation**

***Texas v. United States*** **-** Challenge to Affordable Care Act

- On December 14, 2018, Judge Reed O'Conner (USDC ND Texas) held:
  - That the individual mandate enacted as part of the ACA is unconstitutional because it cannot be justified under Congress' taxing power (Congress reduced tax penalty to $0).
  - The entire ACA must be invalidated because the individual mandate is not severable and essential to the ACA's operation.
- If ACA struck down, ICHIA would also be struck down.
- Appealed to USCA for the Fifth Circuit.
- 483 tribes and tribal organizations (including NPAIHB) joined an amicus brief.
- On March 25, 2019, a coalition of states intervened in the case in order to defend the ACA while Department of Justice filed a two-sentence letter with the court announcing that the U.S. had changed its position in the litigation.
- On July 9, 2019, a three-panel judge in the Fifth Circuit heard oral arguments.
- Ruling expected in the coming months.

***Brackeen v. Bernhardt*** **-** Challenge to ICWA

- On 10/5/18, Judge Reed O'Conner (USDC ND Texas) ruled that ICWA is unconstitutional in Brackeen v. Zinke.
- Found that *Morton v. Mancari* rule does not apply because ICWA extends to Indians who are not members of tribes.
- ICWA struck down in violation of equal protection.
- Appealed to USCA for the Fifth Circuit and now titled, *Brackeen v. Bernhardt*.
- Many tribes and tribal organizations (including NPAIHB) joined the amicus brief.
- On March 13, 2019, oral argument occurred before a panel of 3 judges.
- Decision pending in Fifth Circuit

**Opioid Litigation**

- All federal court lawsuits have been combined in multi-district litigation under Federal District Judge Dan A. Polster (USDC-ND Ohio)
- Over 100 tribes and tribal organizations joined 1,000 state and local governmental plaintiffs in the litigation.
- Tribal Amicus Brief: 448 tribes and tribal organizations signed on and provided statements of interest (NPAIHB, ATNI, NCAI, and NIHB).
- **Status**:
  - Two Tribal Cases selected as bellweather cases ---Muscokee (Creek) Nation and Blackfeet Tribe.
  - On June 13, 2019, Judge Polsner issued a Motion Opinion and Order ruling on the Motions to Dismiss.
  - The Order adopts most of the recommendations by Magistrate David Ruiz recommending to the court that the Motions to Dismiss be denied with respect to the vast majority of tribes' claims.
  - In the multidistrict litigation, plaintiffs continue to pursue a settlement.

# *Summary of Minutes*

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| | **Upcoming National/Regional Meetings**<br>**July-September 2019**<br>• TSGAC Quarterly Meeting, July 16-19, Washington, D.C<br>• MMPC/TTAG Meeting, July 23-25, Washington, D.C.<br>• 16th Annual DSTAC Meeting, July 30-31, Albuquerque, NM<br>• Region X Opioid Summit, August 6-9, Vancouver, WA<br>• 2019 Diabetes in Indian Country Conference, August 6-9, Oklahoma City, OK<br>• Center for State, Tribal, Local and Territorial Support (CSTLTS), CDC/ATSDR Tribal Advisory Committee (TAC) Meeting and 19th Biannual Tribal Consultation; August 13-14, Cherokee, NC (Testimony Due: 7/19/19)<br>• NCAI Impact Days, September 10-11, Washington, D.C.<br>• TSGAC Strategy Session, September 10-11, Washington, D.C.<br>• HHS STAC Meeting, September 12-13, Washington, D.C.<br><br>**September-October 2019**<br>• NIHB National Tribal Health Conference, September 16-19, Temecula, CA<br>• IHS TSGAC Quarterly Meeting, October 2-3, Washington, D.C.<br>• ATNI Fall Convention, October 7-10, Suquamish<br>• PRC Workgroup Meeting, October 15-17, Washington, D.C.<br>• NCAI Annual Convention, October 20-25, Albuquerque, NM<br>• Quarterly Board Meeting, October, 21-24, Pendleton, OR | | |
| **RESOLUTIONS:**<br>Review joint resolutions, Laura Platero | • **#19-04-02 *A Call to Congress to Support Advance Appropriations for the Indian Health Service***<br>o Motion by Andrew Shogren, Suquamish Tribe, 2nd by Kim Thompson, Shoalwater Bay; **MOTION PASSES** | **MOTION** | **PASSED** |

# *Summary of Minutes*

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| | • **#19-04-03** ***Full Funding for Indian Health Service***<br>o Motion by Andrew Shogren, Suquamish Tribe, 2nd by Kim Thompson, Shoalwater Bay; **MOTION PASSES** | **MOTION** | **PASSED** |
| | • **#19-04-04** ***A Call to Congress to Support Mandatory Appropriations for the Indian Health Service***<br>o Motion by Andrew Shogren, Suquamish Tribe, 2nd by Kim Thompson, Shoalwater Bay; **MOTION PASSES** | **MOTION** | **PASSED** |
| | • **#19-04-05** ***A Call to Congress to Fully Fund Section 105(l) Indian Self-Determination and Education Assistance Act (ISDEAA) Lease Obligations to Tribes and Tribal Organizations***<br>o Motion by Jim Steinruck, Tulalip Tribe, 2nd by Andrew Shogren, Suquamish Tribe; **MOTION PASSES** | **MOTION** | **PASSED** |
| | • **#19-04-06** ***A Call to Congress to Enact Mandatory Appropriations in Support of the National Child Traumatic Stress Initiative***<br>o Motion by Patty Kinswa-Gaiser, Cowlitz Tribe, 2nd by Kim Thompson, Shoalwater Bay; **MOTION PASSES** | **MOTION** | **PASSED** |
| | • **#19-04-07** ***Support of Enacting Legislation to Ensure Medicaid Fulfills Federal Trust Responsibility to American Indians/Alaska Natives***<br>o Motion by Jim Steinruck, Tulalip Tribe, 2nd by Andrew Shogren, Suquamish Tribe; **MOTION PASSES** | **MOTION** | **PASSED** |
| | • **#19-04-08** ***Department of Health and Human Services Office of Minority Health American Indian/Alaska Native Health Research Advisory Committee***<br>o Motion by Patty Kinswa-Gaiser, Cowlitz Tribe, 2nd by Andrew Shogren, Suquamish Tribe**; MOTION PASSES** | **MOTION** | **PASSED** |
| | • **#19-04-09** ***Support for Increased Funding for the Special Behavioral Health Pilot Program and Option for Funding through Title I and Title V Funding Agreements*** | | |

# *Summary of Minutes*

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| | o Motion by Patty Kinswa-Gaiser, Cowlitz Tribe, 2nd by Andrew Shogren, Suquamish Tribe**; MOTION PASSES** | **MOTION** | **PASSED** |
| | • **#19-04-10** ***A Call to Indian Health Service to Move the Purchased/Referred Care (PRC) Dependent Factor in the PRC Funding Formula to the Annual Adjustment Category*** | **MOTION** | **PASSED** |
| | o Motion by Shawna Gavin, Confederated Tribes of Umatilla, 2nd by Kim Thompson, Shoalwater Bay; **MOTION PASSES** | | |
| | • **#19-04-11** ***Support for Legislation that Establishes a Department of Veterans' Affairs (VA) Tribal Advisory Committee (TAC)*** | **MOTION** | **PASSED** |
| | o Motion by Patty Kinswa-Gaiser, Cowlitz, 2nd by Shawna Gavin Confederated Tribes of Umatilla; **MOTION PASSES** | | |
| | • **#19-04-12** ***Support for Permanent Reauthorization of the Special Diabetes Program for Indians and Change to Indian Self-Determination Education Assistance Act (ISDEAA) to Support SDPI Funding through Title I and Title V Funding Agreements*** | **MOTION** | **PASSED** |
| | o Motion by Patty Kinswa-Gaiser, Cowlitz Tribe, 2nd by Kim Thompson, Shoalwater Bay; **MOTION PASSES** | | |
| | • **#19-04-13** ***Urging the Substance Abuse and Mental Health Service Administration (SAMHSA) to Remove Unnecessary Government Performance and Results Modernization Act Reporting Requirements for Opioid Treatment Services Provided by Tribes and Urging Congress to Increase Funding for these Services*** | **MOTION** | **PASSED** |
| | o Motion by Greg Abrahamson, Spokane Tribe, 2nd by Shawna Gavin, Confederated Tribes; **MOTION PASSES** | | |
| | **BOARD SPECIFIC RESOLUTIONS:** | | |
| | • **19-04-14** ***Support Funding from North Sound Accountable Communities of Health for DHAT Education and Training*** | **MOTION** | **PASSED** |

# *Summary of Minutes*

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| | o Motion by Greg Abrahamson, Spokane Tribe, 2nd by Tino Batt, Shoshone-Bannock Tribe; **MOTION PASSES**<br>• **19-04-15** ***Northwest Traditional Foods Policy Project***<br>o Motion by Patty Kinswa-Gaiser, Cowlitz Tribe; 2nd by Greg Abrahamson, Spokane Tribe; **MOTION PASSES**<br>• **19-04-16** ***Public Health Improvement and Training – Tribal Public Health Capacity Building and Quality Improvement Umbrella Cooperative Agreement – 2019 Supplements***<br>o Motion by Patty Kinswa-Gaiser, Cowlitz Tribe; 2nd by Shawna Gavin, Confederated Tribes of Umatilla; **MOTION PASSES** | **MOTION**<br><br>**MOTION** | **PASSED**<br><br>**PASSED** |
| **CHAIRMAN'S REPORT, ANDY JOSEPH** | It has been an honor to serve as the Chairman of the Northwest Portland Area Indian Health Board. I could not have imagined that this would be my last quarter on my tribe's council or as Chairman of the health board, at least for now. I'm glad that I did as much as I could this quarter to fight for our People.<br><br>After the last QBM, April 23-24, I attended the HHS Annual Tribal Budget Consultation for FY 2021 in Washington, D.C. and directed requests to HHS and agency leadership, and provided testimony. I was able to make many of the asks on our tribes' policy priority list.<br><br>On May 7, I testified to the Senate Committee on Indian Affairs for NIHB but also submitted testimony for our health board.<br><br>On May 13th, I travelled to Albuquerque to attend the NIHB Public Health Summit. On May 15th, I travelled to Phoenix, Arizona for the PRC Workgroup as the Portland Area representative. | | |

# *Summary of Minutes*

On May 20-23, I attended the ATNI Mid-Year Convention in Spokane, Washington. Two of our resolutions were passed that were able to move forward to NCAI: a resolution on the FY 2019 President's Budget for the Indian Health Service, and a resolution to treat ISDEAA 105(l) lease costs like CSC.

On June 11-13, I attended the NIHB Board meeting in Washington, D.C. Later in the month, June 24-27, I attended the NCAI Mid-Year Convention in Reno, Nevada. Our ISDEAA 105(l) lease resolution passed at NCAI. On June 27, I was also able to attend the National Tribal Budget Formulation Workgroup Meeting. I was pleased that the Workgroup has decided that we should ask for full funding for FY 2022, something I always supported, rather than 12-year phased in funding.

In thinking about my time as your Chair, I'm most proud of my contributions to:

- The Indian Health Care Improvement Act, which includes long term care for elders;
- HB 1564, Washington State Legislation that supports a Medicaid alternative rate for nursing and long term care facilities that will benefit my tribe's nursing home;
- Medical inflation rate included in the Contract Support Costs (CSC) formula, which brings more funds to all tribes;
- MOU with VA and IHS;
- Legislation that will create a VA Tribal Advisory Committee; and
- Tribal Behavioral Health Agenda and work on the SAMHSA TTAC.

Lastly, as Chair of the Healing Lodge of the Seventh Nations Board, my work on an encounter rate.

I hope to be back, or stay involved in some way, and hope you will all stay in touch. You will

# *Summary of Minutes*

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| | all be in my thoughts and prayers as you continue the fight for health care for our People. | | |
| **BUSINESS** | **FINANCE REPORT**, Eugene Motifi, Motion by Andrew Shogren, Suquamish, 2nd by Patty Kinswa-Gaiser; **MOTION PASSES**<br><br>**APPROVAL OF MINUTES**: Motion Shawna Gavin, Confederated Tribes of Umatilla, 2nd Andrew Shogren, Suquamish; **MOTION PASSES**<br><br>**Recess at 2:51 p.m.** | **MOTION**<br><br>**MOTION** | **PASSED**<br><br>**PASSED** |
| **NPAIHB & CRIHB JOINT MEETING WEDNESDAY, JULY 17, 2019** | | | |
| | | | |
| **NATIONAL INDIAN HEALTH BOARD (NIHB) UPDATE, STACY BOHLEN, NIHB EXECUTIVE DIRECTOR** | *Please see PowerPoint Presentation* | | |
| **INDIAN HEALTH SERVICES (IHS) UPDATE, DEAN SEYLER, PORTLAND AREA IHS DIRECTOR AND BEVERLY MILLER, CALIFORNIA AREA IHS DIRECTOR:** | *Please see PowerPoint Presentation* | | |

# *Summary of Minutes*

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| **RESOLUTIONS:**<br>NPAIHB, Laura Platero and CRIHB, Mark LeBeau | • #19-04-02/#334-08-19 A Call to Congress to Support Advance Appropriations for the Indian Health Service<br>• #19-04-03/#335-08-19 Full Funding for Indian Health Service<br>• #19-04-04/#336-08-19 A Call to Congress to Support Mandatory Appropriations for the Indian Health Service<br>• #19-04-05/#337-08-19 A Call to Congress to Fully Fund Section 105(l) Indian Self-Determination and Education Assistance Act (ISDEAA) Lease Obligations to Tribes and Tribal Organizations<br>• #19-04-06/#338-08-19 A Call to Congress to Enact Mandatory Appropriations in Support of the National Child Traumatic Stress Initiative<br>• #19-04-07/#339-08-19 Support of Enacting Legislation to Ensure Medicaid Fulfills Federal Trust Responsibility to American Indians/Alaska Natives<br>• #19-04-08/340-08-19 Department of Health and Human Services Office of Minority Health American Indian/Alaska Native Health Research Advisory Committee<br>• #19-04-09/#341-08-19 Support for Increased Funding for the Special Behavioral Health Pilot Program and Option for Funding through Title I and Title V Funding Agreements<br>• #19-04-10/#342-08-19 A Call to Indian Health Service to Move the Purchased/Referred Care (PRC) Dependent Factor in the PRC Funding Formula to the Annual Adjustment Category<br>• #19-04-11/#343-08-19 Support for Legislation that Establishes a Department of Veterans' Affairs (VA) Tribal Advisory Committee (TAC)<br>• #19-04-12/#344-08-19 Support for Permanent Reauthorization of the Special Diabetes Program for Indians and Change to Indian Self-Determination Education Assistance Act (ISDEAA) to Support SDPI Funding through Title I and Title V Funding Agreements<br>• #19-04-13/345-08-19 Urging the Substance Abuse and Mental Health Service Administration (SAMHSA) to Remove Unnecessary Government Performance and | | |

# *Summary of Minutes*

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| | Results Modernization Act Reporting Requirements for Opioid Treatment Services Provided by Tribes and Urging Congress to Increase Funding for these Services<br><br>**NPAIHB:** Motion to pass resolutions as group; Motion by Andrew Shogren, Suquamish Tribe,2nd by Shawna Gavin, Confederated Tribes of Umatilla; **MOTION PASSES**<br><br>**CRIHB**: Motion by Archie Super, Karuk Tribe, 2nd by Trinidad Krystall, Torres-Martinez Desert Cahuilla Indians, 1 No, 2 abstain; **MOTION PASSES** | **MOTION**<br><br>**MOTION** | **PASSED**<br><br>**PASSED** |
| **EPICENTER**<br>**DIRECTOR UPDATE, VANESSCIA CRESCI, MSW, MPA, ACTING EPIDEMIOLOGY MANAGER, CALIFORNIA TRIBAL EPIDEMIOLOGY CENTER, DIRECTOR, RESEARCH & PUBLIC HEALTH DEPARTMENT, CALIFORNIA RURAL INDIAN HEALTH BOARD, INC. AND VICTORIA WARREN-MEARS, PHD, RDN,** | *Please see PowerPoint Presentation* | | |

# *Summary of Minutes*

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| **FAND, DIRECTOR, NORTHWEST TRIBAL EPIDEMIOLOGY CENTER, NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD:** | | | |
| **CRIHB TELEHEALTH & WORKFORCE DEVELOPMENT INITIATIVES - HEALTH SYSTEMS DEVELOPMENT DEPARTMENT, DR. THOMAS KIM:** | *Please see PowerPoint Presentation* | | |
| **VA OFFICE OF TRIBAL GOVERNMENT RELATIONS, TERRY BENTLEY, TRIBAL GOVERNMENT RELATIONS SPECIALIST AND KARA HAWTHORNE, PROGRAM MANAGER, VA** | *Please see PowerPoint Presentation* | | |

# *Summary of Minutes*

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|---|---|---|---|
| **IHS/THP REIMBURSEMENT AGREEMENT PROGRAM:** | | | |
| **TRIBAL COMMUNITY HEALTH PROVIDER AND COMMUNITY HEALTH AIDE PROGRAM PROJECTS, CHRISTINA PETERS, TCHPP DIRECTOR AND SUE STEWARD, CHAPP DIRECTOR** | *Please see PowerPoint Presentation* | | |
| **LISTENING SESSION ON TRIBAL PUBLIC HEALTH ACCREDITATION, KAYE BENDER, PHAB PRESIDENT/CEO:** | *Please see PowerPoint Presentation* | | |
| | | | |
| **JOINT NPAIHB & CRIHB THURSDAY JULY 18, 2019** | | | |
| **LEGISLATIVE** | *Please see PowerPoint Presentation* | | |

# *Summary of Minutes*

| | | | |
|---|---|---|---|
| **UPDATE, GEOFF STROMMER, PARTNER HOBBS STRAUS DEAN & WALKER, LLP:** | | | |
| **SWINOMISH DIDGʷÁLIČ WELLNESS CENTER, JOHN STEPHENS, EXECUTIVE DIRECTOR:** | *Please see PowerPoint Presentation* | | |
| **TACKLING THE OPIOID EPIDEMIC IN CALIFORNIA INDIAN COUNTRY, VANESSCIA CRESCI, MSW, MPA ACTING EPIDEMIOLOGY MANAGER, CALIFORNIA TRIBAL EPIDEMIOLOGY CENTER DIRECTOR, RESEARCH AND PUBLIC HEALTH DEPARTMENT: PROJECT ECHO,** | *Please see PowerPoint Presentation* | | |

# *Summary of Minutes*

| | | | |
|---|---|---|---|
| **JESSICA LESTON, HIV/HCV/STI CLINICAL SERVICES DIRECTOR:** | | | |
| **ROBIN THUNDERSHIELD, CALIFORNIA NATIVE VOTE PROJECT** | *Variable Presentation* | | |
| **YOUTH GROUP – PRESENTATIONS** | *Please see PowerPoint Presentation* | | |
| **NATIVE CENSUS UPDATE AND VIDEO BY LINDSAY MCCOVEY, US CENSUS TRIBAL PARTNERSHIP SPECIALIST AND SHANA RADFORD, US CENSUS TRIBAL PARTNERSHIP SPECIALIST** | *Please see PowerPoint Presentation* | | |
| | **CLOSING REMARKS**: by Greg Abrahamson, NPAIHB Secretary and Spokane Tribe, Joe Finkbonner, NPAIHB Executive Director, Mark LeBeau, CRIHB Executive Director, and Lisa Elgin, CRIHB Chairwoman and Board member of Sonoma County Indian Health Project<br><br>**MOTION TO ADJOURN**: Patty Kinswa-Gaiser, Cowlitz Tribe, 2nd by Andrea ---; | **MOTION** | |

# *Summary of Minutes*

| | | | |
|---|---|---|---|
| | Vickie closing prayer<br>**ADJOURN at 2:30 p.m.** | | **ADJOURN** |

# *QUARTERLY BOARD MEETING*

**The Northwest Portland Area Indian Health Board**
**Thunder Valley Resort, Lincoln, CA**

**July 15 – 18, 2019**
**MINUTES**

## TUESDAY JULY 16, 2019

**Call to Order:** at 9:10 am by Andy Joseph, Chairman

**Invocation:** Janice Clements

**Roll Call:** Shawna Gavin, Secretary, called roll:

| | |
|---|---|
| Burns Paiute Tribe – **Present** | Nisqually Tribe – **Absent** |
| Chehalis Tribe – **Absent** | Nooksack Tribe – **Absent** |
| Coeur d'Alene Tribe – **Absent** | NW Band of Shoshone – **Present** |
| Colville Tribe – **Present** | Port Gamble Tribe – **Present** |
| Grand Ronde Tribe – **Present** | Puyallup Tribe – **Absent** |
| Siletz Tribe – **Present** | Quileute Tribe – **Present** |
| Umatilla Tribe – **Present** | Quinault Nation – **Present** |
| Warm Springs Tribe – **Present** | Samish Nation – **Absent** |
| Coos, Lower Umpqua & Siuslaw Tribes – **Present** | Sauk Suiattle Tribe – **Present** |
| Coquille Tribe – **Present** | Shoalwater Bay Tribe – **Present** |
| Cow Creek Tribe – **Present** | Shoshone-Bannock Tribe – **Present** |
| Cowlitz Tribe – **Present** | Skokomish Tribe – **Absent** |
| Hoh Tribe – **Absent** | Snoqualmie Tribe – **Absent** |
| Jamestown S'Klallam Tribe – **Absent** | Spokane Tribe – **Present** |
| Kalispel Tribe – **Present** | Squaxin Island Tribe – **Absent** |
| Klamath Tribe – **Present** | Stillaguamish Tribe – **Absent** |
| Kootenai Tribe – **Absent** | Suquamish Tribe – **Present** |
| Lower Elwha Tribe – **Absent** | Swinomish Tribe – **Present** |
| Lummi Nation – **Present** | Tulalip Tribe – **Present** |
| Makah Tribe – **Present** | Upper Skagit Tribe – **Absent** |
| Muckleshoot Tribe – **Absent** | Yakama Nation – **Absent** |
| Nez Perce Tribe – **Present** | |

There were 26 delegates present, a quorum is established.

## PORTLAND IHS AREA DIRECTOR REPORT DEAN SEYLER:

**Portland Area P.L. 93-638 ISDEAA Orientation**

- July 23 – 24
- 8:00AM to 4:30PM
- Embassy Suites by Portland Airport
- Questions? Call Rena Macy (503) 414-7792 or e-mail at rena.macy@ihs.gov

**Area Staff Changes**

- CAPT Thomas Weiser, MD – Acting CMO
- CAPT Marcus Martinez, Director, Office of Environmental Health and Engineering
- Ashley Tuomi – Director, Office of Clinical Support
- CDR Roney Won – Acting Area Diabetes Consultant
- Currently Advertising for:
  - Area Chief Medical Officer
  - CEOs at Wellpinit and Warm Springs Service Units
  - Clinical Directors at Ft. Hall and Warm Springs Service Units
  - Area Diabetes Consultant

**Tribal Leader Letters**

- July 5, 2019 – Tribal Leaders invited to provide updates to Facilities Master Plan
- July 3, 2019 – New appointments and updates to the IHS senior leadership team.
- June 21, 2019 – Consultation and Confer session on the Opioid Grant Program
- June 7, 2019 – Deadline extended on CHAP comment period
- May 24, 2019 – Update on IHS Sanitation Deficiency System
- May 15, 2019 – PRC Tribal Consultation results
- May 8, 2019 – Initiate Tribal Consultation on draft CHAP Policy
- April 23, 2019 – FY19 Small Ambulatory Program
- www.ihs.gov/newsroom/triballeaderletter/

**Portland Area IHS FY 2022 Budget Formulation Meeting**

- Thursday, November 14, 2019
- Embassy Suites Portland Airport
- **Tribal Representatives for Portland**
  - Andrew Joseph, The Confederated Tribes of the Colville Reservation
  - Steve Kutz, Cowlitz Indian Tribe
- **Technical Support Team**
  - CAPT Arnett, PAIHS, Executive Officer
  - Nichole Swanberg, PAIHS, Director, Division of Financial Management
  - Joe Finkbonner, NPAIHB, Executive Director

- Laura Platero, NPAIHB, Policy Analyst

**FY18 Catastrophic Health Emergency Fund**

- **Status as of June 25, 2019**
  - 79 total cases
  - 53 amendments
  - $3,277,045.00 in reimbursements
  - $66,291.49 pending reimbursements
  - 98% Reimbursed
  - **FY18 CHEF Balance: $ 582,067.00**

**FY19 Catastrophic Health Emergency Fund**

- **Status as of June 25, 2019**
  - 21 total cases
  - 2 amendments
  - $547,964.00 in reimbursements
  - $35,765.82 pending reimbursement
  - 93% reimbursed to date

**CHEF Online Tool**

- Fully automated paperless process for identifying, documenting and submitting CHEF cases for reimbursement.
- Implemented for Federal PRC Programs on May 1, 2019
- Tribal programs have the option to opt-in/opt-out
- Area Office is currently onboarding interested Tribal sites. If your site is interested, please contact:
  - Peggy Ollgaard, Director, Division of Business Operations
  - (503) 414-5598
  - Peggy.Ollgaard@ihs.gov

**Office of Environmental Health & Engineering (OEH&E)**

**Staffing Highlights:**

- CAPT Marcus Martinez, P.E., OEH&E Director Effective August 1.
- Jeffrey Esteban is an Environmental Engineer for the Olympic District Office, Effective June 23.
- Samantha Handrock Transferred to Yakama Field Office June 9. She is the New Environmental Engineer.
- Scotty Riddle is the New Project Accountant for OEHE, Effective April 14.

**Transitions in Division of Sanitation Facilities Construction (SFC):**

CAPT Mathew J. Martinson, SFC Director transferred to EPA

- Served as the Director, Division of Sanitation Facilities Construction for Over 6½ Years.
- As of July 1, Branch Chief at EPA Region 10 in Seattle, Overseeing Drinking Water, Infrastructure and Clean Water Act Permitting.

CDR Craig Haugland, P.E., will Serve as Acting Director Until the Position is Filled on a Permanent Basis.

- Project Engineer from the Port Angeles Field Office.
- 30-years Engineering and Project Management Experience

**Office of Environmental Health & Engineering (OEH&E)**

**Staffing Highlights (continued):**

- ***Acting Division Director for Sanitation Facilities Construction***
  - *CDR Craig Haugland, P.E., Acting Director, craig.haugland@ihs.gov*
- ***Spokane District and Fort Hall Field Office (Eastern Washington, Idaho)***
  - *CDR Steve Sauer, P.E., BCEE, District Engineer, steve.sauer@ihs.gov*
- ***Olympic District (Washington, West of the Cascade Mountains)***
  - *CDR Roger Hargrove, P.E., District Engineer, roger.hargrove@ihs.gov*
- ***Oregon District (Oregon Tribes + Yakama Field Office)***
  - *LT Derek Hancey, P.E., Supervisory Environmental Engineer, derek.hancey@ihs.gov*
- ***District Utility Consultant (Area-wide coverage)***
  - *CDR Ben Chadwick, P.E., District Engineer (Utility Consulting) - Arrives July 22nd*

**FY 19 Facilities Appropriation Update**

- Backlog of Essential Maintenance, Alteration, and Repair (BEMAR)
  - $1.7M is Reserved for Tribal Facilities
  - Only Previously Reported Facility Deficiencies Are Eligible
  - DHFE Sent Request for Additional Info to THD's on Tribal Priorities, Due June 28th
  - PAFAC Assist with Prioritization; Final Fund Allocation by End of the FY
- Small Ambulatory Program (SAP)
  - Applications Were Due June 28th
  - $2.0M Max Award
  - Timeline for Award Determination Not Yet Established, Applicants will be Notified
- Joint Venture Construction Program
  - New Announcement Under Consideration in Near Future, Nothing Official
  - If Interested, Focus on Getting Projects "Shovel Ready" (Site, Funding, Preliminary Design)

CMO Updates:

- Recent Special General Memos
  - SGM 19-01 Assuring Access to Medication Assisted Treatment for Opioid Use Disorder
  - SGM 19-02 Hepatitis C Universal Screening and Treatment
- Other
  - Circular 19-03 Wait Times for Primary Care Visits in IHS Direct Care Facilities

Medical Epidemiologist Updates

- Immunizations
  - State-led Tribal Immunization Summits
  - Updates to RPMS
- Measles
  - Highest number of cases in 1 year since measles declared eliminated in the US in 2000
  - Recent outbreaks in WA, OR and 1st cases in ID in 20 yrs.
  - No Tribal communities or facilities involved so far

## NPAIHB EXECUTIVE DIRECTOR REPORT, JOE FINKBONNER:

***Personnel***

**Interns & Temps:**

- Chandra Wilson (Klamath Modoc)
- Rowan Lutz (Lummi Nation)
- Josephine Lutz (Lummi Nation)
- Anna Feroglia (Lakota Sioux)
- Chiarra Bettega (Round valley Indian Tribes)

**Recognition:**

- **Dr. Tom Becker 20 Years ~ plaque will be given in October**

***Meetings***

**APRIL**

- PHAB Executive Committee Meeting, Washington, DC (4/24 – 4/26)

**MAY**

- 2019 Portland Area Dental Meeting, Portland, OR (4/15 – 4/16)
- ATNI, Spokane, WA (5/20 – 5/21)

- Vacation

***Upcoming Meetings***

**AUGUST**

- Region 10 Opioid Summit, Vancouver, WA (8/6 – 8/9)
- Nike Native Fitness, Nike HQ (8/15 – 8/16)

**SEPTEMBER**

- NIHB National Tribal Health Conference, Temecula, CA (9/16 – 9/19)
- Arcora Foundation Board Retreat, Skamania, WA (9/19 – 9/21)
- Washington Governor's Centennial Accord, TBD (9/24 – 9/25)
- Dancing in the Square Downtown Portland, OR (9/27)

**OCTOBER**

- NPAIHB Staff Retreat, Sun River, OR (10/1 – 10/3)
- ATNI, Suquamish, WA (10/7 – 10/10)
- NPAIHB QBM, Pendleton, OR (10/22 – 10/24)

HONORING of Andy Joseph, Jr. time as NPAIHB Chairman, blanket presented.

## NATIONAL AND REGIONAL COMMITTEE UPDATES

**National and Regional Committees**

- U.S. Department of Health and Human Services (HHS)
- Indian Health Service (IHS)
- Substance Abuse Mental Health Services Administration (SAMHSA)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare and Medicaid Services (CMS)
- National Institutes of Health (NIH)

**HHS Secretary's Tribal Advisory Committee (STAC)**

- Primary purpose of HHS Secretary's Tribal Advisory Committee (STAC) is to seek consensus, exchange views, share information, provide advice and/or recommendations; or facilitate any other interaction related to intergovernmental responsibilities or administration of HHS programs, including those that arise explicitly or implicitly under statute, regulation or Executive Order.
- Portland Area Representatives:
  - Ron Allen, Jamestown S'Klallam (Primary)
  - Gail Hatcher, Klamath (Alternate)
- Meetings:
  - Last meeting: HHS Updates May 7-11 in Scottsdale, Arizona
  - **Next meeting: September 12-13 in Washington, D.C.**

The last STAC meeting was hosted by Gila River in AZ May 7-11 in Scottsdale. Klamath Vice Chairwoman Gail Hatcher attended STAC meeting.
Deputy Secretary Hargan talked about recruiting issues in Indian country and the success of the CHAP program. He visited the program in Alaska.

- Councilwoman Hatcher let Secretary Hargan know about the CHAP work in our area and that HHS/IHS must find a way to work with areas that are ready for CHAP expansion.
- Secretary Hargan was also asked about Advance Appropriations for IHS. He said his hands are tied on it and that's up to Congress.
- Secretary Hargan was also asked about ACA litigation. He said that if courts determine that the ACA unconstitutional, and ICHIA impacted, he will reach out to tribes.

For CMS- Chris Traylor said that he CMS cannot provide a national AI/AN exemption on work requirements.

- STAC members also brought up the opposition to Medicaid block grants to him.
- He will take back tribes' comments about tribal sovereignty and opposition to block grants.
- [Unfortunately, Mr. Traylor left the administration at the end of May].

For IHS-RADM Weahkee provided an update on several items.

- Councilwoman Hatcher recommended that IHS work with Congress to change SDPI to allow tribal shares. He acknowledged that this recommendation is consistent with behavioral health recommendations.
- Councilwoman Hatcher also asked about FY 2021-2025 SDPI funding and requested budget changes related contractors hired by IHS for administration, evaluation and data support.
- He stated that he would take this back to Dr. Bullock.
- Tribes should be able to compete at the national level going out to vendors especially if TECs able to do the work.

The next STAC meeting will be held September 12-13, 2019 in Washington, D.C.

- There are national at large position openings on the STAC – 3 National at large delegate positions are open; and 1 alternate position. The deadline is July 26.

**IHS Tribal Leader Diabetes Committee (TLDC)**

- The IHS Director established the Tribal Leaders Diabetes Committee (TLDC) in 1998 to assist in developing a successful partnership between IHS and Tribal diabetes programs and in deciding the process for distribution of resources from the Balanced Budget Act of 1997 Special Diabetes Program for Indians (SDPI).
- Portland Area Representatives:
  - Cassandra Sellards-Reck, Cowlitz (Primary)
  - Sharon Stanphill, Cow Creek (Alternate)
    - Conference calls-Third Wednesday of every month 1-2pm PST.
    - Last meeting: June 18-19 in Billings, Montana.

- **Next meeting: August 7-9 in Oklahoma City, Oklahoma**

- Portland Area Representatives Cassie Sellerds-Reck and Sharon Stanphill attended the meeting and Sarah attended as the Technical Advisor.
- The TLDC developed questions to be submitted to IHS to recommend for inclusion in a Dear Tribal Leader Letter for consultation with tribes regarding the SDPI FY 2021-2015 grant cycle.
- We are handing out the questions.

**IHS Budget Formulation Workgroup**

- IHS organized the Budget Formulation Workgroup to assist the agency in formulating upcoming fiscal year budgets. Develops program priorities, policies, budget recommendations by ensuring active participation of tribal governments and tribal organizations in the formulation of the IHS budget request and annual performance plan.
- Portland Area Representatives:
  - Workgroup Co-Chair, Andy Joseph, Jr., Colville
  - Steve Kutz, Cowlitz Tribe
- FY 2021 National Budget Formulation Meeting:
  - Last national meeting: June 27-28 in Reno, Nevada
  - **Portland Area Meeting: November 14 in Portland, Oregon.**
  - **Next national meeting: February 13-14, 2020 in Washington, D.C.**

- National Tribal Budget Formulation Workgroup (NTBFW) met on June 27-28 in Reno, Nevada. Andy. was able to attend the meeting for Portland Area.
- Workgroup decided to request full funding now (not 12 year phased in funding).
  - An analysis will be conducted to determine what that amount is.
  - Workgroup would like to have a consistent message as to what full funding. We say IHS funded at half the level of need and also say full funding is at $37 billion. Workgroup decided that a consistent message is needed.
- Recommendation for FY 2022 will be based on NTBFW request for FY 2021, plus 30%.
- Portland Area Budget Formulation Meeting is November 14, 2019 in Portland, Oregon-location TBD.

**IHS PRC Workgroup**

- The charge of the IHS Director's Workgroup is to provide recommendations to the Director on strategies to improve the agency's PRC programs. Reviews input received to improve PRC program, evaluates the existing formula for distributing PRC funds, and recommends improvements in the way PRC operations are conducted within the IHS and Indian Health System.
- Portland Area Representatives:

  - Andy Joseph, Jr., Colville (Primary)
  - John Stephens, Swinomish (Alternate)
- Meetings:
  - Last meeting: May 16-17, 2019 in Phoenix, Arizona
  - **Next meeting: October 15-17 in Washington, D.C**

Recommendations from October PRC Workgroup:

- As to CHEF data- ORAP will provide an update on number of CHEF cases and reimbursements by Area to the group.
- As to Balance billing – IHS will reach out to the Office of CLAS and weigh in on the issues of balance billing to include citations in the congressional bills being discussed currently that include PRC.
- There was a discussion on a no show policy for patients. IHS will look at the legality of paying for no shows or patients being financial responsible for no shows. Possible draft policy being considered, e.g., 3 no shows; escrow payments, extenuating circumstances such as travel. IHS may look at correlation between CHRs and no shows related to PRC.
- As to GAO, Workgroup to formally write a thank you to the GAO and invite the GAO to the next meeting if held in Rockville. All PRC issues were closed out with GAO.
- As to CHEF proposed rule, IHS will find a path forward to move the CHEF regulation forward.
- As to CHEF tool, IHS involved in ongoing maintenance of CHEF online tool.

Agenda items for next meeting:
Formula change- future PRC agenda item (CRIHB's proposal).
GAO
Other issues to be identified
Best practice on the workflow process of care coordination as done by the Rapid City.
Are there any issues that our Area representatives need to raise at the October PRC Workgroup meeting?

**IHS CSC Workgroup**

- The CSC Workgroup meets to further the federal government's administration of CSC within the IHS. The agency is in active participation with Tribes, has developed a comprehensive CSC policy to implement the statutory provisions of ISDA.
- Portland Area Representative:
  - Tribal Co-Chair, Andy Joseph, Jr., Colville
- Meetings:
  - Last meeting: April 23, 2018 12:00pm-1:30pm in Albuquerque, NM
  - **Next meeting: August or September 2019**

**IHS DSTAC**

- IHS Director established the Direct Service Tribes Advisory Committee (DSTAC) to address health service delivery issues and concerns important to direct service tribes. The work of the Committee is specifically aimed at the areas of trust, data and budget.
- Portland Area Representatives:
  - Janice Clements, Warm Springs (Primary)
  - Greg Abrahamson, Spokane (Alternate)
- Meetings:
  - Last meetings: May 29-30 in Rapid City, South Dakota
  - **Next meeting: July 29-31 in Albuquerque, New Mexico**

**IHS TSGAC**

- At the recommendation of self-governance tribes, representatives from the self-governance tribes and Indian Health Service staff developing guidelines for establishment of the Tribal Self-Governance Advisory Committee (TSGAC). Provides information, education, advocacy, and policy guidance for implementation of self-governance for implementation of self-governance within the Indian Health Service.
- Portland Area Representatives:
  - Ron Allen, Jamestown S'Klallam (Primary)
  - Tyson Johnston, Quinault (Alternate)
- Meetings:
  - Last meeting: April 24-25, 2019 in Washington D.C.
  - **TSGAC strategy session: September 10-11, 2019 in Washington, D.C.**
  - **Next meeting: July 17-18, 2019 in Washington, D.C.**

**IHS IHCIF Workgroup**

- Indian Health Care Improvement Fund (IHCIF) Workgroup was established in anticipation of a FY 2018 IHCIF appropriation to assess the impact of past allocations to address inequities, effects of the current health care environment, and make recommendations that will be sent out for tribal consultation.
- Portland Area Representatives:
  - Gail Hatcher, Klamath (Primary)
  - Steve Kutz, Cowlitz (Alternate)
- Meetings:
  - Last meeting: February 12-13, 2019 in Crystal City, VA.
  - **Next meeting: In person meetings completed; conference call(s) to be scheduled to review draft report.**

**IHS CHAP TAG**

- The Community Health Aide Program (CHAP) Tribal Advisory Group (TAG) will provide subject matter expertise, program information, innovative solutions, and advice to the Indian Health Service (IHS) to establish a national CHAP.
- Portland Area Representatives:
  - John Stephens, Swinomish (Primary)
  - Andy Joseph, Jr., Colville (Alternate)
- Meetings:
  - Last meeting: April 3, 2019 at the Self Governance Conference in Acme, MI.
  - **Next meeting: Summer, 2019**

**IHS NTAC**

- The National Tribal Advisory Committee (NTAC) on Behavioral Health acts as an advisory body to the Division of Behavioral Health and to the Director of the Indian Health Service, with the aim of providing guidance and recommendations on programmatic issues that affect the delivery of behavioral health care for American Indian and Alaska Natives.
- Portland Area Representatives:
  - Cassandra Sellards Reck, Cowlitz (Primary)
  - Cheryl Sanders, Lummi (Alternate)
    - Last meeting: March 13-14, 2019 in Alpine, CA
    - **Next meeting: August 27 or August 28, 2019 in Rockville, MD (proposed)**

**IHS FAAB**

- Facilities Advisory Appropriation Board (FAAB) is charged with evaluating existing facilities' policies, procedures, and guidelines for recommending changes, if necessary. Participates in the development and evaluation of any proposed new policies, procedures, and guidelines of facilities construction priorities.
- Portland Area Representatives:
  - Tim Ballew, Lummi (Primary)
  - Andy Joseph, Jr., Colville (Alternate)
- Meetings:
  - Last meeting: March 19-20, 2019 in Rockville, MD; last call on April 10, 2019.
  - **Next meeting: August 13-14 in Rockville, MD**

**CDC TAC**

- CDC Tribal Advisory Committee (TAC) advises CDC/ATSDR on policy issues and broad strategies that may significantly affect AI/AN communities. Assists CDC/ATSDR in fulfilling its mission to promote health and quality of life by preventing and controlling disease, injury, and disability through established and ongoing relationships and consultation sessions.

- Portland Area Representatives:
  - Steve Kutz, Cowlitz (Primary)
  - Cassandra Sellard-Recks, Cowlitz (Alternate)
- Meetings:
  - Last meeting: February 4-5, 2019 in Atlanta, GA
  - **Next meeting and Tribal Consultation: August 13-14, 2019 in Cherokee, NC**

**SAMHSA TTAC**

- SAMHSA formed the Tribal Technical Advisory Group (TTAC) in recognition of 2008 Presidential Executive Orders and Memorandum of Tribal Consultation to enhance the government-to-government relationship to honor the federal trust responsibility and obligations to tribes and AI/AN.
- Portland Area Representative:
  - Jeremiah Julius, Lummi (primary)
  - Nickolaus Lewis, Lummi (alternate)
- National At-Large Representative:
  - Andrew Joseph, Jr., Colville
- Meetings:
  - Last meeting: March 13-14, 2019 in Alpine, CA
  - **Next meeting-virtual: July 30-31 (3 hrs per day)**

**CMS TTAG**

- The CMS Tribal Technical Advisory Group (TTAG) serves as an advisory body to CMS. Provides expertise on policies, guidelines, and programmatic issues affecting the delivery of health care for AI/AN served by Titles XVIII, XIX, and XXI of the Social Security Act or any other health care program funded (in whole or in part) by CMS.
- Portland Area Representatives:
  - John Stephens, Swinomish (Primary)
  - Nickolaus Lewis, Lummi (Alternate)
- Meetings:
  - Last meeting: February 20-21 in Washington D.C.
  - Last conference call: April 10, 2019
  - **Next meeting: July 24-25, 2019 in Washington D.C.**

**MMPC**

- The Medicare, Medicaid and Health Reform Policy Committee (MMPC) is a standing committee of the National Indian Health Board. The committee is chaired by a member of the NIHB Board of Directors. The primary purpose of the MMPC is to provide technical support to the CMS TTAG.
- Membership in MMPC is open to individuals authorized to represent a tribe, tribal organization, urban Indian program, or IHS.

- Meetings:
  - Last meetings: February 19, 2019 in Washington D.C.
  - Last conference call: May 7, 2019
  - **Next meeting: July 23, 2019 in Washington D.C.**

**NIH TAC**

- The National Institutes of Health (NIH) Tribal Advisory Committee (TAC) is advisory to the NIH, and provides a forum for meetings between elected Tribal officials (or their designated representatives) and NIH officials to exchange views, share information, and seek advice concerning intergovernmental responsibilities related to the implementation and administration of NIH programs.
- Portland Area Representatives:
  - Robyn Sigo, Suquamish (Primary)
  - Jeromy Sylvan, Port Gamble S'Klallam (Alternate)
- Meetings
  - Last meeting: March 21-22, 2019 in Bethesda, MD
  - Consultation: June 24, 2019 in Reno, NV
  - **Next meeting: August 19-23 2019 in Fairbanks, AK**

**Other Meetings**

- IHS Information Systems Advisory Committee (ISAC)
- IHS Catastrophic Health Emergency Fund (CHEF) Workgroup
- IHS Health Promotion/Disease Prevention Policy Advisory Committee (HP/DP)
- Portland Area Fund Distribution Workgroup (FDWG)
- Portland Area Facilities Advisory Committee (PAFAC)

## LEGISLATIVE UPDATE, LAURA PLATERO, GOVERNMENTAL AFFAIRS/POLICY DIRECTOR AND SARAH SULLIVIAN, HEALTH POLICY ANAYLST:

**Report Overview**

1. Hot Topics
2. Legislation
3. Future IHS Appropriations & Budget Formulation
4. New & Pending Federal Policies
5. Litigation
6. Upcoming National/Regional Meetings

**Hot Topics**

- *Texas v. United States* - Threat to the ACA/IHCIA
- House Appropriations for IHS and HHS
- SDPI Reauthorization and Funding
- Lower Health Care Costs/Surprise Billing
- CMS Work Requirements

**Legislation**

**FY 2020 Labor HHS Education Appropriations**

- On 6/19/19, House passed four-bill FY 2020 appropriations package (226 to 203)
  - HHS: $99.4 billion (+$8.9 billion above FY 2019 enacted level)
    - NIH: $41.1 billion (+2 billion)
    - CDC: $8.3 billion (+$938 million)
    - SAMHSA: $5.9 billion (+129 million)
    - HRSA: $7.6 billion (+$485 million)
    - CMS: $4 billion (+$315 million)
    - ACF: $27.9 billion (+$4.7 billion)
    - ACL: $2.3 billion (+$180 million)
    - Office of the Secretary: $550 million (+$5 million)
- Senate Bill Status: Not released; testimony submitted

**FY 2020 House Labor HHS Education Appropriations- Indian programs**

- CDC:
  - Good Health and Wellness in Indian Country- $21m (level)
- SAMHSA:
  - Tribal Opioid Response Grants-$50m (level)
  - Medication Assisted Treatment Grants for Tribes-$10m (level)
  - AI/AN Zero Suicide Program-$2.2m
  - AI/AN Suicide Prevention-$2.9m
- ACL:
  - Native American Nutrition and Supportive Services-$37.2m (+$3m)
  - Native American Caregiver Support Services-$12m (+$2m)
- HRSA
  - NHSC Loan Repayment Program to individuals who work for I/T/Us-$15m

**FY 2020 Interior IHS Appropriations Summary**

- National Tribal Budget Formulation Workgroup recommended over $7 billion for IHS for FY 2020 (36% increase over FY 2017 enacted level).
- President Released Budget on 3/11/19

  - $82.6m increase above FY 2019 for services and facilities (1.7%) or $115 m (2%) increase overall above 2019 enacted level
- House Bill Status:
  - On 6/25/19, House passed Interior appropriations bill (with 4 others).
    - $6.3 billion or $537m above FY 2019 enacted level
- Senate Bill Status: Not released; testimony submitted

**FY 2020 Interior IHS Appropriations- President & House**

| | FY 2019 Enacted | Pres Req. FY 2020 | House Bill FY 2020 | Enacted vs. House Bill |
|---|---|---|---|---|
| Clinical Svcs | $3,739,961 | $3,996,963 | $4,120,282 | +$380,321 |
| Prev Health | 174,742 | 118,257 | 181,062 | +$6,320 |
| Other Svcs | 188,487 | 171,321 | 255,526 | +67,039 |
| **Total Services** | **4,103,190** | **4,286,541** | **4,556,870** | **+453,680** |
| Facilities | 878,806 | 803,026 | 964,121 | +85,315 |
| **Total w/o CSC** | **$4,981,996** | **$5,089,567** | **$5,520,991** | **+$538,995** |
| CSC | 822,227 | 820,000 | 820,000 | -2,227 |
| **Total w/CSC** | **$5,804,223** | **$5,909,567** | **$6,340,991** | **+$536,768** |

Advance Appropriations: Committee directs IHS to examine its existing processes and determine what changes are needed to develop and manage an advance appropriation and report to the Committee within 180 days of enactment of this Act on the processes needed and whether Congressional authority is required in order to develop the processes.

**FY 2020 IHS Clinical Services-President & House**

| | FY 2019 Enacted | Pres Req. FY 2020 | House Bill FY 2020 | Enacted vs. House Bill |
|---|---|---|---|---|
| H&HC* | $2,147,343 | $2,363,278 | $2,420,568 | +273,235 |
| EHR | 0 | 25,000 | 25,000 | +25,000 |
| Dental | 204,672 | 212,369 | 227,562 | +22,890 |
| MH | 105,281 | 109,825 | 125,332 | +20,051 |
| Alcohol/SA | 245,566 | 246,034 | 280,151 | +34,485 |

| | | | | |
|---|---|---|---|---|
| PRC | 964,819 | 968,177 | 969,479 | +4,660 |
| IHCIF | 72,280 | 72,280 | 72,280 | |
| **Totals:** | **$3,739,961** | **$3,996,963** | **$4,120,282** | **+$380,321** |

*H&HC Highlights: includes $20m for CHAP expansion; $4m increase for DV prevention; $2m increase for TECs; $17m increase for 105(l) leases; $25m for HIV/HCV treatment and prevention

**FY 2020 IHS Preventative Health- President & House**

| | FY 2019 Enacted | Pres Req. FY 2020 | House Bill FY 2020 | Enacted vs. House |
|---|---|---|---|---|
| **PH Nursing** | **$89,159** | **$92,084** | **$95,307** | **+$6,148** |
| **Health Educ*** | **20,568** | **0** | **20,669** | **+101** |
| **CHRs*** | **62,888** | **24,000** | **62,913** | **+$25** |
| **Immun AK** | **2,127** | **2,173** | **2,173** | **+46** |
| **Totals:** | **$174,742** | **$118,257** | **$181,062** | **+$6,320** |

*Health Education & CHRs: House bill includes increases for both line items.

**FY 2020 IHS Other Services- President & House**

| | FY 2019 Enacted | Pres Req. FY 2020 | House Bill FY 2020 | Enacted vs. House Bill |
|---|---|---|---|---|
| **Urban Health** | **$51,315** | **$48,771** | **$81,000** | **+$29,685** |
| **IHP*** | **57,363** | **43,612** | **90,656** | **+33,293** |
| **Tribal Mngt** | **2,465** | **0** | **2,521** | **+56** |
| **Direct Ops** | **71,538** | **74,131** | **75,385** | **+3,847** |
| **Self Gov** | **5,806** | **4,807** | **5,964** | **+158** |
| **Totals:** | **$188,487** | **$171,321** | **$255,526** | **+67,039** |

*IHP Highlight: Bill language provides $50m for the loan repayment program

**FY 2020 IHS Facilities- President & House**

| | FY 2019 Enacted | Pres Req. FY 2020 | House Bill FY 2020 | Enacted vs. House Bill |
|---|---|---|---|---|
| M&I | $167,527 | $168,568 | $174,336 | +$6,809 |
| Sanitation | 192,033 | 193,252 | 193,577 | +1,544 |
| HC Fac Const* | 243,480 | 165,810 | 304,290 | +60,810 |
| Fac & Envir. | 252,060 | 251,413 | 266,831 | +14,771 |
| Equipment | 23,706 | 23,983 | 25,087 | +1,381 |
| **Totals:** | $878,806 | $803,026 | $964,121 | +85,315 |

*Health Care Facilities Construction: Includes $10m for Green Infrastructure.
Joint Venture Construction Program: Committee urges the Service to consult with tribes to determine and open competitions on a regular cycle of between three to five years.

**Other Directives in House Bill**

- 105(l) Leases:
  - Report required within 90 days on treatment of 105(l) leases like CSC and estimated costs in current and next fiscal year.
- Electronic Health Records (EHR):
  - Must provide notice at least 90 days before funds are obligated or expended by IHS; and directive to look at VA system.
- VA MOU:
  - Urges IHS to look at performance measures related to MOUs.
- Electronic Dental Records (EDR):
  - Directs IHS to include EDR in its assessment.

**Advanced Appropriations Bills for BIA/BIE/IHS and IHS only**

- **S. 229 & H.R. 1122 – Advanced Appropriations for BIA and BIE at DOI and IHS at HHS.**
  - Senate Bill introduced by Sen. Tom Udall (D-NM) on 1/25/19.
  - House Bill introduced by Rep. Betty McCollum (D-MN-4) on 2/8/19.
  - **Status**: Both referred to respective House and Senate Committees.
- **H.R. 1135 –Advanced Appropriations for IHS.**
  - House Bill introduced by Rep. Don Young (R-AK- At Large) on 2/8/19; referred to Committees.
  - Senate Bill anticipated to be introduced.
  - **Status**: In House Committees.

**Special Diabetes Program for Indians Reauthorization**
**SDPI expires September, 2019. Several bills to reauthorize:**

- **H.R. 2328- Community Health Investment, Modernization, and Excellence Act of** 2019 (Rep. Tom O'Halleran (D-AZ)-4 years at $150m)
  - **Status: 7/11/19- House E&C Health Markup**
- **H.R. 2668 – Special Diabetes Program Reauthorization Act of 2019** (Rep. Diana DeGette (D-CO)-5 years at $200m)
  - Status: 6/4/19- House E&C Health Subcommittee Hearing
- **H.R. 2680 – Special Diabetes Programs for Indians Reauthorization Act of 2019** (Rep. Tom O'Halleran (D-AZ)- 5 years at $200m)
  - Status: 6/4/19-House E&C Health Subcommittee Hearing
- **H.R. 2700 – Lowering Prescription Drug Costs and Extending Community Health Centers and Other Health Priorities Act** (Rep. Michael Burgess (R-TX)- 1 year extension at $150m)
  - Status: 6/26/19- In Committees
- **S. 192 - Community and Public Health Programs Extensions Act**) (Sen. Lamar Alexander (R-TN) – 5 years at $150m)
  - **Status: 1/18/19- In HELP Committee**
- **S. 1895- Lowering Health Care Costs** Act (Sen. Lamar Alexander (R-TN) – 5 years at $150m)
  - Status: 7/8/19- Placed on Senate Leg Calendar

**Indian Health Professions Bills**

- **H.R. 3340- Tribal Healthcare Careers Act**
  - Introduced by Jimmy Gomez (D-CA) on 6/19/19
  - Provides a set-aside of funds for Indian populations under the health profession opportunity grant program under Section 2008 of the Social Security Act.
  - **Status**: Referred to Ways & Means
- **H.R. 3343- Technical Assistance for Health Grants Act**
  - Introduced by Daniel Kildee (D-MI) on 6/19/19
  - Provides for technical assistance under health profession opportunity grant program under section 2008 of Social Security Act.
  - **Status**: Referred to Ways & Means

**Other Indian Specific Health & DOI Bills**

- **Pay Our Doctors Act (H.R. 195)**
  - **Status**: In Committee
- **Native American Suicide Prevention Act of 2019 (S. 467 & H.R. 1191)**
  - **Status:** In House and Senate Committees
- **Assessment of the Indian Health Service Act (S. 498)**

  - **Status:** In Committee
- **Urban Indian Health Parity Act (S. 1180/H.R. 2316)**
  - **Status:** In House and Senate Committees
- **PROGRESS for Indian Tribes Act (S. 209 & H.R. 2031)**
  - **Status**: Passed Senate on 6/17/19; In House Committee

**Opioid Bills**

- **Comprehensive Addiction Resources Emergency Act of 2019 (CARE) (S. 1365 & H.R. 2569)**
  - Provides emergency assistance to states, territories**, tribal nations**, and local areas affected by the opioid epidemic, and financial assistance, for the development, organization, coordination and operation of more effective and efficient systems for the delivery of essential services to individuals with substance use disorder and their families.
  - **S. 1365**- Introduced by Sen. Elizabeth Warren (D-MA) on 5/8/19.
    - **Status**: In HELP Committee
  - **H.R. 2569**- Introduced by Rep. Elijah Cummings (D-MD) on 5/8/19.
    - **Status**: 5/13/19-Referred to Indigenous Peoples of the United States Subcommittee (Natural Resources)
- **Examining Opioid Treatment Infrastructure Act of 2019 (H.R. 1303)**
  - **Status**: In Committee

**Other Health Bills**

- **Lower Health Care Costs Act (S. 1895)-**Sen. Alexander Lamar (R-TN)
  - Purpose is to lower health care costs, extend community health centers and SDPI
    - **Status:** 7/8/19: Placed on Senate Legislative Calendar
- **Aligning 42 CFR Part 2 with HIPAA**
  - **Protecting Jessica Grub's Legacy Act (S. 1012)**-Sen. Joe Manchin (D-WV)
    - **Status**: 4/3/19-In HELP Committee
  - **Overdose Prevention and Patient Safety Act (H.R. 2062)**-Rep. Earl Blumenauer (D-OR)
    - **Status**: 4/3/19-In E&C Committee
- **PrEP Assistance Program Act (H.R. 1643) & PrEP Coverage Access and Coverage Act (S. 1926)**
  - **Status:** In House and Senate Committees

**Veterans' Bills**

- **Tribal HUD-VASH Act of 2019 (S. 257)**
  - **Status**: 6/27/19-Passed Senate; Referred to House Committee on Financial Services

- **Veterans Improved Access and Care Act of 2019 (S. 450)**
  - **Status**: 5/22/19-Senate VA Hearings
- **Department of Veterans Affairs Tribal Advisory Committee Act of 2019 (S. 524 & H.R. 2791)**
  - **Status**: 5/22/19-Senate VA Hearings; 5/16/19-Referred to House Committee on VA Affairs
- **Commander John Scott Veterans Mental Health Improvement Act of 2019 (S. 785)**
  - **Status**: 5/22/19-Senate VA Hearings
- **Tribal Veterans Health Care Enhancement Act (S. 1001)**
  - **Status**: 5/22/19-Senate VA Hearings

**DV & Missing AI/AN Bills**

- **Violence Against Women's Act of 2019 (H.R. 1585)**
  - **Status:** 4/4/19-Passed House; 4/10/19-Placed on Senate Legislative Calendar
- **Not Invisible Act (S. 982 & H.R. 2438)**
  - **Status:** 6/19/19- SCIA; 5/10/19-Referred to Indigenous Peoples of the U.S. Subcommittee
- **Studying the Missing and Murdered Indian Crisis Act of 2019 (S. 336)**
  - **Status:** 2/5/19- SCIA

**Future IHS Appropriations & Budget Formulation**
**FY 2021 IHS Budget Formulation**

- National Tribal Budget Formulation Workgroup met on March 14-15, 2019 in Washington D.C. and recommended full funding for IHS at $37.61 billion to be phased in over 12 years.
- For FY 2021, a total of $9.1 billion for IHS is requested. Includes:
  - $257 m for full funding of current services
  - $413 m for binding fiscal obligations
  - $2.7 b for program increases (46% above FY 2019 enacted level)
  - And more!
- Other recommendations for IHS:
  - Support preservation of Medicaid, IHCIA and Indian-specific provisions of the ACA.
  - Fund critical infrastructure investments (Health IT/HCFC)
  - Exempt Tribes from Sequestration
  - Support Advance Appropriations
  - Allow federally-operated health facilities and IHS headquarters to use federal dollars efficiently and adjust programmatic funds flexibly across accounts at the local level
  - Support funding of tribes outside of grants based system.

  - Permanently authorize SDPI and increase funding to $200 m per year plus annual inflationary increases.
  - Take a adequate steps to fully address 105(l) leasing obligations and work proactively with Congress to ensure its full payment as an indefinite appropriation.
- Available at: https://www.nihb.org/legislative/budget_formulation.php

**FY 2022 IHS Budget Formulation**

- National Tribal Budget Formulation Workgroup (NTBFW) met on June 27-28 in Reno, Nevada.
- Workgroup decided to request full funding now (not 12 year phased in funding).
  - An analysis will be conducted to determine what that amount is.
- Recommendation for FY 2022 will be based on NTBFW request for FY 2021, plus 30%.
- Portland Area Budget Formulation Meeting for FY 2022 is November 14, 2019 in Portland, Oregon- location TBD.

**New & Pending Federal Policies**
**Executive Orders**

- **Improving Price and Quality Transparency in American Health Care to Put Patients First**-Issued 6/24/19
  - Within 60 days, HHS Secretary must issue a proposal to require hospitals to post standard charge information
  - Within 90 days, Secretaries of HHS, Treasury and Labor to issue a proposal to require providers, issuers and plans to facilitate access to information that tells patients about expected out-of-pocket costs before they receive care
- **Evaluating and Improving the Utility of Federal Advisory Committees**
  - Directs agencies to terminate at least 1/3 of its current committees established under 9(a)(2) of FACA, including other committees.
  - Agencies must send OMB a list of all their advisory committees and recommendations on which ones to eliminate by August 1.
  - OMB has one month to take recommendations to President
  - **We understand that no tribal advisory committees will be impacted at IHS or HHS (per IHS leadership)**

**Pending Responses from HHS**

- **HHS Office of National Coordinator (ONC) 21st Century Cures Act and CMS Interoperability, Information Blocking and the ONC Health IT Certification Program**; issued 3/4/19; comments due 6/3/19; comments submitted
- **HHS Office of HIV/AIDS and Infectious Disease Policy STD Federal Action Plan;** issued 5/3/19; comments due 6/3/19; expected June, 2020

- **HHS RFI on National HIV/AIDS Strategy and National Viral Hepatitis Action Plan**; issued 2/8/19; comments submitted; expected June, 2020
- **HHS Pain Management Best Practices Inter-Agency Task Force Draft Report on Pain Management Best Practices**; issued 12/31/18
- **HHS Tribal Consultation Policy**; DTLL 10/22/18; comments submitted
- **HHS Draft Strategy to Reduce Regulatory and Administrative Burden of Health IT and EHRs**; comments submitted
- **Disbanding of the OMH AI/AN Health Resource Advisory Committee (HRAC)**

**CMS Nondiscrimination in Health and Health Education Programs or Activities**

- Issued: 6/14/19; comments due 8/13/19
- In May 2016, OCR HHS published a final rule (2016 Rule) that sought to codify nondiscrimination requirements and set forth new standards for implementing Section 1557 of the Affordable Care Act (ACA), particularly with respect to the prohibition of discrimination on the basis of sex.
- HHS interpreted that Congress did not intend for Section 1557 of the ACA to prohibit discrimination based on gender identity and termination of pregnancy.
- Senate Health Committee ranking Democrat Patty Murray (WA) and 30 Democratic Senate colleagues are demanding HHS withdraw its recent proposed rule that scales back the protections under Section 1557.
- The Senators want HHS to explain its reasoning for removing protections for transgender individuals, women who have terminated pregnancy and people with limited English proficiency by July 18th.

**Pending Responses and/or Ongoing Issues with CMS**

- **CMS Medicaid and CHIP Managed Care Proposed Rule** - comments submitted 1/28/19.
- **CMS Work Requirements**
- **CMS Four Walls Limitation- FAQs**
- **CMS Decision on Appeal of Washington DHAT SPA**

**National Institutes of Health**

- Tribal consultation on three initiatives:
  - Tribal Consultation on NIH Intellectual Property Rights in Biomedical Research; comments due 8/22/19.
  - Request for Comments on NIH Draft Policy on Data Sharing Management; DTLL 4/17/19; comments due 8/22/19.
  - Tribal Consultation and Listening Session on the All of Us Research Program; comments/testimony due 8/31/19.
    - Feedback received through the tribal consultation and other public engagement efforts will result in a plan for working with Tribal Nations.

- More info available at: https://allofus.nih.gov/about/all-us-tribal-engagement

**Recent IHS DTLLs**

- **Invitation to Provide Updated Facility Master Plans and/or Identified Health Care Facility Needs to Local IHS Area Facilities Program Director for Possible Inclusion in the 2021 IHS and Tribal Health Care Facilities Needs Assessment Report to Congress**; DTLL 7/5/19; data due on 12/31/19
- **Update on New Appointments and Updates to the Indian Health Service Senior Leadership Team**; DTLL 7/3/19
- **Initiation of Tribal Consultation and Urban Confer on Developing IHS Opioid Grant Program to Distribute the FY 2019 Opioid Funding**; DTLL 7/5/19; comments due 8/1/19
    - Related to $10m for Special Behavioral Health Program for Indians FY 2019 appropriation
- **Update on Sanitation Deficiency System-A Guide for Reporting Sanitation Deficiencies for AI/AN Homes and Communities;** DTLL 5/24/19.
    - IHS Facilities Appropriations Advisory Board reviewed comments and provided recommendations
- **Results of Tribal Consultation on the Indian Health Manual Part 2, Chapter 3-PRC**; DTLL on 5/15/19.
    - PRC Workgroup was advised of changes

**Pending IHS Responses**

- **Tribal Consultation on Community Health Aide Program Interim Policy**; DTLL on 5/8/19; comments due 7/8/19; comments submitted.
    - IHS Community Health Aide Program (CHAP) Workgroup to review comments
- **Tribal Consultation on Long and Short Term Options for Meeting ISDEAA 105(l) Requirements**; DTLL on 3/12/19; comments submitted.
    - IHS technical workgroup trying to determine costs
- **Update on the Mechanism to Distribute Behavioral Health Initiative Funding**; DTLL on 12/11/18; comments submitted.
    - IHS National Tribal Advisory Committee (IHS NTAC) provided a recommendation to RADM Weahkee.
- **Contract Support Costs – Indian Health Manual, Chapter 3 CSC**, rescission of 97/3 split language; DTLL 4/13/18; comments submitted.
    - CSC Workgroup Tribal Chairman, Andy Joseph, Jr., requested an update; IHS close to finalizing a decision & meeting in Aug/Sept

**HRSA UPDATES**

- HRSA Shortage Designation Modernization Project (SDMP) will update existing Auto-HPSA designation scores in August 2019 through an online portal.
- New Auto-HPSA scores will be applicable to the 2020 National Health Service Corp application cycle.
  - Clinics will be able to update their HPSA score in the online portal after the national rollout.
  - Clinics should collect and submit facility-specific data and supplemental data to increase scores in replacement of the ACS data.
  - HRSA and IHS are working to identify data sources to assist in increasing scores for I/T/Us prior to national rollout.
- June 25 Webinar: Auto-HPSA Portal Training for I/T/Us.
  - Webinar recordings available at: https://bhw.hrsa.gov/sdmp
- Apply for the NHSC Rural Community Loan Repayment Program Grant Application through July 18

**VA Updates**

- VA DTLL: Requests comments on implementation of VA MISSION Act; DTLL on 4/16/19; Comments submitted 6/10/19.
- VA and White House launched a Veteran Suicide Prevention Task Force to create a roadmap to empower veterans and end the national tragedy of suicide (PREVENTS Executive Order)
  - Inclusion of a community integration and collaboration proposal, a national research strategy and an implementation strategy.
- VA extends Agent Orange presumption to Blue Water Navy Veterans who served offshore of the Republic of Vietnam between 1962 and 1975 to be eligible for disability compensation benefits.

**Litigation**

***Texas v. United States*** **-** Challenge to Affordable Care Act

- On December 14, 2018, Judge Reed O'Conner (USDC ND Texas) held:
  - That the individual mandate enacted as part of the ACA is unconstitutional because it cannot be justified under Congress' taxing power (Congress reduced tax penalty to $0).
  - The entire ACA must be invalidated because the individual mandate is not severable and essential to the ACA's operation.
- If ACA struck down, ICHIA would also be struck down.
- Appealed to USCA for the Fifth Circuit.
- 483 tribes and tribal organizations (including NPAIHB) joined an amicus brief.

- On March 25, 2019, a coalition of states intervened in the case in order to defend the ACA while Department of Justice filed a two-sentence letter with the court announcing that the U.S. had changed its position in the litigation.
- On July 9, 2019, a three-panel judge in the Fifth Circuit heard oral arguments.
- Ruling expected in the coming months.

***Brackeen v. Bernhardt* -** Challenge to ICWA

- On 10/5/18, Judge Reed O'Conner (USDC ND Texas) ruled that ICWA is unconstitutional in Brackeen v. Zinke.
- Found that *Morton v. Mancari* rule does not apply because ICWA extends to Indians who are not members of tribes.
- ICWA struck down in violation of equal protection.
- Appealed to USCA for the Fifth Circuit and now titled, *Brackeen v. Bernhardt*.
- Many tribes and tribal organizations (including NPAIHB) joined the amicus brief.
- On March 13, 2019, oral argument occurred before a panel of 3 judges.
- Decision pending in Fifth Circuit

**Opioid Litigation**

- All federal court lawsuits have been combined in multi-district litigation under Federal District Judge Dan A. Polster (USDC-ND Ohio)
- Over 100 tribes and tribal organizations joined 1,000 state and local governmental plaintiffs in the litigation.
- Tribal Amicus Brief: 448 tribes and tribal organizations signed on and provided statements of interest (NPAIHB, ATNI, NCAI, and NIHB).
- **Status**:
  - Two Tribal Cases selected as bellweather cases ---Muscokee (Creek) Nation and Blackfeet Tribe.
  - On June 13, 2019, Judge Polsner issued a Motion Opinion and Order ruling on the Motions to Dismiss.
  - The Order adopts most of the recommendations by Magistrate David Ruiz recommending to the court that the Motions to Dismiss be denied with respect to the vast majority of tribes' claims.
  - In the multidistrict litigation, plaintiffs continue to pursue a settlement.

**Upcoming National/Regional Meetings**
**July-September 2019**

- TSGAC Quarterly Meeting, July 16-19, Washington, D.C
- MMPC/TTAG Meeting, July 23-25, Washington, D.C.
- 16th Annual DSTAC Meeting, July 30-31, Albuquerque, NM
- Region X Opioid Summit, August 6-9, Vancouver, WA

- 2019 Diabetes in Indian Country Conference, August 6-9, Oklahoma City, OK
- Center for State, Tribal, Local and Territorial Support (CSTLTS), CDC/ATSDR Tribal Advisory Committee (TAC) Meeting and 19th Biannual Tribal Consultation; August 13-14, Cherokee, NC (Testimony Due: 7/19/19)
- NCAI Impact Days, September 10-11, Washington, D.C.
- TSGAC Strategy Session, September 10-11, Washington, D.C.
- HHS STAC Meeting, September 12-13, Washington, D.C.

**September-October 2019**

- NIHB National Tribal Health Conference, September 16-19, Temecula, CA
- IHS TSGAC Quarterly Meeting, October 2-3, Washington, D.C.
- ATNI Fall Convention, October 7-10, Suquamish
- PRC Workgroup Meeting, October 15-17, Washington, D.C.
- NCAI Annual Convention, October 20-25, Albuquerque, NM
- Quarterly Board Meeting, October, 21-24, Pendleton, OR

Break for lunch at 12:20 pm

1:37 p.m. call to order

**RESOLUTIONS:** Review joint resolutions, Laura Platero

- **#19-04-02** ***A Call to Congress to Support Advance Appropriations for the Indian Health Service***
    - Motion by Andrew Shogren, Suquamish Tribe, 2nd by Kim Thompson, Shoalwater Bay; **MOTION PASSES**
- **#19-04-03** ***Full Funding for Indian Health Service***
    - Motion by Andrew Shogren, Suquamish Tribe, 2nd by Kim Thompson, Shoalwater Bay; **MOTION PASSES**
- **#19-04-04** ***A Call to Congress to Support Mandatory Appropriations for the Indian Health Service***
    - Motion by Andrew Shogren, Suquamish Tribe, 2nd by Kim Thompson, Shoalwater Bay; **MOTION PASSES**
- **#19-04-05** ***A Call to Congress to Fully Fund Section 105(l) Indian Self-Determination and Education Assistance Act (ISDEAA) Lease Obligations to Tribes and Tribal Organizations***
    - Motion by Jim Steinruck, Tulalip Tribe, 2nd by Andrew Shogren, Suquamish Tribe; **MOTION PASSES**
- **#19-04-06** ***A Call to Congress to Enact Mandatory Appropriations in Support of the National Child Traumatic Stress Initiative***

- Motion by Patti Kinswa-Geiser, Cowlitz Tribe, 2nd by Kim Thompson, Shoalwater Bay; **MOTION PASSES**

- **#19-04-07** ***Support of Enacting Legislation to Ensure Medicaid Fulfills Federal Trust Responsibility to American Indians/Alaska Natives***
  - Motion by Jim Steinruck, Tulalip Tribe, 2nd by Andrew Shogren, Suquamish Tribe; **MOTION PASSES**
- **#19-04-08** ***Department of Health and Human Services Office of Minority Health American Indian/Alaska Native Health Research Advisory Committee***
  - Motion by Patti Kinswa-Geiser, Cowlitz Tribe, 2nd by Andrew Shogren, Suquamish Tribe**; MOTION PASSES**
- **#19-04-09** ***Support for Increased Funding for the Special Behavioral Health Pilot Program and Option for Funding through Title I and Title V Funding Agreements***
  - Motion by Patti Kinswa-Geiser, Cowlitz Tribe, 2nd by Andrew Shogren, Suquamish Tribe**; MOTION PASSES**
- **#19-04-10** ***A Call to Indian Health Service to Move the Purchased/Referred Care (PRC) Dependent Factor in the PRC Funding Formula to the Annual Adjustment Category***
  - Motion by Shawna Gavin, Confederated Tribes of Umatilla, 2nd by Kim Thompson, Shoalwater Bay; **MOTION PASSES**
- **#19-04-11** ***Support for Legislation that Establishes a Department of Veterans' Affairs (VA) Tribal Advisory Committee (TAC)***
  - Motion by Patti Kinswa-Geiser, Cowlitz, 2nd by Shawna Gavin Confederated Tribes of Umatilla; **MOTION PASSES**
- **#19-04-12** ***Support for Permanent Reauthorization of the Special Diabetes Program for Indians and Change to Indian Self-Determination Education Assistance Act (ISDEAA) to Support SDPI Funding through Title I and Title V Funding Agreements***
  - Motion by Patti Kinswa-Geiser, Cowlitz Tribe, 2nd by Kim Thompson, Shoalwater Bay; **MOTION PASSES**
- **#19-04-13** ***Urging the Substance Abuse and Mental Health Service Administration (SAMHSA) to Remove Unnecessary Government Performance and Results Modernization Act Reporting Requirements for Opioid Treatment Services Provided by Tribes and Urging Congress to Increase Funding for these Services***
  - Motion by Greg Abrahamson, Spokane Tribe, 2nd by Shawna Gavin, Confederated Tribes; **MOTION PASSES**

**BOARD SPECIFIC RESOLUTIONS:**

- **19-04-14** ***Support Funding from North Sound Accountable Communities of Health for DHAT Education and Training***
  - Motion by Greg Abrahamson, Spokane Tribe, 2nd by Tino Batt, Shoshone-Bannock Tribe; **MOTION PASSES**
- **19-04-15** ***Northwest Traditional Foods Policy Project***

- Motion by Patti Kinswa-Geiser, Cowlitz Tribe; 2nd by Greg Abrahamson, Spokane Tribe; **MOTION PASSES**

- **19-04-16** ***Public Health Improvement and Training – Tribal Public Health Capacity Building and Quality Improvement Umbrella Cooperative Agreement – 2019 Supplements***
  - Motion by Patti Kinswa-Geiser, Cowlitz Tribe; 2nd by Shawna Gavin, Confederated Tribes of Umatilla; **MOTION PASSES**

## CHAIRMAN'S REPORT, ANDY JOSEPH

It has been an honor to serve as the Chairman of the Northwest Portland Area Indian Health Board. I could not have imagined that this would be my last quarter on my tribe's council or as Chairman of the health board, at least for now. I'm glad that I did as much as I could this quarter to fight for our People.

After the last QBM, April 23-24, I attended the HHS Annual Tribal Budget Consultation for FY 2021 in Washington, D.C. and directed requests to HHS and agency leadership, and provided testimony. I was able to make many of the asks on our tribes' policy priority list.

On May 7, I testified to the Senate Committee on Indian Affairs for NIHB but also submitted testimony for our health board.

On May 13th, I travelled to Albuquerque to attend the NIHB Public Health Summit. On May 15th, I travelled to Phoenix, Arizona for the PRC Workgroup as the Portland Area representative.

On May 20-23, I attended the ATNI Mid-Year Convention in Spokane, Washington. Two of our resolutions were passed that were able to move forward to NCAI: a resolution on the FY 2019 President's Budget for the Indian Health Service, and a resolution to treat ISDEAA 105(l) lease costs like CSC.

On June 11-13, I attended the NIHB Board meeting in Washington, D.C. Later in the month, June 24-27, I attended the NCAI Mid-Year Convention in Reno, Nevada. Our ISDEAA 105(l) lease resolution passed at NCAI. On June 27, I was also able to attend the National Tribal Budget Formulation Workgroup Meeting. I was pleased that the Workgroup has decided that we should ask for full funding for FY 2022, something I always supported, rather than 12-year phased in funding.

In thinking about my time as your Chair, I'm most proud of my contributions to:

- The Indian Health Care Improvement Act, which includes long term care for elders;
- HB 1564, Washington State Legislation that supports a Medicaid alternative rate for nursing and long term care facilities that will benefit my tribe's nursing home;

- Medical inflation rate included in the Contract Support Costs (CSC) formula, which brings more funds to all tribes;
- MOU with VA and IHS;
- Legislation that will create a VA Tribal Advisory Committee; and
- Tribal Behavioral Health Agenda and work on the SAMHSA TTAC.

Lastly, as Chair of the Healing Lodge of the Seventh Nations Board, my work on an encounter rate.

I hope to be back, or stay involved in some way, and hope you will all stay in touch. You will all be in my thoughts and prayers as you continue the fight for health care for our People.

**FINANCE REPORT**, Eugene Motifi, Motion by Andrew Shogren, Suquamish, 2nd by Patti Kinswa-Geiser; **MOTION PASSES**

**APPROVAL OF MINUTES**: Motion Shawna Gavin, Confederated Tribes of Umatilla, 2nd Andrew Shogren, Suquamish; **MOTION PASSES**

**Recess at 2:51 p.m.**

## NPAIHB & CRIHB JOINT MEETING WEDNESDAY, JULY 17, 2019

**Call to Order:** at 9:12 am by Lisa Elgin, CRIHB Board Chair and Andy Joseph, NPAIHB Board Chair

**Invocation: Hannah ---**

**Welcoming and Introductions:** Joe Finkbonner, NPAIHB Executive Director and Mark LeBeau, CRIHB Executive Director

**Tribal Leaders introductions**

## NATIONAL INDIAN HEALTH BOARD (NIHB) UPDATE, STACY BOHLEN, NIHB EXECUTIVE DIRECTOR:

The NIHB National Tribal Health Conference will take place September 16-19, 2019 at Pechanga Resort and Casino. Thank you to our partner California Rural Indian Health Board for hosting us. There will be a pre-conference day with institutes, trainings and listening sessions and consultations. There will be consultations from the IHS and VA and HRSA

Culture Night, presented by California Rural Indian Health Board will be on Tuesday, September 17th, 2019 at the Pechanga Resort and Casino

The Annual Heroes in Health Awards Gala will be held on Wednesday, September 18th, 2019, from 6 PM – 9 PM on the Event Lawn at Pechanga Resort and Casino. Our Master of Ceremonies will be Reno Franklin, Former Chairman of NIHB. NIHB received over 85 nominations for 44 awards. Winners will be notified by the end of this week!

**Be a Conference Partner! Here's Why…**

- Advance appropriations for the Indian Health Service;
- Keeping the Special Diabetes Program for Indians funded – which expires in September;
- Protecting Native Veteran's health care;
- Winning tribal funding carve outs; like; Tribal opioid response funding/direct Tribal HIV funding;
- Protecting the Indian Health Care Improvement Act from legal threats;
- Winning considerable increases for the Good Health and Wellness Program in Indian Country – even though the President's budget zeroed the program out every year;
- Conducting the Annual, Year-Long Native Youth Health Policy Fellowship: NIHB builds future leaders

**NIHB is Hiring!**

- Director of Congressional Relations
- Congressional Relations Associate
    - Focus on Communications & Oral Health
- Public Health Project Coordinator
- Public Health Project Associate
- Event and Meeting Manager

Email jobs@nihb.org!

**Legislative Overview**

1. Special Diabetes Program from Indians
2. Appropriations for Tribal Health
3. Indian Health Service Advance Appropriations
4. Medicaid Legislative Priorities
5. Public Health Legislation
6. Native Veterans' Care
7. Harm Reduction
8. Community Health Representatives/Community Health Aide Program

**Special Diabetes Program for Indians**

There are also state specific fact sheets on SDPI.
They are available on our website www.nihb.org/sdpi

### §254c–3. Special diabetes programs for Indians

**(a) In general**

The Secretary shall make grants for providing services for the prevention and treatment of diabetes in accordance with subsection (b).

**(b) Services through Indian health facilities**

For purposes of subsection (a), services under such subsection are provided in accordance with this subsection if the services are provided through any of the following entities:

(1) The Indian Health Service.

(2) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act [25 U.S.C. 5321 et seq.].

(3) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act [25 U.S.C. 1651 et seq.].

**(c) Funding**

**(1) Transferred funds**

Notwithstanding section 1397dd(a) of this title, from the amounts appropriated in such section for each of fiscal years 1998 through 2002, $30,000,000, to remain available until expended, is hereby transferred and made available in such fiscal year for grants under this section.

**(2) Appropriations**

For the purpose of making grants under this section, there is appropriated, out of any money in the Treasury not otherwise appropriated-

(A) $70,000,000 for each of fiscal years 2001 and 2002 (which shall be combined with amounts transferred under paragraph (1) for each such fiscal years);

(B) $100,000,000 for fiscal year 2003;

(C) $150,000,000 for each of fiscal years 2004 through 2017; and

(D) $150,000,000 for each of fiscal years 2018 and 2019, to remain available until expended.

**Special Diabetes Program for Indians (SDPI)**

- SDPI expires on September 30, 2019
- Senate Health Education Labor and Pensions (HELP) Committee leaders introduced a 5-year renewal for SDPI at the current $150 million/ year
    - Voted out of Committee on June 26
    - Included in Lower Health Care Costs Act of 2019
    - Awaiting Senate Floor Vote
    - Schedule uncertain
- Rep. O'Halleran (D-AZ) introduced House bill
    - H.R. 2680: $200 million/year for 5 years!
    - Huge win for Indian Country!
    - BUT: on July 10 the House Energy and Commerce Health Subcommittee amended bill to $150 million for 4 years
    - NIHB working to secure funding increase
    - Full Committee markup expected today (7/17) or tomorrow (7/18)
    - Bill extends other public health programs, like Community Health Centers, so Committee needs to find a way to pay for all the expenditures
    - Very limited availability for extra funds for an increase to SDPI

- Working with partners at American Diabetes Association, Juvenile Diabetes Research Foundation and the Endocrine Society to ensure renewal

**SDPI Congressional Letters**

- NIHB helped draft and circulate letters from House and Senate Diabetes Caucuses
    - Letters showed support for SDP and SDPI
    - Members could choose to sign on
    - 379 House members (85%) signed the letter!!
- 68 Senators!!
- Members of both parties signed the letter
- Congress members representing Indian Country were even more likely to sign on!
- SDP funds the National Institutes of Health to research treatments for Type 1 diabetes

**What's Next for SDPI?**

- House of Representatives:
    - Week of July 15
        - Working on Amendments
        - Energy and Commerce Full Committee Mark Up
    - Week of July 22
        - Floor Vote Expected
- Senate:
    - Date of Vote on Senate Floor not yet set
    - Opportunity to amend legislation
- Conference Committee
    - Opportunity to amend legislation
- Signed into Law by the President

**NIHB National Tribal Diabetes Summit - Thursday, September 19th, 2019**

- Will be immediately following the close of the National Tribal Health Conference at Pechanga Resort and Casino
- To discuss making the Tribal Diabetes Program for Indians subject to self-governance contracts and compacts under the Indian Self Determination and Assistance Act
- Other Hot Topics in Diabetes in Indian Country

**The Budget Deal Explained…or lack thereof**

- Congress must pass a budget deal or sequestration takes effect
- Budget deal sets the total amount of discretionary funding Congress will spend for the upcoming fiscal year
- Then, Appropriations Subcommittees fight over their share of the funding

- Once each Appropriations Subcommittees have their allocation of funding, they craft draft appropriations bills
- The House drafted and passed their Appropriations bills even without a budget deal
- Senate is waiting for budget deal to pass
- Unclear if/when budget deal will happen

Andy Joseph testified before the Senate Committee on Indian Affairs on May 8 on the FY 2020 IHS budget, highlighting the same priorities shared with the House Appropriations Committee.

**Indian Health Service (IHS) Appropriations**

- The House bill includes significant increases for IHS, including a $537 million overall increase above the 2019 enacted level, bringing the total to $6.3 billion.
- The House package includes an increase to $2.42 billion overall for Hospitals and Clinics, including the $20 million for a national CHAP; $25 million for HIV/AIDs and Hepatitis C prevention; and $25 million for modernization of EHRs included in the President's budget.
- Other notable increases include $53 million for 105(l) leases, which is $17 million above the 2019 enacted level;
    - $125.3 million for Mental Health (+ $20 million);
    - $280 million for Alcohol and Substance Abuse (+ $34.4 million);
    - $81 million for urban Indian health (+ $29.6 million);
    - $90.6 million for Indian Health Professions (+ $33.2 million);
    - and $304.2 million for Health Care Facilities Construction (+ $60.8 million).
- The House package also rejected the proposed cuts to Community Health Representatives (CHRs) and Health Education, instead giving them a slight boost to $62.9 million and $20.6 million respectively.

**Labor HHS Appropriations**

- House approved bill on June 19
- Senate Labor HHS Bill expected once budget deal is reached
    - NIHB Submitted Testimony in June
- House Appropriations bill released in April
    - Total funding for HHS: $189.8 billion for FY 2020
    - Funds $50 million Tribal set aside in **opioid response grants** authorized in 2018.
    - Maintains $15 million set aside for placement of **National Health Service Corps** within IHS/Tribal/Urban Indian Health facilities.
    - Includes $14 million for the **Zero Suicide program**, an increase of $5 million over last year.
    - Maintains **Good Health and Wellness** at $21 million, and **Tribal Behavioral Health Grants** at $40 million

**IHS Advance Appropriations**

- NIHB has been working very hard this year to get IHS advance appropriations. This would mean IHS gets its funding passed into law a year before it would be spent, so that there would be no impacts from government shutdowns or sequestration cuts. NIHB has had a resolution on this since at least 2011, but with the recent 35-day shutdown in close memory, it is a good time to get Congress to move on this.
- It would create parity with other federal health providers like Veteran's Administration who already have advance appropriations.
- It is also a good time to get Congressional support for this effort because the Government Accountability Office came out with a report last fall that identified a lot of strong arguments from Tribes and the IHS on why advance appropriations would be helpful in the delivery of health care. Among other things, it cited the extra costs that go along with continual CRs and shutdowns.
- What advance appropriations IS NOT:
- "forward funding" allows funds to become available beginning late in the budget year and is carried into next year. Forward funding is counted against the same budget year. i.e. - it has a cost score!
- "Mandatory appropriations" is automatic when Congress passes an authorization law. Medicare and Medicaid (entitlement programs) are funded through mandatory spending.

Because it is so rare, there is not one specific pathway to achieving IHS advance appropriations. However, we do know several things. That should (or must) happen before IHS advance appropriations can be achieved.

1) Each year the Budget Resolution – which sets forth the rules by which Congress can write the budget each year – contains a prohibition on advance appropriations EXCEPT for a few program explicitly listed. (these exemptions include certain VA programs as well as the Corporation of Public Broadcasting)
2) Under the House rules, the Chairman of the Budget Committee must sign off
3) If we get enacting legislation passed by both Chambers, it makes it easier to do the appropriation that would be required in advance.
4) If all these things happen the Appropriations Committee will be able to make 2 appropriations. The second appropriation will not count against the current fiscal year, 2021. So, it does not have a cost.

This year – FY 2020 – is especially interesting because it is not likely that either chamber will advance a budget resolution. That means, there is an opening for Advance Appropriations to take hold.

- Three bills on Advance Appropriations
    - S. 229 / H.R. 1128 – Indian Programs Advance Appropriations Act
        - Sponsors: Sen. Udall (D-NM)/ Rep. McCollum (D-MN)

- IHS, Contract Support Costs, Bureau of Indian Affairs
- H.R. 1135 – IHS Advance Appropriations Act
  - Rep. Don Young (R-AK)
  - All of IHS, not BIA
  - Senate bill coming soon

**Activities**:

- Letter to Appropriations Committee on Hearing
- Meeting with Chairman of the Budget Committee and Reps. Kennedy and Kildee
- Meeting with Senate Budget Committee Democratic Staff
- Sign on Letter to House Budget Committee
  - 60 Signatures

**Actions needed!**

- Legislation Co-sponsorship!
- IMPACT STORIES!!
- Every time you meet with your Representatives, talk about Advance Appropriations!

**Medicaid Legislative Initiative**

- Medicaid is 68% of IHS's Third Party Revenue!
- Medicaid must be as strong as possible to fund the Indian Health system
- Wanted to have Centers for Medicare and Medicaid Services decision on Washington State Dental Therapy program before advocating for legislation
  - Still waiting for decision, and don't want to lose momentum
- Legislative Strategy:
  - Senator Udall (NM) and Rep. Lujan (NM) interested
  - Seeking Senate Republican Lead on Finance committee
- We need Resolution Support from Tribes and Areas:
  - Albuquerque Area Indian Health Board
  - California Rural Indian Health Board
  - Great Lakes Tribal Health Board
  - Great Plains Tribal Health Board
  - Inter-Tribal Council of Arizona
  - Navajo Nation
  - Rocky Mountain Tribal Leaders Council

1. Allow states to extend Medicaid to all AI/ANs under 138% of the federal poverty level.
   - Implements Medicaid expansion for all eligible AI/ANs.
2. Authorize Indian health system to receive Medicaid reimbursement for services authorized under IHCIA.
   - Reinforces the direct relationship between Tribes and the federal government, rather than relying on state authority.

- Currently, IHS & Tribes can only receive reimbursement for services authorized through the state Medicaid agency.

3. Extend 100% federal reimbursement to Medicaid services by Urban Indian providers to AI/ANs.
   - Currently, only services provided at IHS & Tribal facilities are reimbursed by the federal government at 100%.
4. Clarify in federal law and regulations that—
   - State Medicaid programs can't override Indian-specific provisions in federal Medicaid law.
   - AI/ANs cannot be negatively impacted by state requirements such as work requirements or adding co-pays and monthly premiums.
5. Allow billing for services provided outside a clinic facility's "four walls".
   - Under the current system, Tribes and IHS can only get reimbursed for services provided ***inside*** the facility.
   - This restricts reimbursements for home visits, or services referred outside the IHS or Tribal facility

**Public Health Legislation**

- Comprehensive Addiction Resources Emergency (CARE) Act
  - $800 million in direct funding to Indian Country for substance use prevention/treatment
  - Modeled off Ryan White/HIV Aids Legislation from 1990s
  - Senator Warren (D-MA) and Rep. Cummings (D-MD)
- Senate Committee on Indian Affairs Tribal Public Health Roundtable in May 2019
  - NIHB discussed the need to authorize public health emergency grants for Tribes and codify the Tribal Advisory Committee at CDC in statute
  - NIHB and Tribes want direct funding set-asides for public health programs within HHS

**Veteran's Affairs Tribal Advisory Committee Act**

- S. 524 introduced in February
  - Tester (D-MT), Sullivan (R-AK), Udall (D-NM), Murkowski (R-AK)
  - House companion bill H.R. 2791
- Introduced last year in different form
- Current bill better reflects NIHB's asks
  - 15 members – one from each IHS area + 3 at large
  - ½ of members are veterans
  - Provides recommendations to VA on Native Veteran issues, including behavioral health challenges
  - Committee reports annually to Congress on activities

- Replicates the success STAC and other committees have created at HHS agencies

**Northwest Portland Area Indian Health Board and National Indian Health Board Harm Reduction Collaboration**

- This represents a new area of work for NIHB
    - Interconnected to our opioid, HIV, and hepatitis work
- Hosted a panel on harm reduction during 2019 Tribal Public Health Summit Plenary Session
    - Leaders from Pascua Yaqui, White Earth, Eastern Band of Cherokee, and Lummi Nation
- Attended White Earth Harm Reduction Conference in May 2019
    - Delivered opening remarks to approximately 500 attendees
    - Co-facilitated a one-day strategic planning on a national Tribal opioid response for 70 people
    - Conducted a one-day training on strengthening advocacy for harm reduction efforts
- Applying for foundation funding to facilitate a national, Native harm reduction network
    - To provide Tribal capacity building, and national level advocacy

**Nursing Home Care for Native American Veterans Act**

- Expected to be introduced by Sen. Sinema (D-AZ) and Rep. O'Halleran (D-AZ) in the near future
- Requires VA to reimburse Tribes for care provided in nursing home facilities
- NIHB requesting Tribal set asides for grant funding

**Community Health Representatives and Community Health Aide Program**
**Community Health Representatives**

- Perform vital health screening services for Tribes nationwide
- Help patients handle logistics of health care access
- Can work in or out of facilities

**Community Health Aide Program**

- Operates in Alaska
    - IHS expanding CHAP currently
- Provides frontline medical, behavioral, and dental health services
- Often CHAP providers work in village clinic settings
- Administration wants to combine programs
- Each performs distinct roles in different settings
- Some Tribes prefer to keep CHRs, others want CHAP, others want to use both
- **Funding for CHAP expansion must not come from CHR program or any other IHS appropriation!**

**BREAK**

## INDIAN HEALTH SERVICES (IHS) UPDATE, DEAN SEYLER, PORTLAND AREA IHS DIRECTOR AND BEVERLY MILLER, CALIFORNIA AREA IHS DIRECTOR:

**IHS Strategic Plan FY 2019-2023**
TBD

**What's New?**

- Timeline
  - FY 2019-2023
- Additional Content related to:
  - Introduction / Background
  - Performance
  - Strategic Plan Development
- Minor language updates:
  - Goals
  - Objectives
  - Strategies
- Appendices
  - Crosswalks

- **Mission:** To raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.
- **Vision:** Healthy communities and quality health care systems through strong partnerships and culturally responsive practices.
- **Access**
  - Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people.
    - Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce.
    - 12 Strategies
    - Objective 1.2: Build, strengthen, and sustain collaborative relationships.
    - 5 Strategies
    - Objective 1.3: Increase access to quality health care services.
    - 14 Strategies

- **Quality**
  - Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization.
    - Objective 2.1: Create quality improvement capability at all levels of the organization.
    - 8 Strategies
    - Objective 2.2: Provide care to better meet the health care needs of American Indian and Alaska Native communities.

- 6 Strategies

- **Management and Operations**
  - Goal 3: To strengthen IHS program management and operations.
    - Objective 3.1: Improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public.
      - 6 Strategies
    - Objective 3.2: Secure and effectively manage the assets and resources.
      - 10 Strategies
    - Objective 3.3: Modernize information technology and information systems to support data driven decisions.
      - 9 Strategies

**Implementation of the Strategic Plan**

- Road map that will guide IHS forward over the next five years.
- Implementation is no small task and requires input from across IHS.
- Everyone has a role and stake in its success.
- IHS employees are expected to identify how their work contributes to the IHS Strategic Plan.
- Anyone can provide feedback on the plan and ideas for implementation by emailing: IHSStrategicPlan@ihs.gov.

**Resources**

- IHS Strategic Plan web site
  - Download a PDF version
  - DTLL/UIOLL link
  - Download Response to Comments
- Questions or comments?
  - E-mail: IHSStrategicPlan@ihs.gov

**Tribal Leader Letters**

- June 21, 2019 – Consultation and Confer session on the Opioid Grant Program
- June 7, 2019 – Deadline extended on CHAP comment period
- May 24, 2019 – Update on IHS Sanitation Deficiency System
- May 15, 2019 – PRC Tribal Consultation results
- May 8, 2019 – Initiate Tribal Consultation on draft CHAP Policy
- April 23, 2019 – Accepting applications for the FY19 Small Ambulatory Program
- www.ihs.gov/newsroom/triballeaderletter/

**FY18 Catastrophic Health Emergency Fund**

- **Status as of June 25, 2019 for the Portland Area**
  - 79 total cases
  - 53 amendments
  - $3,277,045.00 in reimbursements
  - $66,291.49 pending reimbursements
  - 98% Reimbursed
  - **FY18 CHEF Balance: $ 582,067.00**
- **Status as of July 8, 2019 for the California Area**
  - 9 total cases
  - 5 amendments
  - $556,405 in reimbursements
  - $88.428 pending reimbursements
  - 84% Reimbursed
- **Status as of July 8, 2019 for the California Area**
  - 1 case
  - 0 amendments
  - $0 in reimbursements
  - $53.876 pending reimbursements
  - 0% Reimbursed

**CHEF Online Tool**

- Fully automated paperless process for identifying, documenting and submitting CHEF cases for reimbursement.
- Implemented for Federal PRC Programs on May 1, 2019
- Tribal programs have the option to opt-in/opt-out

**Indian Health Care Improvement Fund (IHCIF)**

- FY 2018 Results Posted www.ihs.gov/IHCIF/
- FY 2019 Workgroup results to be presented to Principal Deputy Director on July 31st
- Phase II of the IHCIF workgroup is to make recommendations for potential revision to the formula, which would impact any future funding increases (if provided by Congress)

**Indian Health Care Improvement Fund Workgroup Members**

- **Tribal Representatives for Portland**
  - Gail Hatcher
  - Steven Kutz (alternate)

- **Technical Support Team**
  - CAPT. Ann Arnett, Executive Officer

- ❖ Nichole Swanberg (alternate)

- ❖ **Tribal Representatives for California**
  - ❖ Chris Devers, Tribal Representative, Pauma Band of Luiseno Indians
  - ❖ Mark LeBeau, Executive Director, California Rural Indian Health Board, Inc.
- ❖ **Technical Support Team**
  - ❖ Christine Brennan, CAIHS, Statistician

**Highlights of the FY 2020 President's Budget**

5.9 billion total discretionary budget authority

- Current Services $69 million (pay costs, inflation & pop growth)
- Services $4.3 billion
  - $2 million quality and oversight
  - $8 million recruitment and retention
  - $12 million Tribes that received federal recognition
  - $20 million expansion of the Community Health Aide Program (CHAP)
  - $25 million initial investment in modernizing the Electronic Health Record system
  - $25 million establishing the Eliminating Hepatitis C and HIV/AIDS in Indian Country Initiative
- Facilities $803 million
  - $166 million health care facilities construction
  - $193 million sanitation facilities construction
  - $444 million maintenance and improvement, medical equipment, and the Facilities and environmental Health Support program
- Contract Supports Costs $855 million (remains an indefinite discretionary appropriation for full funding)

**Indian Health Service Senior Leadership Team Announcements**

- Mr. Christopher Mandregan, A Tribal member of the Aleut Community of St. Paul, Alaska, to serve as the new IHS Deputy Director for Field Operations
- Rear Admiral Chris Buchanan, current IHS Deputy Director, will also serve as Acting Deputy Director for Management Operations at IHS Headquarters until a permanent replacement is selected
- Mr. Mitchell Thornbrugh, an enrolled member of the Muscogee Creek Nation, as the permanent Chief Information Officer and the Director of the IHS Office of Information Technology

**Upcoming Events**

- July 22-26: National Combined Councils Meeting – Scottsdale, AZ

- July 23-25: Tribal American Indian and Alaska Native Injury and Violence Prevention Conference – Denver, CO
- July 28: Work Hepatitis Day
- July 29: National 4th Quarter Direct Service Tribes Advisory Committee Meeting, Albuquerque, NM
- July 30-31: Direct Service Tribes National Meeting, Albuquerque, NM
- August 6-9: Diabetes in Indian Country Conference – Oklahoma City, OK
- August 24-30: National Clinical & Community-Based Services Conferences – Tigard, OR
- September 30: Federal Government Fiscal Year End 2019

## RESOLUTIONS:

NPAIHB, Laura Platero and CRIHB, Mark LeBeau

- #19-04-02/#334-08-19 A Call to Congress to Support Advance Appropriations for the Indian Health Service
- #19-04-03/#335-08-19 Full Funding for Indian Health Service
- #19-04-04/#336-08-19 A Call to Congress to Support Mandatory Appropriations for the Indian Health Service
- #19-04-05/#337-08-19 A Call to Congress to Fully Fund Section 105(l) Indian Self-Determination and Education Assistance Act (ISDEAA) Lease Obligations to Tribes and Tribal Organizations
- #19-04-06/#338-08-19 A Call to Congress to Enact Mandatory Appropriations in Support of the National Child Traumatic Stress Initiative
- #19-04-07/#339-08-19 Support of Enacting Legislation to Ensure Medicaid Fulfills Federal Trust Responsibility to American Indians/Alaska Natives
- #19-04-08/340-08-19 Department of Health and Human Services Office of Minority Health American Indian/Alaska Native Health Research Advisory Committee
- #19-04-09/#341-08-19 Support for Increased Funding for the Special Behavioral Health Pilot Program and Option for Funding through Title I and Title V Funding Agreements
- #19-04-10/#342-08-19 A Call to Indian Health Service to Move the Purchased/Referred Care (PRC) Dependent Factor in the PRC Funding Formula to the Annual Adjustment Category
- #19-04-11/#343-08-19 Support for Legislation that Establishes a Department of Veterans' Affairs (VA) Tribal Advisory Committee (TAC)
- #19-04-12/#344-08-19 Support for Permanent Reauthorization of the Special Diabetes Program for Indians and Change to Indain Self-Determination Education Assistance Act (ISDEAA) to Support SDPI Funding through Title I and Title V Funding Agreements
- #19-04-13/345-08-19 Urging the Substance Abuse and Mental Health Service Administration (SAMHSA) to Remove Unnecessary Government Performance and Results

Modernization Act Reporting Requirements for Opioid Treatment Services Provided by Tribes and Urging Congress to Increase Funding for these Services

**NPAIHB:** Motion to pass resolutions as group; Motion by Andrew Shogren, Suquamish Tribe,2nd by Shawna Gavin, Confederated Tribes of Umatilla; **MOTION PASSES**

**CRIHB**: Motion by Archie Super, Karuk Tribe, 2nd by Trinidad Krystall, Torres-Martinez Desert Cahuilla Indians, 1 No, 2 abstain; **MOTION PASSES**

**PHOTOS TAKEN**

**LUNCH**

## EPICENTER DIRECTOR UPDATE, VANESSCIA CRESCI, MSW, MPA, ACTING EPIDEMIOLOGY MANAGER, CALIFORNIA TRIBAL EPIDEMIOLOGY CENTER, DIRECTOR, RESEARCH & PUBLIC HEALTH DEPARTMENT, CALIFORNIA RURAL INDIAN HEALTH BOARD, INC. AND VICTORIA WARREN-MEARS, PHD, RDN, FAND, DIRECTOR, NORTHWEST TRIBAL EPIDEMIOLOGY CENTER, NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD:

**Tribal Epidemiology Centers (TEC)**

- Established via Indian Health Care Improvement Act (IHCIA)
- Four TECs were started in 1996, now 12 TECs
- TECs function independently, but also as part of a national group called TEC-Consortium

**TECs as Public Health Authorities**

- Established through permanent reauthorization of the Indian Health Care Improvement Act (IHCIA) as part of the Patient Protection and Affordable Care Act (2010)
  *The Secretary "shall grant to each epidemiology center… access to use of the data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary."*
  25 U.S.C.A. § 1621m(c)
- Health and Human Services (HHS) directive gives TECs access to HHS data systems and protected health information
- Centers for Disease Control and Prevention must provide TECs technical assistance
- Each Indian Health Service (IHS) Area must have TEC access

**California Tribal Epidemiology Center**

- Formed in 2005
- Housed within the California Rural Indian Health Board's Research and Public Health Department
- Guided by an Advisory Council, but reports to CRIHB Board of Directors
- Staff by 6 Epidemiologists, 4 Program Evaluators, 2 Project Coordinators, 1 Research Associate, and 1 Outreach Coordinator

**Northwest Tribal Epidemiology Center**

- Formed in1996
    - Tribal leaders had approved the concept and function of a tribal research and epidemiology center prior to this time.
- Housed within the Northwest Portland Area Indian Health Board
- Guided by the Public Health Committee of the NPAIHB, and report to the NPAIHB Board
- Functions as a departmental designation with oversight of over 30 employees

**7 Core Functions**

- Collect data
- Evaluate data and programs
- Identify health priorities with Tribes
- Make recommendations for health service needs
- Make recommendations for improving health care delivery systems
- Provide epidemiologic technical assistance to Tribes and Tribal organizations
- Provide disease surveillance to Tribes

**1. Collect Data**

- Tribal Behavioral Risk Factor Survey (adult and youth)
- Community Health Assessments
- California Health Interview Survey: AIAN oversample
- Health Priorities Survey
- Oral Health Needs Assessment
- California Tribal Opioid Strategic Plan
- NWTEC does data linkage work with the Northwest Tribal Registry to correct misclassification of individuals in State and Regional data systems, who are not correctly identified as AI/AN.
- NWTEC collects original data from surveys and projects
- NWTEC collects both numeric and story based data

**2. Evaluate Data and Programs**

- Good Health and Wellness in Indian Country

- MSPI/DVPI Technical Assistance Provider
- California Tribal Comprehensive Cancer Control Program
- Tribal Personal Responsibility and Education Program
- Native Connections
- Building Public Health Infrastructure in Indian Community
- Tribal Public Health Capacity Building
- Project Pathway
- Tribal Opioid Response
- Dental Transformation Initiative
- Provide specialized evaluation to Tribal projects upon request
- NWTEC evaluates behavioral health programs in our region
- NWTEC evaluates Good Health and Wellness activities
- Conduct internal evaluation on all of our programs
- Provide specialized evaluation to tribal projects upon request

**3. Identify Health Priorities**

- Health Priorities Survey: Statewide to community, 2017
- Annual Health Priorities Survey: THP/UIHP Directors
- Multi-site THP priorities reports
- NWTEC conducts an annual health priorities survey with regional tribal leadership and health directors
- NWTEC staff scan the environment for emerging public health topics.
- NWTEC collaborates with the Portland Area Office of Indian Health Service to identify priority health concerns.

**4. Make Recommendations for Health Service Needs**

- Provide feedback and data for Tribal consultations
- Serve as a resource for federal agency Tribal Advisory Committees' California delegates
- Develop and publish data reports
- NWTEC publishes data to inform the decision making processes around health service needs.
- NWTEC provides data to support regional consultation and budget development for HHS programs.
- Provide technical assistance for advocacy.

**5. Improving Healthcare Delivery Systems**

- Collaborate with Medical Director/Medical Epidemiologist and Public Health Nurse on projects
- Summer Research Assistant Program
- Annual Data, Evaluation, and Grant Writing training

- Tribal Adverse Childhood Experiences pilot project
- NWTEC staff has created communities of practice for Hepatitis C, Opioid treatment and Diabetes.
    - More communities of practice are on the horizon to assist communities with treatment of complex disease cases.
    - Have provided opportunities for other health boards to develop these services.
- Conduct data analysis for SDPI programs within our area
- Conduct various trainings regionally and nationally to improve care

**6. Provide Technical Assistance**

- Access to data
- Data collection
- Data interpretation and dissemination
- Program evaluation
- Survey development
- Evaluation plan development
- Focus groups
- Key Informant Interviews
- Community health assessments
- Community Readiness Model
- Outbreak response
- Surveillance
- Data management and use

**Provide Epidemiologic TA**

- NWTEC offers training in a variety of topics, including health data literacy to assist tribes in understanding and using data.
- Provide access to linkage corrected data to both States and Tribes.
- Provide technical assistance across all of our program areas for health promotion and disease prevention.
- Staff include a Centers for Disease Control and Prevention Epidemic Intelligence Service Officer (EISO) and Public Health Associate Program Staff.
- House the Portland Area Office IHS medical epidemiologist to ensure close collaboration to benefit Area tribes.

**7. Provide Disease Surveillance and Promotion of Public Health**

- Development of a Disease Outbreak Response Protocol
- Development of a Disease Surveillance Protocol
- Monitor infectious diseases
    - Disseminated information regarding Zika and Measles outbreak
- Emergency Preparedness staff capacity development

**7. Provide Disease Surveillance and Promotion of Public Health: Opioid Surveillance**

- Implement a Tribal Opioid Surveillance Assessment
    - Assess Tribal-specific capacity and gaps
- Partner with Tribes and Stakeholders to improve opioid surveillance

- Partner with California Department of Public Health to improve AIAN reporting via California Opioid Surveillance Dashboard
- Address and improve data issues related to racial classification across data systems
  - Partner with 2 Tribal Health Programs to link AIAN data with death vital statistics to assess racial misclassification
- Improve non-fatal overdose data collection
  - Work with 2 Tribal Health Programs and hospitals to assess data issues and improve data sharing
  - Partner with a Tribe to pilot ODMAP use
- Improve fatal overdose data collection
  - Develop partnerships with medical examiners, coroners, funeral directors

**Provide Disease Surveillance and Promotion of Public Health**

- NWTEC has provided a Public Health Emergency Preparedness conference, annually over the last 13 years to enhance jurisdictional collaboration during an emergency.
- NWTEC provides assistance with tasks related to Public Health Accreditation preparation.
  - Assists with MOU development for medical countermeasures and disease investigation
- Staff assisted States of Washington and Oregon with recent measles outbreak

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## CRIHB TELEHEALTH & WORKFORCE DEVELOPMENT INITIATIVES - HEALTH SYSTEMS DEVELOPMENT DEPARTMENT, DR. THOMAS KIM:

**Unique Advantages of Indian Health Boards**

- Sit in a unique place – we sit among many stakeholders
- We have a particular perspective on the issues that face us
- Able to make connections to create models of care/services to address needs

**CRIHB Telehealth Program - *Identifying our Assets***

- Recruitment of independent specialists
- Bundling clinic demand for price negotiation
- CRIHB administrative support, training, TA
- Streamlined payment mechanism through buy-back
- IHS-MOA Medi-Cal rate = $455 per visit

***See PowerPoint for additional graphics***

**Results Over Two Years**

- Multiple specialties
    - Adult Psychiatry
    - Pediatric Psychiatry
    - Endocrinology
    - Pain Medicine
    - Behavioral Health Counseling (LCSW)
    - Primary Care
- **993** contracted service hours of **$224,620** value
- Full financial analysis pending

**Workforce Development**

***Discovering our Assets***

- Motivated clinic staff and community members
- Demonstrated commitment to the community
- Academic partnerships
- Private foundation funding
- Aligned with Tribal sovereignty & self-determination

**Results**

- Medical Assistant Training Program (2 yrs)
    - San Francisco State University

- 29 graduates
- 100% pass rate for national certification exam
- 72% working in Tribal Clinics

- Community Health Representative Training (2 yrs)
  - Washington State Department of Health
  - 39 participants
  - 12 Tribal Health Programs + Tribal Head Start
  - 25% clinics using *PRAPARE Social Determinants of Health Survey*
- Medical Scribe Certification Program (starting Aug 2019)
  - Shasta Community College

**Lessons Learned**

- Importance of community outreach to increase telehealth demand and acceptance
- Need for continual support and training of Telehealth Coordinators
- Role of eConsult services to preserve PRC funds and improve care
- Creating entry point and pipeline for health care career
- Importance of soft skills training for professional success
- Importance of providing training in social determinants health and team-based care
- Need for Health Information Management (CAC) and Practice Management training leading to certification

*Indian Health Boards are uniquely positioned to create high impact programs*

**BREAK**

## VA OFFICE OF TRIBAL GOVERNMENT RELATIONS, TERRY BENTLEY, TRIBAL GOVERNMENT RELATIONS SPECIALIST AND KARA HAWTHORNE, PROGRAM MANAGER, VA IHS/THP REIMBURSEMENT AGREEMENT PROGRAM:

**VA Communications with Tribes**
**Mission Act**

- Sept. 2018 Office of Academic Affiliations (OAA) held Q&A NIHB Oklahoma City, OK
- Oct. 2018 OAA presented to the Tribal Self-Governance Advisory Committee in DC
- March 2019 Office of Community Care (OCC) invited Alaska Tribal Leaders to participate in Tribal Self-Governance in Traverse, MI
- April 2019 OCC presented to National Tribal Self-Governance Conference, Traverse City, MI
- April & May 2019 DTLL Office Enterprise Integration, VA Compiling feedback w/ anticipation of release tribes
- June 2019 dTLL OTGR sent key information on implementation of Mission Act

- June 2019 SECVA taping with national syndicated radio show "Native American Calling" to discuss Mission Act

**VA Communications with Tribes**
**Reimbursement Agreements**

- March 2019 Office of Community Care (OCC) met with Alaska Native Tribal Health Consortium
- TBD DTLL seeking nominees for the Care Coordination Workgroup

**Regional Update**
**Highlights**

- Tribal Veteran Representative Training – 3 events, 1 OR, 2 CA anticipate 1 CA and 1 WA – these training are in collaboration with State Departments of Veterans Affairs and hosted by tribes
- Claims Events – 3 so far and 2 more scheduled – connecting Veterans to benefits and services in Indian Country
- Working with Urban Indian Health Programs to connect with VA programs
- Working with Senior Tribal Programs to connect with VA programs
- Working on National "I am Not Invisible Campaign" featuring Native Women Veterans who have served in the military
- VA will be releasing 2018 Executive Summary Report on VA Claims Events in Indian Country – Guide for Best Practice
- VA released its 2018-2024 Strategic Plan updated May 2019 – see link: https://www.va.gov/performance/

**VA ~ Office of Tribal Government Relations**
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**VA Indian Health Service (IHS) /Tribal Health Program (THP) Reimbursement Agreement Program, Kara Hawthorne, Program Manager**

**Background**

- The VA- IHS/THP Reimbursement Agreements Program provides a means for IHS and THP health facilities to receive reimbursement from the VA for direct care services provided to eligible American Indian/Alaska Native (AI/AN) Veterans.
- This program is part of a larger effort set forth in the VA and IHS Memorandum of Understanding signed in October 2010 to improve access to care and care coordination for our nation's Native Veterans.
- The National VA-IHS Reimbursement Agreement signed in December 2015, and we began executing individual THP Agreements at that time.
- The National Agreement and THP Reimbursement Agreements with individual THPs and Alaska THPs extended to June 30, 2022.

**IHS/THP Milestones**

- October 1, 2010: the VA Under Secretary for Health and the IHS Director signed a Memorandum of Understanding (MOU).
    - March-May 2012: VA, IHS, and THPs initiated tribal consultation on a draft national agreement.
    - June 2012: Confirmed the approach of one National Agreement with IHS and individual sharing agreements under 38 USC 8153 for THPs due to their sovereign nature.
    - August 24, 2012: VA Under Secretary for Health signed and distributed the Dear Tribal Leader Letter with program guidance.
    - December 5, 2012: VA-IHS National Agreement signed.
    - June 28, 2018: VA-IHS National Agreement was extended through June 30, 2022.
    - June 2018 - present: Most THPs Agreements were extended through June 30th, 2022.
    - Present: Ongoing coordination and onboarding of THPs.

**Benefits**

- **Collaboration** - Promotes quality health care through collaborative relationships both intergovernmental by sharing resources and with the community
- **Choice of Provider and Access -** Eligible AI/AN Veterans can choose to receive their health care from the IHS/THP facility and/or VA facility closer to their homes in a culturally sensitive environment.
- **Pharmacy** – facilities will be reimbursed for outpatient medications dispensed by the facility that are on the VA's formulary. This is not limited to emergent prescriptions
- **No Copayment** – Pursuant to section 405(c) of the Indian Health Care Improvement Act (IHCIA), VA copayments do not apply to direct care services delivered by the IHS or THP healthcare facility to eligible AI/AN Veterans under agreements with VA.
- **No Outstanding Balances**

- For United States lower 48 states, IHS and THP medical facilities bill third parties prior to billing VA. This means VA is only responsible for the balance remaining after third party reimbursements.
- For Alaska Tribal Facilities, VA reimbursement payment under this agreement is considered as payment in full. Alaska THPs or other organizations cannot be reimbursed for such care from entities or individuals other than the VA.

**Direct Care Services**

- Reimbursement is for Direct Care Services
- Direct Care Services are defined as any health service that is provided directly by IHS/THP. This does not include Contract Health Services, unless those services are provided within the walls of the IHS or THP facility.
- VA will not reimburse for any services that are excluded from the Medical Benefits package or for which the eligible AI/AN Veteran does not meet qualifying criteria.

**Payment Methodologies and Fees**

- **Inpatient** hospital services are based on Medicare Inpatient Prospective Patient System (IPPS) for Lower 48 and All Inclusive Per diem Rate for Alaska.
- **Outpatient** services are based on the IHS All Inclusive Rate published in the Federal Register.
- **Critical Access Hospitals** are reimbursed at the established rate as determined by Medicare.
- **Ambulatory Surgical Services** are reimbursed at Medicare rates.
- **Administrative fees** applied to the following claims:
  - Except for Pharmacy, paper claims will incur a $15 fee for the duration of agreements

**Eligibility and Enrollment**

- VA, IHS and THP are responsible for determining eligibility for health care services within their respective programs.
- The eligible Veteran must also meet IHS eligibility requirements and be eligible for services in accordance with 42 C.F.R. Part 136.
- Veterans must be enrolled in the VA system before a claim can be processed and reimbursed.
-

**Status**

- To date, VA has reimbursed over $96 million for direct care services provided by IHS & THPs covering over 10,100 eligible AI/AN Veterans.
- IHS:77 Implementation plans signed.
- THP: Currently 114 signed agreements, with ~40 tribes in progress.

**Basics for Establishing Agreements**


- Using the agreement template, the VAMC, THP, and Contracting Officer work together to complete the draft reimbursement agreement.
- The national template shall always be used.
- Concurrently, the THP works to satisfy local implementation criteria.
- Once the draft is complete, it will be reviewed by Office of Community Care, Network Contracting Office and Regional Counsel, respectively.
- After final signatures, reimbursement for direct care can commence.

**IHS/THP Agreements Versus Other MOUs**

Reimbursement agreements:

- Apply only to AI/AN Veterans receiving direct care services, except in Alaska.
- Do not relate to existing Memorandum of Understandings (MOUs) or sharing agreements.
- Program guidance and authorities for these agreements do not apply to other agreements or MOUs that maybe in progress and/or in place.

While some VA Medical Centers' (VAMCs) staff involved with Reimbursement Agreements might also be the points of contact for other MOU development efforts, the efforts should be considered separate and distinct.

**IHS/THP Resources and Contact Information**

Information on how to establish agreements, templates, forms and guides about the program are housed at Veterans Health Administration (VHA), Office of Community Care

https://www.va.gov/COMMUNITYCARE/programs/veterans/ihs/index.asp

https://www.va.gov/COMMUNITYCARE/providers/info_IHS-THP.asp.

For more information on getting started with Tribal Health Program agreements, please contact us via email at;
tribal.agreements@va.gov

**VA MISSION Act: An Overview of Key Elements**
**What is the MISSION Act?**
The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 will fundamentally transform VA's health care system. It will fulfill the president's commitment to provide Veterans with more choice in their health care providers. The Act includes four main pillars:

1. Consolidating VA's community care programs.
2. Expansion of Caregivers Program
3. Flexibility to align its asset and infrastructure
4. Strengthening VA's ability to recruit and retain health care professionals.

**What is it NOT?**
The MISSION Act is not a step toward privatization. It's about significantly improving Veterans' experience and enhancing their access to care.

**Key Elements**
**Community Care -** Consolidates VA's multiple community care programs into one that is easier to navigate for Veterans and their families, community providers and VA employees.
**Caregivers Program -** The Act expands eligibility for VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC) by including eligible Veterans from all eras of service.
**Asset and Infrastructure -** The Asset and Infrastructure Review (AIR) process in the Act will provide VA the necessary flexibility to align its infrastructure footprint with the needs of the nation's Veterans.
**Recruit and Retain -** The Act will allow for additional, improved recruitment efforts, including a new scholarship program, greater access to VA's education debt-reduction program and improved flexibility for providing bonuses for recruitment, relocation and retention.

**Veteran Community Care: Key Changes**
**New for Veterans**
Veterans receive new benefits under the Veteran Community Care Program. These benefits include

- Access to urgent care

- Expanded eligibility for community care
- Scheduling by the Veteran and VHA
- Technology that streamlines communication

**New for Community Care Providers**
Establishment of the Community Care Network and Veteran Care Agreements. Community providers must now:

- Undergo an industry standard credentialing process
- Be subject to an exclusionary process
- Complete mandatory training
- Technology that streamlines bidirectional communication

**New for VA Staff**
Introduction of new and modernized IT systems and business processes that will result in:

- Fewer manual process / increased automation
- Increased availability of performance metrics
- Broader options for care coordination
- Faster, easier, auditable information sharing

Only direct impact to the IHS/THP reimbursement program is section 101, which allows for the continuation of the program

**Community Care Network (CCN)**
The **Community Care Network (CCN)** is a new set of **region-based** contracts to provide health care services in the community through a contractor who **builds** and **credentials** the associated network and **processes claims**.

**<u>Benefits of the CCN:</u>**

- Gives VA control of Veteran care and experience
  - VA is taking back **scheduling**, **care coordination**, and **customer service** functions
- Gives VA convenient access to a network of qualified, **credentialed providers**
  - by having a provider network **accredited** by a nationally recognized accrediting body
  - by increasing local collaboration on **network development**
  - by having visibility into the **provider network** via the Provider Profile Management System (PPMS)
- Gives VA a streamlined community care processes
  - by including **more services** under CCN
  - by **no longer** adjudicating claims

**Community Provider Resources**
**VA Community Provider Website**

- Update with latest Community Care Network, MISSION Act, etc. fact sheets,
- Post any Community Care programs and policy changes,
- Provide links to external websites of interest/use for providers
- https://www.va.gov/COMMUNITYCARE/providers/index.asp

**VHA Provider Updates Newsletter**
A monthly e-publication for community providers that delivers scheduled updates about programs, policies and changes.
Subscribe at:
https://public.govdelivery.com/accounts/USVHA/subscriber/new?topic_id=USVHA_1240

**VA Community Provider Webinar Series**
Office of Community Care Overview Series: An overview of Community Care Programs.
Accredited Topics Series: Accredited webinars with VA experts presenting on health care-related topics.
Register at: https://www.train.org/vha/welcome

**Community Resources**

- VA Mission Act and New Veterans Community Care Program Fact Sheet
  https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/FactSheet_20-13.pdf
- Video – Community Care Network
  https://youtu.be/T4t4M1cVybE
- Community Providers Webpage
  https://www.va.gov/COMMUNITYCARE/providers/index.asp
- CCN fact sheet
- Community Care Network (CCN) Fact Sheet Library
  https://www.va.gov/COMMUNITYCARE/pubs/factsheets.asp

## TRIBAL COMMUNITY HEALTH PROVIDER AND COMMUNITY HEALTH AIDE PROGRAM PROJECTS, CHRISTINA PETERS, TCHPP DIRECTOR AND SUE STEWARD, CHAPP DIRECTOR

**Goals for Today**

- Provide a brief history of CHAP in Alaska
- Discuss the Draft Interim Policy, CHAP TAG and the President's proposed budget
- Review CHAP and CHR programs, how they complement each other
- Inform about the Portland Area CHAP Board Advisory Workgroup
- Familiarize about the Dental Health Aide Therapist (DHA/T);
- Behavioral Health Aide Practitioner BHA/P; and
- Community Health Aide Practitioner CHA/P
- Conclude with Why CHAP Matters!

**What is CHAP?**

The Community Health Aide Program (CHAP) is a multidisciplinary system of mid-level behavioral, community, and dental health professionals working alongside licensed providers to offer patients increased access to quality care in tribal communities.

- Community Health Aide/Practitioners are primary care, mid-level providers who provide full spectrum, wrap around care for oral, behavioral and medical health in the clinic or in the home. This can include patient history, vitals, diagnostics, assessments, dispensing of medications and follow up care.

**What is CHAP?**

**Inception**

- Remote Alaska access by air or water
- IHS physician visits
- Traditional healers
- Physician extenders
    - CHA/P, BHA/P and DHAT
- TB epidemic
- High rate of infant mortality
- High rate of unintentional injury

**Providers**

- Typically, Tribal or Village Member
- Often Generational
- Role model for the village
- Understands and may also speak the language
- Understands and participates in ceremonies
- Is familiar with and open to Tribal based or best practices understanding that evidence based is not always preferred

**National Policy on CHAP (May 2019)**

- *As a result of Tribal Consultation in 2016, where Tribes overwhelmingly supported CHAP expansion outside of Alaska, IHS began putting in motion the necessary step to implement CHAP.*
- *The Indian Health Service, as a result of the 2016 consultation formed the CHAP Tribal Advisory Workgroup (TAG) IHS Circular 18-01*
- *The CHAP TAG in partnership with IHS released a draft interim National Policy on CHAP for Tribal Consultation*
- *This policy development included Tribal and IHS representation*
- *The CHAP TAG does not support eliminating or defunding the CHR program*

**National Policy on CHAP**

- The Purpose of this Interim National Policy on CHAP
  - *To permit those Areas, that do have Resources and Infrastructures to Implement CHAP, to move forward with CHAP expansion at their own expense*
  - *This Policy does not require Tribes or Areas to implement CHAP or hire CHAP providers*
  - *This policy does not affect CHR program or its funding*
  - *Congress has not yet provided funding for this policy implementation*

*There has been NO consultation on the elimination of the CHR program which is separate from the current tribal consultation on CHAP policy*

**CHR and CHAP**

- **Legislative Authority**- CHAP is authorized under 25 USC § 1616 a-d while the CHR Program is authorized under IHCIA PL. 100-713.
- **Funding Sources**- The Alaska CHAP is funded through the hospital and health clinics (H&HC) line item in the IHS budget and CHRs are funded through a specific CHR line item.
- **Scopes of Work**- While the "community health" portion of the names are similar, the scope of work for a Community Health Aide and Community Health Representative are vastly different. CHAs are mid-level primary medical providers who can provide basic medical attention and can connect a patient to clinical care. CHRs provide health promotion, prevention, and outreach to community members.

**Complementary Programs**

**CHR**

- CHRs fill critically important roles to the health of their communities
- Longstanding presence in some communities
- Trained from the community
- May include indigenous knowledge informed systems of care
- Experience navigating patients to care and services in that specific community
- Deep understanding of culture, community, and existing health care infrastructure

**CHAP**

- Broad scope of practice, provides routine, preventative, and emergent care
- Respects the knowledge and resources in the tribal community and grows providers from that source.
- Trains AI/AN community members who speak the native languages and provide culturally appropriate care
- Breaks down barriers to care and barriers to training;
- Training minimizes time away from communities and families.
- Brings care to communities;
- Fosters a team approach to delivering health care services

**Complementary Programs**

- CHR is a great place to recruit for CHAP providers
- Thriving CHR program supports the entire health delivery system
- CHR and CHAP providers work together with the rest of the medical/dental team to improve the health of the community

**President's FY 2020 proposed budget (March 2019)**

The President's FY 2020 proposed budget includes a cut of $39 million from the CHR program and at the same time creates a new $20-million-line item for CHAP nationalization.

- *The Administration has indicated their intent to transition CHRs into the CHAP*
- *Congress has not yet funded this proposal*
- *Tribes oppose CHAP expansion at the expense of reducing or eliminating the CHR Program*
- *Tribes would like to preserve and strengthen the CHR program*
- *For those Tribes that CHOOSE to implement a transition from CHR to CHAP, then resources and technical assistance must be provided by IHS*

**CHAP Board Advisory Workgroup**

**Priorities**

IHS Interim Policy for CHAP;
Portland Area CHAP Certification Board (PACCB);

PACCB Membership Recommendations;
Portland Area Standards and Procedures for DHAT, BHA/P and CHA/P; and
Dental Health Academic Review Committee (DHARC), Behavioral Health Academic Review Committee (BHARC) and Community Health Academic Review Committee (CHARC)

- Andrew Shogren, Chair – Suquamish
- Libby Cope, Co-Chair - Makah
- Kay Culbertson, Secretary - Cowlitz
- CHAP Board Advisory established 7/18/18
- 36-member workgroup
- Meets monthly via zoom and in person at QBMs

**Progress toward PACCB**
**DHAT Education**

- DHAT Curriculum
  - Year 1: basic health sciences, basic dental concepts, professional role development, introduction to clinic, patient and facilities management.
  - Year 2: clinical year, expansion of concepts learned in first year, extractions, community project, village dental rotations.

**DHAT Scope of Practice**

- **Primary DHA (CDHC)**
  - Oral Health Educators
- **Expanded Function DHA**
  - Restorations, cleanings, temporary fillings
- **DHA Hygienist**
  - Local anesthesia
- **DHA Therapist (DHAT)**
  - Prevention, operative, urgent

Supervised providers Teams led by Licensed Dentists

**BHA Education & Training**
**BHA-I**

- Screening
- Initial intake process
- Case management
- Community education, prevention, early intervention

**BHA-II**

- Substance abuse assessment and treatment

**BHA-III**

- Rehabilitative services for clients with co-occurring disorders
- Quality assurance case reviews

**BHP**

- Team leadership
- Mentor/support BHA-I, II, and III

**Behavioral Health Aides / Practitioners**

- Village-based counselors to provide culturally-informed, community-based, clinical services
- Provide behavioral health prevention, intervention, aftercare, and postvention
- Training and practicum requirements
- On-the-job training
- Four levels of certification

**CHA Education & Training**

- Hired, usually by village council
- **Pre-session:** Intro to CHAM/CHA role/ETT or EMT
- **Session I:** 4 weeks ~ 60 hours in village clinic
- **Session II:** 4 weeks ~ 200 hours in village clinic
- **Session III:** 3 weeks ~ 200 hours in village clinic
- **Session IV:** 4 weeks ~ 200 hours in village clinic
- **Session IV Blended:** 18 weeks (16 weeks in village via Distance Learning Network, 2 weeks at Training Center) ~ 200 hours in village clinic, Blended Session I/II in progress
- **Preceptorship:** 1 week-skills & patient encounters; exam

**Community Health Aides and Community Health Practitioners**
**CHA/Ps**

- Local people
- Initially described as "the eyes, ears and hands of the physician"
- 300,000 encounters per year
- Includes emergency, acute, chronic, and preventive health components
- Does not include differential diagnosis but does provide an assessment
- Under medical supervision of a licensed physician

**Alaska Education Includes**

- CPR / AED
- Emergency Trauma Technician or Emergency Medical Technician Certification
- Remote clinics operate as 24-hour access to emergency care

**Why CHAP Matters**

- Proven history of safe, quality care in Alaska for over 50 years
- Uniquely developed for Alaskans by Alaskan and the same is true for Lower 48 Tribes
- Tribes can tailor their programs to their needs
- Decreases travel for routine or non-emergency care
- Increases AI/AN local workforce
    - Home grown, culturally knowledgeable and respected providers

- Competency based, skilled providers who increase access to care
- Extend the reach of services into hard to access areas
- Creates wrap around care and referral services for Tribes
- Increases the number of AI/AN providers
- Creates a career path for AI/AN providers

## LISTENING SESSION ON TRIBAL PUBLIC HEALTH ACCREDITATION, KAYE BENDER, PHAB PRESIDENT/CEO:

**Public Health Accreditation Board**

- The Public Health Accreditation Board (PHAB) is the national, non-profit organization that administers accreditation for state, local, tribal, and territorial health departments.
- Located in Alexandria, VA
- Incorporated in 2009; issued first accreditations in 2013.
- Our development was funded by the CDC and the RWJF. Accreditation fees are now almost half of our budget.

***Please see PowerPoint for additional graphics***

**Benefits One Year after Accreditation**
**% Strongly Agree or Agree**

**91%*** •Accreditation has stimulated greater collaboration across HD departments/units
**88%** •Accreditation has improved the management processes used by the leadership team
**86%*** •Accreditation has improved the credibility of the HD within the community and/or state
**83%** •Accreditation has improved the HD's accountability to external stakeholders
*Post-Accreditation Survey, N=118 *N=35*

**Financial Effects**
**% Strongly Agree or Agree**
**56% Accreditation** has improved the utilization of resources within the health department
**42%** •Accreditation has improved the health department's competitiveness for funding
*Post-Accreditation Survey, N=118 and 72, respectively*

> **Respondent Quote:** *Accreditation "created some **efficiencies**, especially with QI projects. As we try to diffuse that culture of QI throughout the agency, we get lots of suggestions for QI projects that **save staff time and resources**."*

**How Was the Document Developed?**

- The document was developed in partnership with the Tribal Public Health Accreditation Advisory Board, part of the National Indian Health Board.
- It was reviewed by the PHAB Board of Directors.
- It was placed for public comment on PHAB's website for approximately three months.

**Purpose and Use of the Document**

- The document was developed to be used with the PHAB standards and Measures, Version 1.5in order to provide some Tribal specific guidance related to the documentation and process requirements.
- PHAB recommends that the user of this document put it side-by-side with the standards and measures so as to appropriately apply the supplemental guidance.
- This webinar does not attempt to re-state the language in the document. It is a guide to use the document. Tribal health departments should refer to the specific language in the document and not these slides when working on their documentation.

https://www.nihb.org/tribalasi/tribal_asi_tools.php

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## JOINT NPAIHB & CRIHB THURSDAY JULY 18, 2019

**Call to Order:** Greg Abrahamson called the meeting to order at 8:50 a.m**.**

## LEGISLATIVE UPDATE, GEOFF STROMMER, PARTNER HOBBS STRAUS DEAN & WALKER, LLP

**Discussion Topics**

- IHS Advance Appropriations Initiative
- SDPI Reauthorization and Funding
- Section 105(*l*) Leasing
- Contract Support Cost and IHS Policy
- *Texas v. United States* – ACA Litigation
- Opioid Litigation

**Advance Appropriations**

- For many years tribes have sought advance appropriations for IHS funding to address negative impacts of CRs and government shutdowns
- Advance appropriations is **not** the same as forward funding
- Advance appropriations has applied to VA medical accounts for many years
- Legislation was previously introduced in House that would implement this initiative and House directed GAO to conduct a study on feasibility
- GAO issued study last year making it clear concepts can work for IHS
- Recent 35-day government shutdown increased interest in advance appropriations and led to introduction of new legislation

- There are 3 pending bills
    - HR 1135 by Rep. Don Young (R-AK). It would authorize advance appropriations for IHS Services and Facilities Accounts. There are 23 co-sponsors from both parties. Referred to the following committees: Natural Resources, Energy and Commerce, and Budget.
    - HR 1128 by Rep. Betty McCollum (D-MN) who is Chair of the House Appropriations Subcommittee on Interior. It would authorize advance appropriations for IHS Services and Contract Support and some BIA/BIE programs. There are 32 co-sponsors from both parties. Referred to the following committees: Natural Resources, Energy and Commerce, and Budget.
    - S. 229 by Sen. Tom Udall (D-NM) who is Ranking Member on the Senate Interior Appropriations Subcommittee. There are 9 co-sponsors, all Democrats. It is the same as HR 1128 and it was referred to the Senate Budget Committee.

- "Advance Appropriations. —In 2018, the Government Accounting Office (GAO) identified considerations for Congress when considering whether to advance appropriate funds to IHS, including whether IHS has the processes in place to develop and manage an advance appropriation. The Committee directs IHS to examine its existing processes and determine what changes are needed to develop and manage an advance appropriation and report to the Committee within 180 days of enactment of this Act on the processes needed and whether additional Congressional authority is required in order to develop the processes." (House Appropriations Committee FY 2020 Interior, Environment, and Related Agencies Bill Committee report (House Report 116-100))
- House Interior Appropriations Chair McCollum noted at the May 22, 2019 markup that the Committee is asking both the IHS and Indian Affairs for additional information as part of the effort to move forward on providing both agencies advance appropriations, although Committee Report mentions only the IHS.
- Numerous national and regional tribal organizations, as well as many tribes support this initiative
- The ABA is about to enact resolution in support of advance appropriations
- Not clear when hearings will happen or when bills will move
- Including ask for extension of advance appropriations to BIA in addition to IHS complicates the landscape

**SDPI Reauthorization and Funding**

- Authorization for SDPI expires on 9/30/2019
- SDPI has been level funded at $150 million per year since fiscal year 2004
- NCAI and NIHB are advocating that Congress increase the annual appropriation for SDPI to $200 million for fiscal year 2020 to begin to address this unmet need
- H.R. 2680, the SDPI Reauthorization Act of 2019.
- On May 10, 2019, bipartisan legislation was introduced in the House of Representatives to extend both SDPI and the Type 1 Diabetes Research Program for five years at $200 million per year (a $50 million annual increase).
- Referred to Committee on Energy and Commerce.
- 379 House Members and 67 Senators signed letters of support urging the extension of these important programs dedicated to preventing and treating diabetes.
- S. 1895.
- This broad healthcare package legislation would extend SDPI authorization through 2024.
- It does not include an increase in appropriations for the program.
- There is concern that other healthcare extenders in the package are too expensive, which may create challenges in securing wide bipartisan support for the bill.

- On June 4, 2019, the House Committee on Energy and Commerce Subcommittee on Health held a hearing which included legislation to extend SDPI and the Type I Special Diabetes Program.
- A total of 12 health care bills, set to expire September 30, 2019, were the subject of the hearing.
- Even though there is bipartisan and bicameral support for extension of these health programs Republican Subcommittee members object because there is no funding offset for the funding increases.
- A National Tribal Summit on SDPI will take place on September 17, 2019, in conjunction with the NIHB 36th Annual National Tribal Health Conference in Temecula, California.
- The Summit is intended to foster a collaborative discussion on extending 638 authorities to SDPI.
- Additional details will be posted on the NIHB website closer to the conference.

**Section 105(*l*) Leasing**

- All tribes use tribal facilities to provide services under ISDEAA agreements
- Appropriated funds for both BIA and IHS have historically been inadequate to fully fund these facility costs
- Section 105(*l*)of ISDEAA:
  - Tribally owned/leased
  - Used for the purpose of providing PFSAs in FA
  - Mandatory: *Maniilaq I* and *II*
- 105(*l*) leasing has spread throughout Indian Country – approx. 125 leases/lease proposals so far.
- Virtually all of the leases negotiated to date have been with IHS. But the provision applies to BIA and BIE as well.
- Supplemental tribal clinics appropriation: Congress has appropriated additional funds for VBC program and 105(*l*) lease compensation since 2016.
- Not enough has been appropriated to fully fund and IHS has had to use other discretionary funds.
- The ideal solution: a separate, indefinite appropriation for 105(*l*) like that for contract support costs.
- The FY 2019 appropriations act included a $36 million supplemental tribal clinics appropriation for IHS—an increase of $25 million to match the amount IHS had to reprogram in FY 2018.
- In 2018 IHS reprogramed mandatory inflation cost funds to pay the total amount.
- With 105(*l*) leasing expected to continue growing in FY 2019, $36 million will almost certainly not be enough to cover all of the 105(*l*) lease obligations.
- Where will IHS find funds to pay any amount over $36 million?

- The House Appropriations Committee's Interior, Environment, and Related Agencies Subcommittee has marked up its FY 2020 Appropriations bill. The recommendation for clinic leases (both VBC and 105(*l*)) is $53 million, which is $42 million over the Administration's request.
- The Senate Interior Appropriations Subcommittee has not yet marked up its FY 2020 appropriations bill.
- The House and Senate have not agreed to a funding cap number for domestic discretionary spending.
  - The House has proceeded to mark up its funding bills anyway with about a 10% increase over FY 2019 enacted levels.
  - The House- recommended funding amounts are generally seen as a starting point for negotiations with the Senate.
- At the TSGAC meeting on July 16-17, 2019, IHS reported that they are struggling with how to estimate costs going forward:
  - Current estimate of need is $54-56 million (per IHS)
  - Recognition of need to convene a dedicated technical workgroup
  - Adding 105(*l*) leases as a funding needs to the FAAB facilities construction report
  - National Tribal Budget Formulation Workgroup seen as natural entity to host further discussion with tribal leaders
- IHS also wants to conduct a survey on tribally-owned and leased facilities being used under ISDEAA and invite feedback on the level of information that would be appropriate to request from tribes

**Contract Support Cost**

- IHS CSC policy has been partially suspended for a number of months: disagreement with tribes over duplication issues and 97/3 default formula for new program funds.
  - At TSGAC meeting earlier this week, RADM Weahkee reported that the CSC Policy is almost ready for the CSC Workgroup's review, but he did not specify exactly when that would be.
- Recent court ruling that may impact future CSC payments: *Navajo Health Foundation – Sage Memorial Hospital v. Burwell*
  - Ruling in one Federal District Court that IHS owed CSC on health care programs and services funded by third-party revenues such as Medicare, Medicaid, and private insurance.
  - IHS dropped the appeal in 10th Circuit so decision has limited applicability.
  - Same issues are currently being litigated by the Swinomish Tribe in Federal Court in the District of Columbia, a court that all tribes have access to.
- Status of other litigation:
  - *Cook Inlet Tribal Council v. Mandregan*.
  - *Seminole Tribe of Florida v. Azar*.

– *Norton Sound v. Azar.*

**Legal Challenges to the Affordable Care Act: *Texas v. United States***

- District Court Decision. In December 2018, a federal district court in Texas held that, following passage of the Tax Cuts and Jobs Act of 2017, the "individual mandate" provision of the Affordable Care Act (ACA) can no longer be considered a valid exercise of Congress's power to tax and is therefore unconstitutional.
- The district court also held that the individual mandate is not severable from the remainder of the Act (meaning it cannot be separated out without affecting the operation of the rest of the law) and went on to declare the Act invalid in its entirety.
- Appeal. The district court's decision was appealed to the Fifth Circuit Court of Appeal, where the case is now pending.
- Tribal Health Impact. The district court's ruling extends to Section 10221 of the ACA, which amended and permanently authorized the Indian Health Care Improvement Act (IHCIA), and to other Indian-specific health care provisions incorporated into the Act, even though they are not dependent on the ACA's individual mandate.
- If the district court's decision is upheld in full, the IHCIA and other Indian-specific provisions in the ACA would therefore be struck down
- **Tribal Amicus. On April 1, 2019, an amicus brief was submitted in the appeal on behalf of a national coalition of Tribes and tribal organizations, arguing:**
- That the district court did not correctly apply long-established severability rules when it invalidated the ACA in its entirety. These rules state that a court should preserve as much of a statute as possible when one provision is found unconstitutional.
- The IHCIA and certain other Indian-specific provisions in particular should be preserved, because: (1) they can operate as intended by Congress without the individual mandate in place; (2) the IHCIA's legislative history shows that it originated as a freestanding bill in 1976, separate from the rest of the ACA, underscoring that it operates independently of the remainder of the ACA; and (3) there is no evidence whatsoever that Congress would have wanted the IHCIA and other Indian provisions to fail if the individual mandate were deemed unconstitutional.
- United States' Litigation Position. In the district court, the United States agreed that the individual mandate is now unconstitutional, but argued that most of the rest of the ACA should be preserved.
- The United States changed its position in the court of appeals, supporting the district court's decision holding that the entire law is invalid.
- The United States brief, filed on May 1, argues that "minor" provisions included in ACA should not be severed.
    - Essentially argues that the IHCIA and Indian provisions are invalid.

- Jurisdictional Questions on Appeal. Shortly before argument was scheduled, the 5th Circuit asked the parties to file supplemental briefs addressing three questions relating to the court's jurisdiction to hear the appeal:

(1) Do the state intervenors and the U.S. House of Representatives—the parties defending the ACA in the litigation—have standing to intervene in the appeal, and were their interventions were timely;
(2) if not, is there still any live case or controversy between the plaintiff states and the federal defendants, given the federal government's new legal position on appeal; and
(3) what is the appropriate conclusion if there is no live controversy between the plaintiff states and the federal defendants and no other party has standing to appeal?

- This raised the question of whether the Fifth Circuit would even consider the merits of the appeal, and if not, whether it would leave the district court's decision in place or order the district court to vacate its ruling.
- However, in their briefs all parties agreed that there is still a live controversy between the plaintiff states and the federal government and that the Fifth Circuit can and should hear the appeal.
- The parties said the federal government is still enforcing the ACA for now, and the Department of Justice is arguing on appeal that the district court's relief was too broad.
- Oral Argument. A three-judge panel heard the case on July 9, 2019.
- Panel made up of judges appointed by Carterm Bush and Trump.
- None of the Judges, and none of the parties' attorneys, specifically raised or addressed the Indian Health Care Improvement Act or other Indian-specific provisions of the ACA.
- One Judge noted that some provisions of the ACA, like a provision requiring certain restaurant menus to include calorie counts, are not related to the law's health insurance reforms.
- Attorneys for the intervenor states and the House argued that Congress clearly intended for the rest of the law to survive when it eliminated the mandate penalty.
- They also pointed out that several Republican lawmakers represented to the American public that they were not touching protections for preexisting conditions or other popular provisions of the law by zeroing out the tax penalty.
- The judges were confused by the Trump Administration's legal position.
    - After defending the ACA in the district court, the DOJ now supports the lower court's *legal* conclusion that the entire ACA is invalid.
    - At the same time, however, the DOJ argued that the district court's *judgment* striking down the whole law is overbroad, and that some unspecified provisions of the law should not be included in the judgment because they don't affect the plaintiffs in the case.
- Possible Outcomes:
    - Back the lower court decision invalidating the ACA, or overturn it entirely.

- Determine that the elimination of the individual mandate penalty only renders certain parts of the ACA unconstitutional.
- Dismiss the entire lawsuit if they determine that no party has standing to pursue the appeal, in which case they would either leave the lower court judgment in place or require that it be vacated.

**Opioid Litigation**

- Disproportionately impacting Indian Country
  - Health services have been overwhelmed
  - Education and addiction therapy costs have substantially increased
  - Evictions from housing for drug-related criminal activity
  - Almost every tribal member has been affected
- Well over 2,000 suits have been filed in the last few years by states and their political subdivisions, insurance carriers, hospitals, individuals, and Indian tribes and tribal organizations.
- There are 3 classes of defendants who bear significant liability for the crisis – and who benefitted from it:
  - Manufacturers
  - Distributors
  - Retail Pharmacies in some cases
- All federal court cases have been combined as "Multidistrict Litigation" (MDL) under the leadership of Cleveland Federal Judge Dan A. Polster.
- MDL is a unique federal court process different than a class action.
- Judge Polster has stated he would prefer to see the parties reach a "global settlement" of opioid claims, although litigation is proceeding in the meantime on a number of tracks.
- Various "bellwether" (test) cases have been selected for pre-trial briefing and, if necessary, trial.
- First bellwether trial in MDL scheduled this October, involving local government plaintiffs.
- There are over 100 tribal cases on behalf of over 340 tribes pending in the MDL litigation.
- Two "tribal track" bellwether cases have been established: Muscogee (Creek) Nation and Blackfeet Tribe.
- In October an amicus brief was filed on behalf of 448 Tribes in both cases.
- Earlier this year the Defendants filed Motions to Dismiss in both cases, asking the court to make a threshold ruling that the Tribes' complaints were not sufficient to state any legal claims for relief.
- On June 13, 2019 the Judge issued an Opinion and Order ruling that rejected most of the Defendants' dismissal arguments.

- Both tribal bellwether cases now proceed to discovery and trial phases. No trial dates scheduled yet.
- A Tribal Leadership Committee (TLC) has been appointed by the Court to advise the Plaintiff's MDL Leadership Committee on litigation and settlement strategy for the tribal cases.
- The TLC has had several meetings with State Attorney Generals who have committed to support a key principal: Tribes will be treated independently (and as sovereigns) in any settlement.
- Methodology that is used to calculate the overall set aside for tribal claimants in any global settlement might be different than the methodology that will be used to reallocate settlement amount among tribes.
- Settlement discussions are still very preliminary. Plaintiffs have claims for past damages, but settlement focus has so far been mainly on prospective remedies to help fix the problem.
- Other plaintiffs in the MDL continue to pursue a settlement as well.
- In one approach, on June 14, 2019 cities and counties across the country filed a Motion to establish a "Negotiation Class."
- If approved, the class would be solely for the purpose of negotiating a comprehensive settlement with regard to such entities—it would not create a class action for purposes of litigation.
- Momentum on all settlement discussions is directly linked to aggressive litigation: more pressure on the defendants is brought through trial dates and removal of cases to State courts for more trials.

Questions?

For more information, please contact:
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## SWINOMISH DIDGʷÁLIČ WELLNESS CENTER, JOHN STEPHENS, EXECUTIVE DIRECTOR:

**Didgʷálič Background**
In 2016, the Swinomish Senate ambitiously decided to use their own funds and resources to combat the opioid crisis

The community understands that this is a local and national issue affecting Native and non-Native populations.

**Serving the Need**
The didgʷálič Wellness Center remains the only facility in Skagit County that provides full-service medication assisted treatment ("MAT") and is the only MAT facility to provide fully-integrated primary care, mental health services, and counseling.

**Critical Treatment Gaps in Opioid Epidemic**

1. **MAT is not available for most patients**. Only 23% of publicly funded treatment programs and fewer than 50% of private programs offer MAT. *American Journal of Public Health*
2. **Most MAT patients don't have adequate access to counseling.** "[B]y itself, medically supervised withdrawal is usually not sufficient to produce long-term recovery, and it may increase the risk of overdose[.]" New *England Journal of Medicine*
3. **Referrals to primary care are ineffective.** Research demonstrates referrals result in only 35% of patients actually receiving primary care. *American Journal of Public Health*

**Two Types of Medication Assisted Treatment (MAT)**

- Methadone and Suboxone are delivered in two "siloed" environments.
- Methadone is highly regulated and can only be provided through licensed Opioid Treatment Programs (OTPs).
- Under the Drug Addiction Treatment Act of 2000, Suboxone is prescribed by physicians.

**See PowerPoint for additional graphics**

**didgʷálič provides patients with *all the tools necessary for success***

Outpatient Treatment Services
Primary Medical Care
Mental Health Counseling
Medication-assisted Therapies
Shuttle Transportation
Case management & referrals
Social Work Services
Group & Family Therapy
On-Site Public Benefits Enrollment
On-Site Childcare

On-Site Security Dental Care

**The didgʷálič Model**

- Holistic – treats the medical and psychological collateral damage caused by opioid use disorder
- Blends best practice, evidence-based treatment with culturally appropriate care
- Eliminates unreliable and non-compliant patient referrals
- Keeps families together – avoids need to send patients far away for treatment
- Continuity of care within the wellness eco-system
- Nationally award-winning program – National Leadership Award from Indian Health Services

**Phase II Expansion**

- Square footage:
  - Current size: 10,000 square feet
  - Expansion size: 20,000 square feet
- 3 story addition to north side of current facility
- Double patient capacity from 250 to 500 patients

**Personnel**

| | | |
|---|---|---|
| **Executive Staff**<br>CEO, COO, CMO, CIO | 3 | **4** |
| **Medical Staff**<br>DR, LPNs, RNs, ARNPs, CNAs | 7 | **12-14** |
| **Chemical Dependency Professionals**<br>Clinical Supervisor, CDP, CDPT | 7 | **14** |
| **Licensed Mental Health Counselors**<br>Clinical Supervisor, LMHC, LMHCA | 3 | **6-8** |
| **Social Worker(s)** | 1 | **2** |

| | | |
|---|---|---|
| **Administration**<br>Office Manager, Admin Ass't, Child Watch Attendants, Data Entry/UA Tech | 8 | **16-18** |
| **Billing**<br>Manager, Specialist, Billing Ass't | 4 | **6** |
| **Security/Transportation/Other**<br>Manager, Security Guards, Transporters | 9 | **18** |
| **Dental**<br>Dentist, Clinical Supervisor, Hygienist, Dental Assistants, Office Support | 0 | 7 |

**Personnel**

- Providing high quality, well-paying jobs for local residents

Medication assisted treatment - when delivered in conjunction with appropriate supportive counseling and behavioral therapies - has long been recognized as the best and most highly effective, evidence-based treatment for opioid addiction.

**Didgʷálič "Integrated Care" Model**

- Brings all necessary treatment components under one roof
- Integrated care vs. coordinated care
- Not a "triage" model
- Patient-centered – care determined by patient need
- Fully integrated Methadone/Suboxone/Vivitrol options
- Integrated primary care and behavioral health
- Removes barriers that otherwise prevent care
- Adaptive to rural or urban environments
- Adaptive to Vermont or Johns Hopkins eco-system
- Accredited as OTP
- Goal is to remove barriers to care

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## TACKLING THE OPIOID EPIDEMIC IN CALIFORNIA INDIAN COUNTRY, VANESSCIA CRESCI, MSW, MPA ACTING EPIDEMIOLOGY MANAGER, CALIFORNIA TRIBAL EPIDEMIOLOGY CENTER DIRECTOR, RESEARCH AND PUBLIC HEALTH DEPARTMENT:

***See PowerPoint for additional graphics***

**What is happening in California? Opioid-related deaths**
37 opioid-related deaths among AIAN alone in 2017.
Anyone identified as AIAN, whether alone or in combination with another race and including Hispanics, **increases to 76**

**Tribal Opioid Capacity Assessment preliminary results**

- Has your Tribal Council passed any policies, laws, or ordinances to address the opioid crisis in your Tribal community?
  - No: 84% (32)
  - Yes: 16% (6)
    - Tribal ordinances, housing policies, pre-employment testing

**Tribal Opioid Capacity Assessment preliminary results**

- Which of the following Tribal organizations in your community have been involved in addressing the opioid crisis?

California Tribal Opioid Summit
*What does an opioid-free Tribal community look like?*

- **North**
  - Limit prescription of pain medication and use **alternative treatments**
  - Overall recovery and healing is inclusive of all community members and everyone has a role in a strong, resilient, and thriving community
  - **Active lifestyles and healthy eating**
  - Increase in behavioral health staff
  - Communities working together
- **Central**
  - Redesign services to reach clients at critical points: jail, prisons, hospitals, wellness courts, treatment centers
  - Transformational housing with mentoring and psychological services
  - Community has **healthy parents, elders, and children**
  - Limit pain medication prescriptions and use **alternative treatments**
  - Telemedicine in remote areas to provide services
  - Cultural and traditional, sober living, and treatment services
  - Integrate services at the Tribal Health Program
- **South**
  - Increased access to **physical and spiritual activities**
  - Drug and alcohol free community events and gatherings
  - Phase out western approaches to wellness and strengthen **traditional medicine**

**How is CRIHB responding?**

- SAMHSA funded Tribal Opioid Response (TOR)
  - Working with 6 Tribal Health Programs, serving 25 Tribes
- CDC funded California Tribal Opioid Strategic Plan
  - Collecting data across the State
- CDPH funded Tribal Medication Assistant Treatment (MAT)
  - Working with 14 Tribal Local Opioid Coalitions
  - Providing training across the State

**Tribal Opioid Response Activities**

- Culturally based Community Education
  - Elder workshops
  - Community workshops
  - Opioids 101

- Medication safety
- Importance of using medications as prescribed
- Proper medication disposal
- Elder abuse prevention
- Pain management alternatives
- Historical trauma
- Building recovery ecosystems
- MAT self-assessment

- Enhance Community Support Services
  - White Bison programming
  - Prayer ties
  - Purification ceremonies
  - Pain management alternative treatment
  - Recovering honoring ceremonies
  - Talking circles
- Culturally appropriate, trauma-informed, harm reduction PSEs in Tribal Health Programs and Tribes
  - Needle exchange
  - Naloxone education and distribution
  - Safe injection sites
  - Safe prescribing guidelines
  - Safe disposal sites
  - Tribal Health Program-wide harm reduction approach
  - Chronic pain management using alternative approaches
- Tribal and Tribal Health Program Leader Engagement
  - Tribal Health Program partnership with Tribe
  - Community stakeholder engagement
  - Community meetings
  - Partner with spiritual leaders
- Other Supportive Activities
  - Increasing the number of x-waivered providers
  - Regional opioid summit
  - MAT program
  - Partnering with California Hub and Spoke Systems to become a spoke
  - Provide treatment, transitional housing, and sober living services

**<u>California Tribal Opioid Strategic Plan</u>**

- Create a Tribal Opioid Strategic Plan
  - 6 Youth Focus Groups
  - 5 Elder Focus Groups

- 15 Key Informant Interviews with adults and elders
- Tribal Opioid Summit feedback

- Form a Tribal Opioid Advisory Committee
  - Provide guidance to all CRIHB opioid projects
  - Guide the development of the Tribal Opioid Strategic Plan
- Implement a Tribal Opioid Capacity Assessment
  - Assess Tribal-specific capacity and gaps
- Tribal Head Start pilot project
  - Focus on developing resiliency-focused, culturally-based interventions

**Tribal Medication Assisted Treatment (MAT)**

- Statewide Opioid Summit and Regional Opioid Trainings
- Distribution and training of Naloxone
- Community opioid education campaign
- Funding 14 Tribal Local Opioid Coalitions
- Telehealth infrastructure support
- Alternative Treatment Options: acupuncture, yoga, reiki, traditional healers, herbalists
- Provider, CHR & MA Training
- Partner with Project ECHO and TeleWell to implement MAT

**Tribal Local Opioid Coalition Framework**

- **Phase 1: Setting Up for Success**
  - Community Readiness Assessment
  - Tribal Action Plan
  - Identify and develop community partnerships
  - Develop coalition work plans
  - Tribal MAT Champions provide coaching
- **Phase 2: Getting the Work Done**
  - Increase access to MAT
  - Implement Safer Prescribing Practices and Guidelines
  - Stigma reduction strategies
  - Support recovery and peer support services
  - Youth prevention activities
  - Community-based, culturally appropriate prevention strategies
  - Expand access to non-opioid pain treatment
  - Link coalitions to Subject Matter Experts
  - Tribal MAT Champions provide coaching
- **Phase 3: Growing & Sustaining**
  - Continue to implement and expand 7 strategies
  - Develop sustainability plan

- Develop Tribal Subject Matter Experts
- Tribal MAT Champions provide coaching

## NPAIHB TRIBAL OPIOID RESPONSE UPDATE, COLBIE CAUGHLAN, TOR PROJECT DIRECTOR:

**Overview**

- Tribal Opioid Response
- What have our communities started?
- What comes next?

**NPAIHB Opioid Projects**

- Tribal Opioid Response (TOR) – SAMHSA
  - Consortium of 22 Tribes (35 Total)
  - *Capacity Building*
- Strategic Planning (CDC)
  - Regional and National Work
  - Comprehensive
- Opioid Overdose Data and Surveillance (CDC)
  - Improve accuracy and access to data on drug and opioid overdoses for Northwest Tribes
- Indian Country Substance Use Disorder ECHO clinic (SAMHSA + OMH)
  - Integrating Medications for Addictions Treatment in Primary Care
  - *Clinical Focus*

"To deal with structural disaggregation of necessary OUD treatment components in the Indian Healthcare system, and provide tribes and clinicians with comprehensive information to do more for our patients and system, the Northwest Portland Area Indian Health Board aims to address the opioid crisis in tribal communities by increasing capacity to address the complex factors associated with a comprehensive opioid response, including:"

**NPAIHB Tribal Opioid Response Consortium**

The overarching goal of the NPAIHB TOR Consortium is to develop a comprehensive and strategic approach to assist Tribes in developing capacity to address the complex factors associated with a comprehensive opioid response. This includes:

- Developing a framework for a NW Opioid Response strategic plan,
- Increasing awareness of opioid use disorder,
- Preventing opioid use disorder,
- Increasing access to treatment and recovery services and overdose reversal capacity
- Reducing the health consequences of opioid use disorder in tribal communities.

**Current Activities**

- Since January 3 Tribes and the NPAIHB have purchased Naloxone (Narcan nasal spray) and started to distribute them.
- At least 3 Tribes have started to develop or have implemented policies related to Naloxone use.

For the Overdose Rescue Kits, we are putting together for Tribes who requested us to purchase their Narcan, we took from example kits we received from the Swinomish Tribe and the White Earth Nation. The one shown has the brochure that a partner of the State of WA created and it includes the WA State Good Samaritan Law.

- 4 Public awareness campaigns have already been implemented and at least a handful more are in the process of developing their campaigns
- At least 5 Clinics who chose to, are beginning to develop, adapt, or have adopted safer opioid prescribing practices and/or policies in the past four months.
- At least 8 Tribes have started providing MAT services by linking to other external clinics or to an IHS clinic.

**Recovery Services**

- Implemented culturally-based recovery services and at least 30 clients have started receiving these services
- Implemented a recovery coaching program with at least 8 people already served
- Implemented housing recovery services with at least 6 people having been served

Recovery services and wraparound services are important to include for Recovery and the state of OR has worked with tribal and non-tribal community members to learn more about it. Together they came up with some really great pain management social marketing campaign materials at www.healsafely.org .

**Prevention & Wraparound Services**

- Implemented prevention programs and have served over 300 community members including at least 130 youth
- Wraparound services provided:
    - community outreach
    - Transportation
    - Benefits
    - legal issues
    - family services
    - general case management
    - assistance/referral for help with housing
    - education regarding OUD and mental health issues

**Challenges**

- Stakeholder buy-in
- Setting up account to purchase Naloxone
- Hiring staff for short term grant
- Prevention activities vs. providing MAT because. . . .
- **Potential Reporting Requirement: GPRA data**

**Best Practice – Indian Country ECHO**

Project ECHO (Extension for Community Healthcare Outcomes) is a collaborative model of medical education and care management that enables clinicians (regardless of where they live) to provide better care to more people, right where they live.

The ECHO model™ does not actually "provide" care to patients. Instead, it increases access to specialty treatment in rural and underserved areas by providing front-line clinicians with the knowledge and support they need to manage patients with complex conditions such as: hepatitis C, HIV, tuberculosis, chronic pain, endocrinology, behavioral health disorders, and many others. It does this by engaging clinicians in a continuous learning system and partnering them with specialist mentors and colleagues.

**DATA 2000 Waiver Training + ECHO Onboarding**

- **Upcoming Trainings:**
  - Rocky Boy, MT – July 30
  - Quinault, WA – August 29
  - Tahlequah, OK– September 12-13
  - Oklahoma City, OK – September 18
- **Want to be the next location?**
  - Contact Eric Vinson at evinson@npaihb.org

Stay Connected! To get custom resources and tailored content for you and your area, you can join our text message service by **texting HCV to 97779**. We'll also be sending out today's slides via text.

## PROJECT ECHO, JESSICA LESTON, HIV/HCV/STI CLINICAL SERVICES DIRECTOR:

**Background – HCV in Indian Country**

American Indians/Alaska Natives (AI/AN) have more than double the national rate of HCV - related mortality, and the highest rate of acute HCV infection.[1]
The most current national study estimates 40,000 persons served by Indian Health Service (IHS) have chronic HCV.[2]

**Background – SUD in Indian Country**
More AI/AN have died of a drug overdose than members of any other racial or ethnic group in the US.[3]
AI/AN had the largest percentage increase in the number of deaths over time.[3]

**Background – Diabetes in Indian Country**
AI/AN have a greater chance of having diabetes than any other US racial group.[4]
Kidney failure from diabetes among AI/AN was the highest of any race.[4]

**Disparities (% greater than US all races) [5]**

| |
|---|
| Alcohol related (520%) |
| TB (450%) |
| Chronic liver disease (368%) |
| Motor vehicle crashes (207%) |
| Diabetes (177%) |
| Unintentional injuries (141%) |
| Poisonings (118%) |
| Homicide (86%) |
| Suicide (60%) |

**The Big Problem**
**A 'Small' Problem –** Lack of specialist availability limits access to medical treatment

**A Solution**
Project ECHO is a learning and guided practice model that rethinks medical education and greatly increases workforce capacity to provide best-practice specialty care and reduce health disparities. The heart of the ECHO model™ is its hub-and-spoke knowledge-sharing networks, co-led by teams who use multi-point videoconferencing to conduct virtual clinics with community providers. In this way, primary care doctors, nurses, pharmacists and other clinicians learn to provide the best specialty care to patients in their own communities.

*We choose to go to the Moon! We choose to go to the Moon in this decade and do the other things, not because they are easy, but because they are hard;* ***because that goal will serve to organize and measure the best of our energies and skills****, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one we intend to win, and the others, too*." – John F. Kennedy

**Indian County ECHO**
Building Relations and Partnerships

**Accomplishments so far…**

- HCV ECHO 2 1/2 years old at the end of January
- Trained over 350 medical professionals on HCV
- 557 patient recommendations for HCV treatment
- SUD clinic started in January, trained over 136 people in MAT and OUD
- Engaged over 100 I/T/U clinics
- Partnerships across Indian Country

**NEW Diabetes ECHO**

- Successful pilot in 2018
- Led to Diabetes ECHO implementation
- Presenting at Annual Diabetes Conference – ECHO Style
- *"Extremely helpful when discussing specific cases"*

**Extra-ECHO Accomplishments**

- Working to change Medicaid policy in "Grade F" states
    - Oregon, South Dakota
- Working with IHS to advocate for resources for HCV treatment
    - 25 million dollars for Ending the HIV Epidemic in Indian Country – ALSO addressing HCV
- Working with IHS to systematically increase DATA Waived providers to increase access to MAT
    - Partnership with HOPE Committee
    - MAT training at NCC

**IndianCountryECHO.org**

| |
|---|
| Hepatitis C – ***Text HCV to 97779*** |
| SUD/OUD – ***Text Opioid to 97779*** |
| Diabetes – ***Text Endo to 97779*** |
| Youth Leadership |
| First People' ECHO Collaborative |
| Harm Reduction – ***Text Harm Reduction to 97779*** |
| Pallative Care (ANTHC) |
| HIV (UNM) |
| PrEP and HIV Prevention – ***Text PrEP – coming soon*** |
| LGBTQ 2-Spirit Health – ***Text LGBTQ2 – coming soon*** |

**Lessons Learned**

- **Tribes and tribal organizations can and should be the hub of delivering ECHO clinics to Indian Country**
- Tribes and tribal organizations are well suited to bring together front line clinicians, tribal partners and medical experts from a variety of fields in a culturally appropriate way
- We work with anyone who has the passion to drive the work – advancing the top of licensure
- We raise up champions to continue to expand
- The key to scaling up has been relationships, often fostered in-person at regional trainings, and site visits

*"Power is the ability to achieve a purpose. Whether or not it is good or bad depends on the purpose."* – Dr. Martin Luther King Jr.

**Equity in Healthcare**

- Mindfulness that power is a determinant
- Empowerment a process
- Health equity as outcome

**References**

1. Centers for Disease Control and Prevention. (2015). Division of viral hepatitis, surveillance for viral hepatitis, United States, Retrieved Aug 28, 2017, from https://www.cdc.gov/hepatitis/statistics/2015surveillance/index.htm
2. Haverkate R, Reilley B. Hepatitis C Virus in Indian Country. Retrieved March 10, 2017 from https://www.ihs.gov/newsroom/ihs-blog/may2017/hepatitis-c-virus-in-indian-country/
3. Joshi S, Weiser T, Warren-Mears V. Drug, Opioid-Involved, and Heroin-Involved Overdose Deaths Among American Indians and Alaska Natives — Washington, 1999–2015. MMWR Morb Mortal Wkly Rep 2018;67:1384–1387.
4. Centers for Disease Control and Prevention. (2017). Native Americans with Diabetes. Retrieved July 11, 2019, from https://www.cdc.gov/vitalsigns/aian-diabetes/index.html
5. Trends in Indian Health 2014 Edition, US DHHS, Indian Health Service

**LUNCH**

Called to order 130 p.m.

**ROBIN THUNDERSHIELD, CALIFORNIA NATIVE VOTE PROJECT**

**YOUTH GROUP – PRESENTATIONS**

**NATIVE CENSUS UPDATE AND VIDEO BY LINDSAY MCCOVEY, US CENSUS TRIBAL PARTNERSHIP SPECIALIST AND SHANA RADFORD, US CENSUS TRIBAL PARTNERSHIP SPECIALIST**

**CLOSING REMARKS**: by Greg Abrahamson, NPAIHB Secretary and Spokane Tribe, Joe Finkbonner, NPAIHB Executive Director, Mark LeBeau, CRIHB Executive Director, and Lisa Elgin, CRIHB Chairwoman and Board member of Sonoma County Indian Health Project

**MOTION TO ADJOURN**: Patti Kinswa Geiser, Cowlitz Tribe, 2nd by Andrea ---;

Vickie closing prayer

**ADJOURN at 2:30 p.m.**

_____ _____

**Prepared by Lisa Griggs,**
**Executive Administrative Assistant** **Date**

_____ _____

**Reviewed by Joe Finkbonner, RPh, MHA,**
**NPAIHB Executive Director** **Date**

_____ _____

**Approved by Greg Abrahamson,**
**NPAIHB Secretary** **Date**

# *QUARTERLY BOARD MEETING*

**The Northwest Portland Area Indian Health Board**

**July 15 – 18, 2019**

**Thunder Valley Resort, Lincoln, CA**

# AGENDA

## MONDAY JULY 15, 2019 (SALON D &E)

| | | |
|---|---|---|
| 9 am – 11 am | CHAP Board Advisory Meeting | |
| | **Tribal Health Director's (THD) Meeting** | |
| 2:00 PM | Welcome & Introductions | |
| 2:15 PM | Northwest Native American Center of Excellence | Dr. Erik R. Brodt |
| 3:00 PM | Health Director Discussion<br>• updates and challenges/needs | • All<br>• Julie A. Johnson, Tribal Affairs Director, Oregon Health Authority |
| 4:00 PM | State Panel Q&A | • Jessie Dean WA HCA, Administrator, Tribal Affairs & Analysis, Division of Policy, Planning & Performance and<br>• Idaho (Invited) |
| **6:00 PM** | **Welcome Reception for CRIHB & NPAIHB (Coconut Pool)** | |

## TUESDAY JULY 16, 2019 (SALON D & E)

**NPAIHB Quarterly Board Meeting (QBM)**

| | | |
|---|---|---|
| 7:30 AM | Executive Committee Meeting | Sierra Room (in High Steaks Steakhouse) |
| 9:00 AM | Call to Order<br>Posting of Flags<br>Invocation<br>Welcome | Cheryle Kennedy, Chairwoman |
| | Roll Call | Shawna Gavin, Treasurer |

# *QUARTERLY BOARD MEETING*

**The Northwest Portland Area Indian Health Board**

**July 15 – 18, 2019**

**Thunder Valley Resort, Lincoln, CA**

# AGENDA

| | | |
|---|---|---|
| 9:30 AM | Portland Area – IHS Director Report **(1)** | Dean Seyler, Portland Area IHS Director |
| 10:15 AM | NPAIHB Executive Director Report **(2)** | Joe Finkbonner, NPAIHB Executive Director |
| 10:30 AM | NPAIHB Committee Updates (National & IHS) | Joe Finkbonner, NPAIHB Executive Director & Committee Members |
| 12:00 PM | ***LUNCH BREAK*** | ***ON YOUR OWN*** |
| 1:30 PM | Legislative Update **(3)** | Laura Platero, Government Affairs/Policy Director |
| 3:00 PM | **BREAK** | |
| 3:00 PM | Resolution Discussion for Joint Meeting | |

Unfinished/New Business

1. **Chairman's Report** — Andy Joseph
2. **Finance Report** — Eugene Mostofi, Account Manager

3. **Approval of Minutes**
   - April 2018

4. **Future Board Meeting Sites:**
   - *October 22 - 24, 2019 ~ Pendleton, OR (Umatilla Tribe)*
   - *January 21- 23, 2020 ~ Portland, OR (Portland, OR)*
   - *April 21-23, 2020 ~ Location TBD (Offers from: Tulalip, Spokane, Chehalis, & Shoshone-Bannock/TBD)*
   - *July, TBD*
   - *October 20-22 ~ Location TBD (Offer from: Grand Ronde)*

4:00 PM **Tour of CRIHB Office (Transportation Provided)**

Northwest Portland Area Indian Health Board

# *Executive Director Report*

*Thunder Valley Resort*
*Lincoln, CA*
*July 16, 2019*

*Joe Finkbonner, RPh, MHA*

Northwest Portland Area Indian Health Board

## ***Personnel***

**INTERNS & TEMPS:**

- Chandra Wilson (Klamath Modoc)
- Rowan Lutz (Lummi Nation)
- Josephine Lutz (Lummi Nation)
- Anna Feroglia (Lakota Sioux)
- Chiarra Bettega (Round valley Indian Tribes)

Northwest Portland Area Indian Health Board

## ***Personnel***

**RECOGNITION:**

- **Dr. Tom Becker 20 Years ~ plaque will be given in October**

Northwest Portland Area Indian Health Board

## Meetings

**APRIL**

- PHAB Executive Committee Meeting, Washington, DC (4/24 – 4/26)

**MAY**

- 2019 Portland Area Dental Meeting, Portland, OR (4/15 – 4/16)
- ATNI, Spokane, WA (5/20 – 5/21)
- Vacation

Northwest Portland Area Indian Health Board

## Upcoming Meetings

**AUGUST**

- Region 10 Opioid Summit, Vancouver, WA (8/6 – 8/9)
- Nike Native Fitness, Nike HQ (8/15 – 8/16)


Northwest Portland Area Indian Health Board

## Upcoming Meetings

**SEPTEMBER**

- NIHB National Tribal Health Conference, Temecula, CA (9/16 – 9/19)
- Arcora Foundation Board Retreat, Skamania, WA (9/19 – 9/21)
- Washington Governor's Centennial Accord, TBD (9/24 – 9/25)
- Dancing in the Square Downtown Portland, OR (9/27)


## ***Upcoming Meetings***

**OCTOBER**

- NPAIHB Staff Retreat, Sun River, OR (10/1 – 10/3)
- ATNI, Suquamish, WA (10/7 – 10/10)
- NPAIHB QBM, Pendleton, OR (10/22 – 10/24)


Questions…?

7/1/2019

# Quarterly Report: Northwest Tribal Epidemiology Center

Questions? Contact:
Victoria Warren-Mears, PhD, RDN, FAND
Director, NWTEC
vwarrenmears@npaihb.org or 503-416-3283

## Northwest Tribal Epidemiology Center Projects' Reports Include:

- **Adolescent Health**
- **Clinical Programs-STI/HIV/HCV**
- **Epicenter Biostatistician**
- **Epicenter National Evaluation Project**
- **Immunization and IRB**
- **Injury Prevention Program (IPP)/Public Health Improvement & Training (PHIT)**
- **Medical Epidemiologist**
- **Native Children Always Ride Safe (Native CARS) Study/TOTS to Tweens Study**
- **Northwest Native American Research Center for Health (NARCH)**
- **Northwest Tribal Cancer Control Project**
- **Northwest Tribal Dental Support Center**
- **Northwest Tribal Registry Project-Improving Data and Enhancing Access (IDEA-NW)**
- **Response Circles – Domestic & Sexual Violence Prevention**
- **THRIVE (Tribal Health: Reaching out InVolves Everyone)**
- **Wellness for Every American Indian to View and Achieve Health Equity (WEAVE)**
- **Western Tribal Diabetes Project**
- **Cancer Prevention and Control Research in AI/AN**
- **Tribal Opioid Response (TOR)**
- **Enhancing Asthma Control for Children in AI/AN communities**
- **Northwest Tribal Juvenile Justice Alliance**

# Adolescent Behavioral Health

*Stephanie Craig Rushing, PhD, MPH, Principal Investigator | Jessica Leston, MPH, PhD(c) Project Director*
*Colbie Caughlan, MPH, THRIVE Project Director | David Stephens, RN, ECHO Director*
*Danica Brown, MSW, PhD, Behavioral Health Manager | Michelle Singer, HNY Manager*
*Celena McCray, THRIVE Project Coordinator | Tommy Ghost Dog, WRN Project Coordinator*
*Tana Atchley-Culbertson, Youth Engagement Coordinator | Paige Smith, THRIVE/DVPI Coordinator*
*Corey Begay, Multimedia Specialist | Eric Vinson, ECHO Specialist*
Contractor: Amanda Gaston, MAT, Native IYG

**Quarterly Report: April – June 2019**

## Technical Assistance and Training

### Tribal Site Visits

- Swinomish Tribe – Meeting Youth Committee, NPAIHB Quarterly Board Meeting, April 16, 2019.

### April Technical Assistance Requests

- 7 NW Tribal TA Requests = IHS, Warm Springs, CNAY, Muckleshoot, Siletz, Klamath, Umatilla
- 2 = ITCA, SecondMuse
- 7 = Native STAND research sites in NM, AZ, NV, CA, CO

### May Technical Assistance Requests

- 3 NW Tribal TA Requests = Grand Ronde, Skokomish, Nimiipuu
- 4 = Multnomah County, San Pasqual Tribe, Northwestern Univ., American Indian Health Service of Chicago, Inc., IHS
- 12 = Native STAND research sites in CA, NM, WA, MI, WI, OR, AZ, OK, SD, ND, NE
- 4 = We R Native Facilitators Guide requests in WA, OR, MI, ND

### June Technical Assistance Requests

- 1 NW Tribal TA Requests = IHS
- 5 = Oregon Research Institute; Johns Hopkins; Institute for Sexual and Gender Minority Health and Wellbeing; PhD Student; Headstream

### Project Red Talon | We R Native

During the quarter, Project Red Talon staff participated in thirteen planning calls, three partner meetings, and facilitated or presented during four conferences/webinars, including:

- Meeting: Working Together - Adolescent Health Action Planning Meeting, Portland, OR. Hosted by HHS and NPAIHB. April 23, 2019. Approximately 20 adults in Portland, 25 in Seattle, and 40 in Alaska.
- Presentation: We R Native, Native Project Youth Leadership Camp, Spokane, WA, April12-14, 2019. Approximately 200 youth in attendance.
- Presentation: We R Native, UNITY Virtual Conference, April 5, 2019. Approximately 20 youth in attendance.
- Webinar: We R Native and Adolescent Sexual Health, IHS Grand Rounds, April 18, 2019. Approximately 30 adults in attendance.

- Workshop: We R Native, Anadarko, OK, June 16-18, 2019. Approximately 50 youth in attendance.
- Workshop: Youth Movement, University of Oregon, Eugene, OR, May 3, 2019. Approximately 200 youth in attendance.
- Zoom: Ask Auntie/ Ask Uncle Planning Meeting, April 11, 2019.

**Gen I / Bootcamps**

- OXDX Bootcamp Training: THRIVE Youth Conference, Portland, OR. June 24-28, 2019. Approximately 20 youth partners in attendance.
- Storytelling and Comic Book Bootcamp Training: THRIVE Youth Conference, Portland, OR. June 24-28, 2019. Approximately 12 youth partners in attendance.
- Domestic Violence Bootcamp Training, Siletz, OR. June 21-22, 2019. Approximately 12 youth partners in attendance.

**Native It's Your Game | Native STAND | Healthy Native Youth**

During the quarter, Healthy Native Youth staff participated in nine planning calls with study partners, and the following trainings/events:

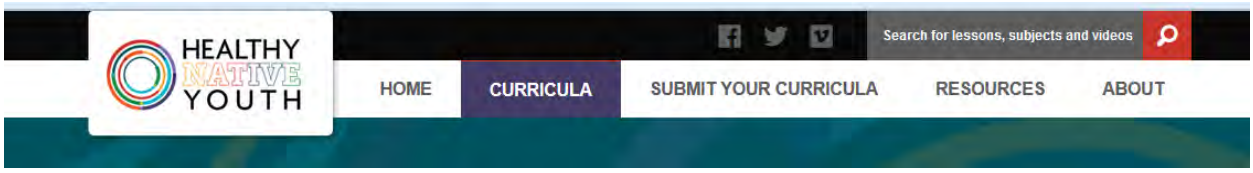
- Meeting: Native STAND 2.0 Updates. THRIVE Conference, Portland, OR, June 25-26, 2019. Approximately 18 Native STAND Facilitators in attendance.
- Presentation: Concerning Posts and HNY. National Tribal Behavioral Health Conference, May 15-17, 2019, in Albuquerque, New Mexico. Approximately 100 participants in attendance.
- Presentation: Concerning Posts and HNY. SPRC Virtual Conference, June 18, 2019. Approximately 75 participants in attendance.
- Presentation: Concerning Posts and HNY. THRIVE Conference Alliance Meeting, June 27, 2019. Approximately 75 participants in attendance.
- Presentation: HNY and I-LEAD. OIEA Conference, May 9, 2019, Eugene, OR. Approximately 30 participants in attendance.
- Presentation: Native STAND and HNY. Protecting Our Children National American Indian Conference on Child Abuse and Neglect, March 31–April 3, in Albuquerque, New Mexico. Approximately 100 participants in attendance.
- Presentation: Native STAND and HNY. Tribal Public Health Conference 2019, April 9-11, in Tulsa, OK. Approximately 20 participants in attendance.
- Zoom: Community of Practice: Session #8 – LGBT and 2S Inclusivity. April 10, 2019. Approximately 32 adult educators attended. Recorded trainings are available at: https://www.healthynativeyouth.org/community-of-practice-sessions
- Zoom: Community of Practice: Session #9 – New to the Rez: Becoming an Ally. May 8, 2019. Approximately 28 adult educators attended. Recorded trainings are available at: https://www.healthynativeyouth.org/community-of-practice-sessions
- Zoom: Community of Practice: Session #10 – Tap into Online Resources: We R Native & I Know Mine. June 12, 2019. Approximately 20 adult educators attended. Recorded trainings are available at: https://www.healthynativeyouth.org/community-of-practice-sessions

**ANA – I-LEAD**

During the quarter, staff participated in five grantee call, thirteen SMS text mentoring chats with 950 "healer" participants," and the following I-LEAD meetings and activities:

- Meeting: Youth Committee, NPAIHB Quarterly Board Meeting, Hosted by the Swinomish Tribe. April 16, 2019.
- Presentation: Envisioning a Healthier Tomorrow: Supporting Our Future Healers and Health Professionals. Oregon Indian Education Association Conference, Eugene, OR. May 9, 2019. Approximately 30 adults in attendance.
- Presentation: Interested in a Health or Wellness Career? THRIVE Youth Conference, Portland OR. June 27, 2019. Approximately 100 youth and adults in attendance.
- Presentation: Interested in a Health or Wellness Career? YTH Conference, San Francisco, CA. May 6, 2019. Approximately 40 adults in attendance.

## Health Promotion and Disease Prevention




**Website**: The Healthy Native Youth website launched on August 15, 2016: www.healthynativeyouth.org

Last month, the **Healthy Native Youth** website received:

- Page views = 1,864
- Average session duration = 2:10

WERNATIVE

**Website**: The We R Native website launched on September 28, 2012: www.weRnative.org

In May, the Monthly reach across the We R Native Channel: **164,339** (5,301/day)

**Text Message Service:**

- Northwest Portland Area Indian Health Board has 7,810 active subscribers.
- We R Native has 5,635 active subscribers.
- The Text 4 Sex Ed service currently has 469 active subscribers, 751 total profiles. Broken down by opt-in path:
    - Sex (Facebook): 303
    - Condom (Text Message): 184
    - Love (Text Message): 312
    - Snag, Banana (Instagram): 36
    - Hook up (twitter): 4
- We R Healers has 371 subscribers.
- STEM has 577 subscribers. :)
- Youth Spirit has 35 subscribers.

- We R Navajo has 197 subscribers.
- I Know Mine has 775 subscribers.
- Native Fitness has 818 subscribers.
- Hepatitis C Patient and ECHO project has 368 subscribers.
- Healthy Native Youth has 559 subscribers.
- THRIVE-DBT has 34 active subscribers.

**April Social Media Messages**: Number/Reach of We R Native messages addressing…

- Bootcamp PSAs = 1 posts, 0 text message, 5,300 people reached
- Concerning Social Media Post Tips = 0 posts, 0 text message, **0** people reached
- Sexual health/Healthy Relationships = 6 posts, 0 text message, **4,572** people reached
- DVPI = 0 posts, 0 text message, 0 people reached
- Sexual Assault Campaign (to be created this year) = 0 posts, 0 text message, 0 people reached
- Substance prevention = 3 post, 0 text message, **2,342** people reached
- Suicide (general) = 1 posts, 0 text message, **4,400** people reached
    - #WeNeedYouHere Campaign (specifically THRIVE) = 0 posts, 0 text message, 0 people reached
    - #WeNeedYouHere - LGBT2S = 0 post, 0 text message, 0 people reached
    - #WeNeedYouHere – Veterans = 0 post, 0 text message, 0 people reached
    - Mental health = 6 posts, 0 text messages, **11,001,** people reached
- Youth leadership/empowerment = 22 posts, 4 text messages, **97,487**, people reached

**May Social Media Messages**: Number/Reach of We R Native messages addressing…

- Bootcamp PSAs = 0 posts, 0 text message, **0** people reached
- Concerning Social Media Post Tips = 0 posts, 0 text message, **0** people reached
- Sexual health/Healthy Relationships = 3 posts, 0 text message, **27,800** people reached
- DVPI = 0 posts, 0 text message, 0 people reached
- Sexual Assault Campaign (to be created this year) = 0 posts, 0 text message, 0 people reached
- Substance prevention = 1 post, 0 text message, **33** people reached
- Suicide (general) = 0 posts, 0 text message, **0** people reached
    - #WeNeedYouHere Campaign (specifically THRIVE) = 0 posts, 0 text message, 0 people reached
    - #WeNeedYouHere - LGBT2S = 0 post, 0 text message, 0 people reached
    - #WeNeedYouHere – Veterans = 0 post, 0 text message, 0 people reached
    - Mental health = 6 posts, 0 text messages, **11,190,** people reached
- Youth leadership/empowerment = 22 posts, 6 text messages, 77,097, people reached

**June Social Media Messages**: Number/Reach of We R Native messages addressing…

- Bootcamp PSAs = 0 posts, 0 text message, 0 people reached
- Concerning Social Media Post Tips = 0 posts, 0 text message, 0 people reached
- Sexual health/Healthy Relationships = 3 posts, 0 text message, **4,071** people reached
- DVPI = 0 posts, 0 text message, 0 people reached
- Sexual Assault Campaign (to be created this year) = 0 posts, 0 text message, 0 people reached

- Substance prevention = 2 post, 0 text message, **5,100** people reached
- Suicide (general) = 0 posts, 0 text message, 0 people reached
    - #WeNeedYouHere Campaign (specifically THRIVE) = 0 posts, 0 text message, 0 people reached
    - #WeNeedYouHere - LGBT2S = 0 post, 0 text message, 0 people reached
    - #WeNeedYouHere – Veterans = 0 post, 0 text message, 0 people reached
- Mental health = 5 posts, 1 text messages, **13,560** people reached
- Youth leadership/empowerment = 29 posts, 3 text messages, **73,969** people reached

## Research and Surveillance

**Concerning Post Social Media**: The NPAIHB has collaborated with the Social Media Adolescent Health Research Team to design educational tools to address concerning posts on social media. We are currently writing a paper that describes the evaluation of the video intervention for adults who work with Native youth.

**Technology and Adolescent Mental Health (TAM):** The NPAIHB is collaborating with the Social Media Adolescent Health Research Team and the mHealth Impact Lab to evaluate We R Native's mental health messaging impact and efficacy. The project is interviewing participants.

**Help-Seeking Messages:** We R Native collaborated with Steven Hafner to carryout formative research to design a violence prevention intervention delivered to Native young men. The team conducted a pilot test of the intervention and made improvements to role-model script and the SMS series based on their feedback. The role model filming took place in April.

STI/HIV/HCV Clinical Programs

*Jessica Leston, MPH, Clinical Programs Director* - Tsimshian
*David Stephens, RN ECHO Clinic Director*
Eric Vinson, BA, ECHO Clinic Manager – *Cherokee*
Megan Woodbury – Opioid Program Coordinator
Danica Love Brown – Behavioral Health Manager – *Choctaw*
Morgan Thomas – CDC Presidential Fellow

Contractors: Brigg Reilley, MPH
Carolyn Crisp, MPH
Crystal Lee, PhD – *Navajo*

**Quarterly Report: April – June 2019**

## Technical Assistance and Training

**NW Tribal Site Visits**

- Swinomish QBM – April 15-17, 2019
- Kalispel Healing Tree Conference- May 1, 2019

- Colville SUD ECHO Training – May 28-29, 2019
- Spokane Behavioral Health/Wellpinit IHS – May 29, 2019

**Out of Area Tribal Site Visits**

- White Earth Nation – April 28 – May 2, 2019
- HCV/SUD ECHO Training – Green Bay, WI – May 1-2, 2019
- White Earth Nation – April 28 – May 2, 2019
- Alaska Indigenous Research Institute-May 6-10, 2019
- HCV/SUD ECHO Training – Green Bay, WI – May 1-2, 2019
- National Tribal Public Health Summit – Albuquerque – May 13-15, 2019
- North Dakota Filming LGBTQ – May 23-27, 2019
- South Dakota P&T Committee Meeting
- Indian Health Service Dental meeting Albuquerque New Mexico

**April Technical Assistance Requests**

- Tribal TA Requests = 10 (Jessica), 20 (David), 6 (Eric), (2) Brigg, Megan (4), Danica (0), Morgan (3)
- Other Agency Requests = 7 (CDC, OMB, SAMHSA, IHS, GPTCHB, CA, WA, OR, ID, AZ, CRIHB, GLITC, NIHB)

**May Technical Assistance Requests**

- Tribal TA Requests = 10 (Jessica), 15 (David), 5 (Eric), (2) Brigg, Megan (4), Danica (0), Morgan (3)
- Other Agency Requests = 7 (CDC, OMB, SAMHSA, IHS, GPTCHB, CA, WA, OR, ID, AZ, CRIHB, GLITC, NIHB)

**June Technical Assistance Requests**

- Tribal TA Requests = 8 (Jessica), 16 (David), 5 (Eric), (4) Brigg, Megan (4), Danica (0), Morgan (3)
- Other Agency Requests = 7 (CDC, OMB, SAMHSA, IHS, GPTCHB, CA, WA, OR, ID, AZ, CRIHB, GLITC, NIHB)

**During the quarter, project staff participated in 145 technical assistance calls and requests.**

## Health Promotion and Disease Prevention


**HCV Overview:** Hepatitis C Virus (HCV) is a common infection, with an estimated 3.5 million persons chronically infected in the United States. According to the Centers for Disease Control and Prevention, American Indian and Alaska Native people have the highest mortality rate from hepatitis C of any race or ethnicity. However, Hepatitis C is curable and our Portland Area IHS, Tribal and Urban Indian primary care clinics have the capacity to provide this cure. Some of these clinics have already initiated HCV

screening and treatment resulting in patients cured and earning greatly deserved gratitude from the communities they serve.

**Goals**: HCV has historically been difficult to treat, with highly toxic drug regimens and low cure rates. In recent years, however, medical options have vastly improved: current treatments have few side effects, taken by mouth, and have cure rates of over 90%. Curing a patient of HCV greatly reduces their risk of developing liver cancer and liver failure. Early detection of HCV infection through routine and targeted screening is critical to the success of treating HCV with these new drug regimens.

To date the estimation is as many as 120,000 AI/ANs are infected with HCV. Sadly, the vast majority of these people have not received treatment. By treating at the primary care level, we can begin to eradicate this disease. Our aim is to provide resources and expertise to make successful treatment and cure of HCV infection a reality in Northwest IHS, Tribal and Urban Indian primary care clinics. More at www.npaihb.org/hcv

Currently, the program has strategic partnerships with Alaska Native Tribal Health Consortium, University of New Mexico, Cherokee Nation, and Northern Tier Initiative for Hepatitis C Elimination, Oklahoma IHS Area, United Southern and Eastern Tribes TEC, Rocky Mountain TEC, Great Plains Tribal Chairmen's Health Board and TEC, Great Lakes Inter Tribal Council TEC, and IHS.

**Text Message service/email marketing:** To date, the project has sent 17,888 and received 1,879 messages from 411 text message subscribers. The project sent 11 marketing emails and had a reach of 3,235 through constant contact in the month of June.

**HCV Print & Video Campaign:** In 2017, the project disseminated the Hepatitis C is Everybody's Responsibility Campaign http://www.npaihb.org/hcv/#Community-Resources To date, 6,000 items (posters, rack cards, pamphlets) have been printed, and the campaign (print + video) has received 547 video views on YouTube, and reached 5,515 on Facebook.

**Example of text message received in November 2018: "***Thank you. I do not know if I am able to respond to you but I am responding anyway. I just want to express my sincere appreciation for all you do. My CIHA (Cherokee Indian Hospital Authority) colleagues and I are energized with the possibility that we can eradicate Hep C in our community. We are meeting weekly to discuss Hep C treatment, patients, issues, ideas and complaints. We are, or I am preparing a presentation for one of our private recovery centers. Our goal in this is to reach out to as many people as we can to educate and spread awareness on all things Hep C. I am preparing the presentation because I am the performance improvement person for our primary care. The nurses are busy caring for our patients. I am also creating a hep B lab guide for our nursing staff to try to eliminate confusion over the hep B labs. I am by education a CLS (clinical laboratory scientist) formerly known as an MT (medical technologist). I went to school to be a lab tech. Not just drawing blood but also running the tests. So for once, I am excited because the lab part of all this is right up my alley. My comfort zone, you could say."*

**Opioid Overview:** NPAIHB's Northwest Tribal Epidemiology Center (TEC) has examined death certificate and hospital discharge data (corrected for AI/AN racial misclassification) to identify the burden and disparities in drug and opioid overdoses experienced by Northwest AI/AN. Since 1997, Northwest AI/AN people have had consistently higher drug and opioid overdose mortality rates compared to non-Hispanic Whites (NHW) in the region. From 2006-2012, AI /AN age-adjusted death rate for drug and prescription, opioid overdoses were nearly twice the rate for NHW in the region. A higher proportion of AI/AN drug and opioid overdose deaths occurred in younger age groups (less than 50 years of age) compared to NHW overdose deaths. A more recent analysis of Washington death certificates found that although AI/AN and NHW had similar overdose mortality rates from 1999–2001, AI/AN overdose rates subsequently increased at a faster rate. From 2013–2015 mortality, rates that were 2.7 times higher than those of NHW were for total drug and opioid overdoses and 4.1 times higher for heroin overdoses.


**Goals**: Opioids and OUD (Opioid Use Disorder) historically has been more prevalent in AI/AN population. In recent years, research has shown that OUD is not just a medical issue, but is more effectively treated when approached holistically. This has led to an increased move towards integrated care and harm reduction approaches to treat the whole individual, not just the disease. Harm reduction is defined as a way of reducing/ mitigating the negative consequences associated with OUD/ opioid misuse through a variety of intervention strategies.

While there are many resources available to the public on harm reduction, they are scattered at best. To ensure that the Tribes are not only aware of current and promising harm reduction practices and strategies for opioid response, both regionally and nationally, the Indian Country Opioid Response Monthly Newsletter and Community of Learning webinar series were developed. The goal of these two tools is to not only use them as a way to cultivate a community of practice, but also to disseminate the strategies and promising practices currently being implemented to address OUD/ opioid misuse across Indian Country. More at http://www.npaihb.org/opioid/#communityresources.

**Text Message service/email marketing:** The project sent 6 constant contact surges and had a reach of 292 through constant contact through the month of June.

**Opioid Print & Video Campaign:** In 2019, the project is developing a number of campaigns for community.

**E-Newsletter/ Community of Learning Reminders and Sessions:** The monthly newsletter is released at the beginning of each month to those subscribed through the Constant Contact listserv (n=204). The Indian Country Opioid Response Community of Learning (COL) occurs the second Thursday of every month. In the months of May and June, the COL sessions have been cancelled due to presenter schedule conflicts.

**LGBTQ & Two Spirit Overview:** Increasingly, healthcare providers across the United States are realizing that traditional European concepts of gender identity (as a male-female binary) and sexual orientation (as attraction to the opposite sex) are too limited. They cannot account for the range of gender identities and sexual orientations people experience.

People who are LGBTQ or Two Spirit have gender identities and/or sexual orientations that exist outside of this limited, European conception. LGBTQ is a general acronym, which stands for lesbian, gay, bisexual, transgender, and queer**.** Two spirit is a term for a Native person who expresses their gender identity or sexual orientation in indigenous, non-Western ways.

Native people who identify as LGBTQ and Two Spirit face barriers to healthcare, including discrimination in healthcare settings and lack of cultural competency among healthcare providers. Overall, they also face health disparities, including increased risk of anxiety, depression, sexual violence, and suicide. However, research suggests when their communities accept people who identify as LGBTQ or Two Spirit, and healthcare providers, these health disparities disappear. When affirmed by relatives, friends, and clinics, Native people who identify as LGBTQ or Two Spirit thrive. Several Native clinics have already begun developing supportive, affirming relationships with their LGBTQ and Two Spirit clients, earning their trust and gratitude.

**Goals:** Native American and Alaska Native people who identify as LGBTQ or Two Spirit face widespread discrimination. Discrimination in healthcare settings causes many people who identify as LGBTQ or Two Spirit to avoid or postpone treatment. Others do not feel safe fully disclosing their identities to their healthcare providers, which can result in incomplete or ineffective care.

We know this experience of discrimination has not always been true for Native people who are LGBTQ or Two Spirit. Prior to colonization, people who identified, as LGBTQ and Two Spirit were often vital, celebrated parts of their Native communities.

To create tribal communities and healthcare settings in which Native LGBTQ and Two Spirit people again feel acknowledged and affirmed, we are creating two documentary-style films celebrating Native LGBTQ and Two Spirit identities and providing recommendations for healthcare providers working with clients who are LGBTQ or Two Spirit.

**LGBTQ 2-Spirit Print & Video Campaign:** We are creating two documentary-style films focused on destigmatizing LGBTQ and Two Spirit identities. Both films include participants from various tribes and regions in the USA, including Alaska, Washington, Oregon, Oklahoma, and North Dakota.

The first, shorter film will include testimony from Native people who identify as LGBTQ or Two Spirit about their experiences with healthcare providers. Additionally, LGBTQ-affirming healthcare providers will share their experiences, best practices, and recommendations when working with clients who identify as LGBTQ or Two Spirit.

The second, longer film will include footage from the daily lives of 3-4 Native people who identify as LGBTQ or Two Spirit. These participants will tell us about their work, their activism and advocacy, their families and communities, their process of understanding identity, and the changes that understanding has created in their lives.

In addition to these films, a print campaign, including 3 posters, 3 rack cards, and 3 instructional pamphlets will promote and support the campaign. These print materials will direct people to the two documentaries. They will also provide introductory guidance for people who identify as LGBTQ or Two Spirit; their relatives, friends, and allies; and their healthcare providers.

Both films and print materials will be disseminated at annual LGBTQ and Two Spirit gatherings this year, as well as through clinics with whom IHS or NPAIHB has a relationship.

**LGBTQ 2-Spirit Text Message Campaign:** Three text message campaigns have been developed to improve health care for LGBTQ and Two Spirit individuals. These campaigns offer information for providers, LGBTQ and Two Spirit individuals, and their families, friends, and allies. They educate recipients about best practices when caring for Two Spirit or LGBTQ patients, self-advocacy in clinical settings, and advocating for or supporting LGBTQ and Two Spirit persons, respectively. Text message campaigns are currently being pilot tested and will be ready to be disseminated and evaluated in August 2019.

**Celebrating Our Magic: A Toolkit for Transgender and Two Spirit Youth who are Transitioning:** Alessandra Angelino wrote a comprehensive toolkit with health and wellness information for Native youth, who are transitioning, their families, and their healthcare providers. Now available on the NPAIHB LGBTQ 2-Spirit webpage: www.npaihb.org/2slgbtq/#print

## Surveillance and Research

**STD/HIV/HCV Data Project:** STD/HIV/HCV Data Project: The project is monitoring STD/HIV GPRA measures for IHS sites throughout Indian Country. National standardized indicators on HIV, HCV, and STD screening are included in the national health informatics platform. These data are then used to identify leading facilities to identify best practices that may have potential to replicate in policy and practice in other I/T/U facilities. In response to national data, a new measure, HIV diagnoses among men 25-45 was added, as this group had significantly higher rates of HIV diagnoses. As per the national screening technical assistance project, data monitoring found that HIV screening coverage of 13-64 year olds increased from from 52% to 55%, HIV screening of STI+ patients increased from 54% to 58%, and HCV screening of persons born 1945-1965 increased from 54% to 63%. The new measure, HIV screening coverage among men ages 25-45 is up from 44% to 48%.

**PWID Study:** To capture the heterogeneous experience of AI/AN PWID and PWHID, this project is being conducted in four geographically dispersed AI/N communities in the United States using semi-structure interviews. The project is based on indigenous ways of knowing, community-based participatory research principles and implementation science.

## Extension of Community Healthcare Outcomes (ECHO)

**ECHO:** Each month, the Northwest Portland Area Indian Health Board offers multiple teleECHO clinics with specialists focusing on the management and treatment of patients with HCV and SUD. The 1-hour long clinics includes an opportunity to present cases, receive recommendations from a specialist, engage in a didactic session and become part of a learning community. Together, we will manage patient cases so that every patient gets the care they need. ***A total of 577 patients have received recommendations via the NPAIHB ECHO HUB.***

## Other Administrative Responsibilities

**Publications**

- AI/AN Methods Paper on PWID Project accepted to Public Health https://doi.org/10.1016/j.puhe.2018.12.002
- AI/AN PWID Results Paper in Review
- Working on OUD Indicators Paper with CDC

**Reports/Grants Submitted**

- Awarded for FYI 2019: SAMHSA ECHO – 524,000
- Awarded for FYI 2019: OMH ECHO – 350,000
- Awarded for FYI 2019: CDC Opioid Response Strategy – 265,000
- Awarded for FYI 2019: SAMHSA TOR – 3.5 Million
- Awarded for FYI 2019: IHS SMAIF HIV 1.3 Million

**Administrative Duties**

- Budget tracking and maintenance: Ongoing
- Managed Project Invoices: Ongoing
- Managed Project Subcontracts: Ongoing
- Staff oversight and annual evaluations: Ongoing

## Epicenter Biostatistician April-June 2019

**Nancy Bennett**

Conference Calls:

- TPHEP 2019 conference planning committee call weekly
- eMars conference call w/ Cayuse to discuss project updates

NPAIHB Meetings:

- All staff meeting – monthly
- Biostat meeting – bi-weekly
- Staff retreat planning meeting
    - Created survey monkey for rooming options
    - Chose facilitators
    - Chose venue

- Onboarding committee meeting
- Safety meeting
    - Took over as committee chair
    - Planned upcoming fire drills
- Asthma data meeting
    - Completed and tested Asthma database, turned over to Mattie to start inputting

Conferences/QBMs/Out of area Meetings

- QBM in Swinomish, WA
- SAS Global Conference Dallas, TX
- Emergency Preparedness conf. Portland, OR

Miscellaneous

Reports:

Sent completed Cots vs EHR data to Sarah, still waiting on feedback

Site Visits:

None

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**EpiCenter National Evaluation Project**

**2nd Quarter Activity Report**

April – June 2019

**Staff:**

Birdie Wermy – Epicenter National Evaluation Project Specialist

**Technical Assistance via telephone/email**

April – June

- Ongoing communication with NPAIHB EpiCenter Director
- Ongoing communication with Tribal sites regarding project updates, information and technical assistance
- Email correspondence with the two to four regarding T.A., reporting and program implementation and their LDCP.

**Reporting**

April

- Good Health and Wellness in Indian Country (GHWIC) All Hands call on 4.03 @ 10am
- TEC APO call on 4.04 @ 11am
- Good Health and Wellness in Indian Country (GHWIC) TEC Workgroup call on 4.10 @ 10am
- Portland MSPI call on 4.17 @ 9am
- Portland DVPI call on 4.17 @ 11:30am

May

- TEC APO call on 5.02 @ 11am
- APO call on 5.30 @ 9am

June

- MSPI/DVPI call on 6.07 @ 11am
- MSPI call on 6.19 @ 9am
- DVPI call on 6.19 @ 11:30am
- Good Health and Wellness in Indian Country (GHWIC) call on 6.26 @ 10am
- Good Health and Wellness in Indian Country (GHWIC) TEC Workgroup call on 6.28 @ 11am

***Updates***

Birdie – continuing to provide evaluation TA to MSPI/DVPI service areas and GHWIC NW WEAVE Project.

- Provided technical assistance to three tribal programs and one non-related to MSPI/DVPI during the month of May.
- Provided a draft agenda and SAVE THE DATE for the1st Annual MSPI/DVPI Convening for August 8 in Portland at the NPAIHB. Six programs can attend in person and two programs can attend by ZOOM. We will determine if we will have an in person meeting or if we can hold this training by ZOOM for 4 hours that day.

***Challenges/Opportunities/Milestones***

Milestone: Completed second annual "Act of Giving" on 4.03 at the Oregon Food Bank in memory of Haruka Weiser.

Opportunity: There were about 25 attendees on both days for the "Wellness in the Workplace" presentation on 4.23 and 4.24. Met with certain program directors and Tribal organizations needing guidance on how to implement a wellness policy in their workplace and/or how to draft a policy. We had a great turnout at each session and we were able to help answer questions about NPAIHB's wellness policy.

Challenges: There were two scheduled calls with one DVPI program not attended by the project coordinator. There is a change of staff at this DVPI program as of 5.29.

Challenges: Continuation application submission deadline was 5.31.19 update on 6.07.19

- Portland MSPI 16 Projects: 14 Submitted, **2 Not submitted**
- Portland DVPI 7 Projects: 6 Submitted, **1 Not Submitted**
- The Portland Area Officer has emailed all 3 programs and worked with each to get their continuation application submitted.

***Meetings/Trainings***

- Y5 Performance Measure Report Webinar on 4.01 @ 10:30am
- Domestic Violence Prevention Project Webinar on 4.04 @ 10am
- NPAIHB Domestic Violence 101 Webinar on 4.10 @ 11am
- Tribal Sovereignty & e-cigarette Companies Webinar on 4.12 @ 9am
- Use of Culturally Informed Assessments Webinar on 4.17 @ 9:30am
- Correlates of Opioid Dispensing Webinar on 4.18 @ 10am
- Wellness Committee Meeting on 4.19 @ 10:45am

- American Indian Institute; Native Women and Men's Wellness and Diabetes Conference 4.22-4.25
- Preventing Suicide Webinar on 5.08 @ 10am
- Indian Day Planning Meeting on 5.10 @ 11am
- Advocating for Prevention in Communities of Color: The Role of Providers Amid the Opioid Crisis Webinar on 5.13 @ 10am
- Wellness Committee Meeting on 5.30 @ 11am
- SOAR for Native Communities Webinar on 5.30 @ 1pm
- Review Snap training on 6.05 @ 10am
- UIHI Webinar on 6.05 @ 11am
- Webinar: Lateral Violence in Native Communities Confirmation on 6.11 @ 11am

***Site Visits***

- None

***Upcoming Calls/Meetings/Travel***

- Wellness Committee Meeting on 7.10 @ 10am
- Joint QBM w/ CRIHB in Sacramento, Ca on 7.15-7.18.
- Good Health and Wellness in Indian Country (GHWIC) All Hands call on 7.17 @ 10am
- DVPI call on 7.18 @ 9am
- MSPI call on 7.24 @ 9am
- Good Health and Wellness in Indian Country (GHWIC) C2 call on 7.24 @ 10am

***Publications***

- NONE

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Clarice Charging
Immunization and IRB Coordinator
Northwest Portland Area Indian Health Board
Quarterly Report
April-June 2019

**Meetings:**

NPAIHB all-staff meeting, April 1, 2019
Indian Day planning meeting, April 5, 2019
NPAIHB staff meeting, May 6, 2019
Dental Conference planning meeting, May 6, 2019
Indian Day planning meeting, May 10, 2019
Indian Day planning meeting, May 17, 2019
Tribal Emergency Preparedness planning meeting, May 22 2019
Tribal Emergency Preparedness planning meeting, May 23, 2019
Tribal Emergency Preparedness planning meeting, May 29, 2019
NPAIHB staff meeting, June 3, 2019

Immunization Policy Action Team (IPAT), OR DOH, June 6, 2019
Indian Health Service Award Presentation June 7, 2019
Assessment, Feedback, Incentives, eXchange (AFIX), OR DOH, June 6, 2019

**Quarterly board meetings/conferences/site visits:**

NPAIHB quarterly board meeting, Swinomish Casino & Lodge, Anacortes, WA, April 15-18, 2018
Cancer Clinicians Update, Residence Inn Riverplace, April 24, 2019
Region X Adult Immunization Stakeholder Meeting, Seattle, WA, April 30, 2019
NW Tribal Diabetes Conference, Embassy Suites, Tigard, OR, May 2, 2019
NPAIHB Dental Support Conference, Embassy Suites, Tigard, OR, May 14-16, 2019
Northwest Tribal Foods Sovereignty Conference, Skokomish, WA, June 4-5, 2019
NPAIHB Emergency Preparedness Conference, Embassy Suites, Portland, OR, June 10-14, 2019
Northwest Tribal Cancer Coalition Meeting, Residence Inn Riverplace, Portland, OR, June 27, 2019

**Conference Calls:**

2019 Emergency Preparedness Conference planning, April 10, 2019
Region 10 Adult Immunization Stakeholder planning meeting, April 10, 2019
Portland Area Immunization Coordinator, April 12, 2019
Region X AISHH debriefing, May 8, 2019
Women's Health Webinar, May 8, 2019
Oregon DOH Immunization, May 8, 2019

**Portland Area (PA) Indian Health Service (IHS) Institutional Review Board (IRB):**

PA IRB Meetings:

PA IHS IRB committee meeting, April 25, 2019
PA IHS IRB committee meeting, May 29, 2019
PA IHS IRB committee meeting, June 19, 2019

During the period of April 1 – June 30, 2019 Portland Area IRBNet program has 166 registered participants, received 7 new electronic submissions, processed 9 protocol revision approvals, approved 11 publications/presentations, and approved 3 annual renewals.

Provided IT and IRB regulation assistance to Primary Investigators from the following Tribes:

1) Confederated Tribes of the Yakama Indian Reservation
2) Cowlitz Tribe
3) NPAIHB
4) Confederated Tribes of Warm Springs Indian Reservation

5) Shoalwater Bay Tribe
6) Shoshone Bannock Tribe
7) Swinomish Tribe
8) Native Project
9) OHSU

**Injury Prevention Program (IPP)/Public Health Improvement & Training (PHIT)**
**Public Health Improvement & Training (PHIT) Project**
**Injury Prevention Project (IPP)**
**2nd Quarter 2019 (April-May-June)**

Bridget Canniff, Project Director
Luella Azule, Project Coordinator
Taylor Ellis, Project Specialist

**Meetings/Calls/Conferences/Presentations**

- 4/3, 10, 17 ,24 Conference calls: Tribal Health Emergency Preparedness (Bridget Luella Taylor)
- 5/1, 8,15, 22, 29 Planning committee conference calls: Tribal Health Emergency Preparedness (Bridget Luella Taylor, Nancy, Clarice)
- 5/20 WA DOH Emergency Prep & Response program update calls (Taylor)
- 6/5 TPHEP Planning Committee call (Taylor, Bridget)
- 6/10-6/14 TPHEP Conference at Embassy Suites in Portland (all IPP/PHIT staff)
- 6/25 Tabling at THRIVE Conference (Taylor)
- 6/26 Washington Firearm Tragedy Prevention Network meeting (Taylor)
- 6/27 Youth Advocates Alliance meeting (Taylor)

**Trainings/Webinars**

- 5/8 Celebrating Women's Health webinar (Taylor)
- 5/17 SMART Objectives Training webinar (Taylor)
- 5/30 Measles Outbreak: Applying Anthropological Understanding (Taylor)
- 6/10-6/11 Isolation and Quarantine Response Strategies in the Event of a Biological Disease Outbreak in Tribal Nations, Portland (Taylor)

**Outreach/Other**

Emails to CPS techs, IP Coalition Committee, IP Tribal contacts:

- NHTSA Distracted Awareness information
- Kids and Cars – Hot cars death e-mail

Injury Prevention Toolkit:

- Submitted rough firearm safety materials for review and graphic design to University of Colorado partners
- Attended Youth Advocates Alliance meeting to provide updates on firearm safety module and receive feedback

**Funding**

- 6/6 Submitted supplement application for CDC Tribal Public Health Capacity Building and QI cooperative agreement, in response to 5 supplement work plans on the following topics:
    - Environmental Health (Celeste)
    - Childhood Immunization (Tam, Tom Weiser)
    - Smoking Cessation (Kerri)
    - Encouraging Students to Pursue Public Health Careers (Stephanie)
    - Public Health Accreditation (Bridget)

**Technical Assistance**

- Warm Springs: At Joe's direction, responded to request for material support during water main break, in coordination with OHA Tribal Liaison Carey Palm – provided water, sanitary supplies, and related items (Bridget and Taylor)

**Travel/Site Visits**

**Tribe:** Swinomish
**Location:** Anacortes, WA
**Date:** 4/15-4/18
**Purpose:** QBM
**Who:** Bridget and Taylor

Quarterly Report
April-June 2019
Thomas Weiser, MD, MPH
**Medical Epidemiologist**
Northwest Portland Area Indian Health Board and Portland Area IHS

**Projects:**

*IRB
*Immunizations Program-routine immunization monitoring
*EIS Supervision
*Hepatitis C
*Children with Disabilities (CWDA)
*Opioid Epidemic
*MCH Assessment
*Suicide Surveillance and Prevention

**Travel/Training:**

*Clinic Duty (Chemawa), 4/9, 4/11, 4/18; QBM (Swinomish) 4/15-4/17; Clinical Cancer Update, (Portland), 4/24; IHS CD Meeting (Portland), 4/25; EIS Meeting (Atlanta, GA), 4/29/5/3, 2019
*USPHS Deployment, SW Border, May19-June 1, 2019
*Idaho Immunization Summit June 3-4, ACIP (Atlanta, GA), June 25-28, 2019

Beginning July 1, I will be appointed acting CMO for the Portland Area IHS. This will require 1-2 days/week out of the office to be present at the area office. Will also require travel to quarterly Governing Board meetings and Accreditation Survey meetings at each of the 6 Federal Service Units.

**Opportunities:**

*IRB met in April, May and June. There were seven new electronic submissions, processed 9 protocol revision approvals, approved 11 publications/presentations, approved 3 annual renewals.
*Immunization Coordinator's Calls-Met in April and May. Travelled to the Idaho Tribal Immunization Summit where three of the five ID tribes attended. The state provided an AFIX evaluation (Assessment, Feedback, Incentive, eXchange). Accepted a request for appointment to RPMS Advisory Committee on Immunizations. Attended CDC ACIP meeting in Atlanta.
*EIS Surveillance Project-EIS site visit by Atlanta supervisor on June 19. No new concerns regarding the assignment or the officer who is completing his requirements. Still editing an article for MMWR Notes from the Field. Discussed potential analyses for meeting analytic CAL and are looking at obtaining data regarding TB incidence and mortality for AI/AN. Made contact with BIA regarding availability of employee health data such as wildland firefighters and other occupations. Presented Washington mortality analysis at CSTE in June.
*Hepatitis C: No new work.
*Children with Disabilities Project: Still one table to complete. Paper for publication in Public Health Reports (Sarah Hatcher, 1st author is working thru final edits.
*Opioid Epidemic: Met with IHS Dashboard workgroup to assist in refinements to the Dashboard. Raised questions about access to substance use data and the new Privacy requirements under 42 CFR, Part 2. No further revisions to the HOPE prescribing metrics document; updates to the Opioid Use Disorder metrics document are pending further discussions on the Privacy rules (P2 filter).
*MCH Assessment: Team meetings have continued. Preparing background materials for a CDC umbrella grant addendum to focus on immunizations. Continue to advocate for infant mortality analysis and PRAMS data analysis projects.
*Suicide Surveillance and Prevention (Colville): No new work to report except have discussed similar issues at two other tribes.

Tam Lutz (Lummi), Co-Investigator/Project Director (Native CARS), Co-PI (TOTS to Tweens)
Jodi Lapidus, Co-PI (Native CARS), Co-Investigator (TOTS to Tweens)
Nicole Smith, Biostatistician (Native CARS and TOTS to Tweens)
Candice Jimenez (Warm Springs), Research Manager (Native CARS and TOTS to Tweens)
Meena Patil, Biostatistician (Native CARS)
Thomas Becker, Co-PI (TOTS to Tweens)
Kai Lei, Temporary Data Analyst (TOTS to Tweens)

**Motor Vehicle Data (Native CARS) Project:**

**Project News and Activities**
This quarter Native CARS with funding award from the National Institute on Minority Health and Health Disparities continued progress on improving the use of Motor Vehicle Data. Additionally, Native CARS formed a partnership with Oregon Health Sciences University (OHSU) and Northwest Washington Indian Health Board (NWWIHB) to move forward with these efforts. This partnership continues the collaboration of Co-PI's Jodi Lapidus and Tam Lutz, as well as current Biostatisticians Nicole Smith and Meena Patil as well as Research Manager, Candice Jimenez - all of which have been part of Native CARS team.

**Disseminating**
**Back at the office, Native CARS staff has kept the Native CARS Atlas** updated and responded to individual tribal site and local tribal organization requests. Our time continues to focus on drafting three new papers (Main Outcomes, Community Based Participatory Research - CBPR and Qualitative findings) to disseminate to peer reviewed journals. Native CARS has continued investigation and preparing for future regional and national venues. Our goal is to get the word out that the Native CARS Atlas is up and running at www.nativecars.org – an online toolkit.

Specific activities of the Portland Native CARS team are as follows:

## Meetings – Conference Calls – Presentations - Trainings

- Staff Meetings – each Monday
- NPAIHB-NWWIHB Partner Meetings
- Health Data Literacy Training
- Lifesavers Conference Presentation and Poster
- Meetings with Tribal Sites – Native CARS Mini Grant

## Program Support or Technical Assistance

- Communication with Jeff Nye/Julia Hammond regarding Atlas Revisions
- Meeting coordination, minutes and action item documentation
- Follow-up communication with tribes, tribal organizations
- Main Outcomes & CBPR Manuscript writing
- Partnership building and information sharing for Motor Vehicle Data Grant

- Presentation and Poster Abstract Submissions for National Conferences
- Motor Vehicle Data Grant Award Letters for Sub-contracts
- Motor Vehicle Project Timeline Preparation
- Sub-award contract preparation – OHSU & NWWIHB
- Drafting of Analysis Plan template
- Sensitivity Analysis for Native CARS Main Outcomes
- Collated code for Native CARS Main Outcomes
- Notice of Motor Vehicle Grant award to Advisory Committee
- Analyzed and prepared Washington state death data
- Reviewed and Identified ICD-10 codes for death data analysis
- Pedestrian -Motor Vehicle fatality analysis and mapping
- Provided data and Letter of Support in support of Yakama Nation Heritage Trail
- Motor Vehicle Data Project article for NPAIHB Health News & Notes Newsletter
- Reviewed NWWIHB prior accident data analysis and related documentation
- Reviewed and provided comment to HNN article

**TOTS to Tweens Study:**

**Project News and Activities**

This quarter TOTS to Tweens Study team continued with data management, cleaning and conducting preliminary analysis of quantitative data collected to preparation for manuscript preparation and individual Tribal specific reports.

Specific activities of the TOTS to Tweens team are as follows:

## Meetings - Conference Calls – Presentations – Trainings

- Project Meetings – Weekly
- Presented at Portland Area Tribal Dental Health Conference
- Site specific meetings – as needed

## Program Support or Technical Assistance

- Meeting coordination, minutes and action item documentation
- Data Management & Preliminary Analysis
- TOTS to Tweens data cleaning and re-coding review
- Communicated progress, timeline and next steps with investigators
- Outlined two potential papers – Main Outcome and Access to Care
- Transcription of elicitation interviews from written recorder notes
- Completion of tribal elicitation interviews
- Completion of qualitative interview recordings for transcription
- Preparation of Elicitation Interview files for analysis
- TOTS to Tweens oral health article for NPAIHB Health News & Notes Newsletter
- Reviewed and provide edits to HNN articles

**Maternal Child Health (MCH) Core Workgroup**

Tam Lutz, Nicole Smith, Candice Jimenez and Meena Patil also contribute efforts to the MCH Core workgroup providing input to other NPAIHB MCH related projects, collaborating on grant proposal and responding to external MCH requests or potential partnership opportunities.

**Meetings - Conference Calls – Presentations – Trainings**

- MCH Workgroup Meetings
- Oregon State PRAMS Advisory Committee Meeting
- Immunization Grant Writing Meeting

**Program Support or Technical Assistance**

- Reviewed breastfeeding rates and best practices for clinic and communities
- Brainstormed approaches we can take as an organization to improve PRAMS response rates
- Reviewed smoking during pregnancy analyses
- Wrote and submitted immunization grant to NIH
- Wrote and submitted MCH-Opioid IRB application
- Responded to IRB request for modifications
- Wrote and submitted CDC immunization umbrella grant
- Coordinated MCH/Injury focused July Health News and Notes

**Additional support to the Epi Center and NPAIHB**

**Meetings - Conference Calls – Presentations – Trainings**

- EpiCenter Staff Meeting
- Project Director's Meeting
- PAIHS IRB
- PRC Advisory Committee Meeting
- Investment Committee Meeting
- Biostatistician Core Meeting
- Wellness Committee Meeting
- Indian Day Meeting
- Safety Committee Meeting
- Online e-MARS Testing for monthly project input
- Facilitated conversations about breastfeeding as a best practice at Diabetes conference
- Quarterly Board Meeting

**No. of Requests Responded to for Technical Assistance, including the following: Data Requests to Tribal and Urban Organizations, Communities or AI/AN Individuals**

| | |
|---|---|
| How many requested: | 4 |
| How Many NW Tribe Specific: | 4 |
| Email assisting with: | 3 |
| Phone assisting with: | 1 |
| How Many Responded To: | 4 |

**No. of Tribal Epidemiology Center-Sponsored Trainings and Technical Assistance Events Provided to Build Tribal Public Health Capacity**

Number of project trainings: 0
Training Titles: 0
Number of individuals in attendance: 0

**Site Visits**

Confederated Tribes of Warm Springs Pi-Ume-Sha Health Fair – June 2019

**Project(s) Contact Information**

Tam Lutz, Co-Principal Investigator, 503-416-3271, tlutz@npaihb.org
Jodi Lapidus, Co-Principal Investigator, lapidusj@ohsu.edu
Candice Jimenez, Research Manager, 503-416-3264, cjimenez@npaihb.org
Nicole Smith, Biostatistician, 503-416-3292, nsmith@npaihb.org
Meena Patil, Biostatistician, 503-416-3307, mpatil@npaihb.org
Kai Lei, TOTS to Tweens Temp Data Analyst, klei@npaihb.org
Tom Becker, Co-PI, tbecker@npaihb.org

## Northwest Native American Research Center for Health (NARCH)

- **Summer Research Training Institute and Travel Scholarships**
  - **Tom Becker, PI**
  - **Victoria Warren-Mears, Director**
  - **Tom Weiser, Medical Epidemiologist**
  - **Ashley Thomas, Program Manager**
  - **Grazia Cunningham**
  - **Jacqueline Left Hand Bull**

- We have awarded roughly 40 travel scholarships to 2018 SI graduates & instructors. We predict to award 45 scholarships by the July 2019 deadline.

- The 2018 Summer Institute manuscript draft is in the final editing stage. We are currently looking into journals that would be most appropriate to publish this paper.

- **Fellowship Support Program for Tribal Graduate Students**
  - **Tom Becker, PI**
  - **Victoria Warren-Mears, Director**
  - **Tom Weiser, Medical Epidemiologist**
  - **Ashley Thomas, Program Manager**
  - **Grazia Cunningham**
  - **Jacqueline Left Hand Bull**

- We continue to support one Fellow with monthly stipends associated with their dissertation coursework and two Board Scholars with expenses associated with their

graduate coursework. Our Fellow is making great progress toward the completion of their degree.

- Our manuscript is in the final stage of editing and will be ready for publication as early as fall 2019.

- **Dissertation Support Program for Tribal Graduate Students**
  - **Tom Becker, PI**
  - **Victoria Warren-Mears, Director**
  - **Tom Weiser, Medical Epidemiologist**
  - **Ashley Thomas, Program Manager**
  - **Jacqueline Left Hand Bull**

- We have been supporting eight (8) Research Support Fellows who are AI/AN graduate students as they conduct scientific research necessary to complete their degrees. One of our fellows has just completed their dissertation and will no longer be receiving financial support, though we will track their career progress and be helpful when possible. We also have recruited two interns.

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**Northwest Tribal Cancer Control Project**
**NTCCP Quarterly Board Report**
**April-June 2019**

**Training**

- Northwest Tribal Comprehensive Cancer Coalition
  - 11 participants, 7 tribe NARA and SPIPA
  - Idaho and Washington Comprehensive Cancer Coordinators
  - Focus – HPV Concept Mapping – Focus group AI/AN cessation materials
- Oregon Quarterly 9 tribes Prevention Meeting
  - Burns – 7 tribes 18 participants
  - Tribal and agency updates
  - Presentation - NPAIHB
  - Grady Britton – Opioid toolkit
- AI/AN Oregon Quit line Media Messaging Workgroup (Charrette)
  - Webinar Follow Up
  - 2 sessions (90 Minutes) 20 participants 9 Oregon tribes, NARA, NAYA
  - Presentation of what is developed: AI/AN quit line cessation resources/media launch
- AI/AN Oregon Quit line Media Messaging Workgroup (Charrette)
  - 27 participants
  - 12 Oregon tribes, 4 tribal urban programs
  - Development of AI/AN quit line cessation resources/media launch
- Northwest Portland Area Dental Meeting
  - 121 participants, 24 tribes, 28 dental programs

    - Presentation tobacco cessation referral and HPV immunizations
- Northwest Regional Diabetes Conference
    - 35 participants
    - 23 tribes
- Clinician's Cancer Update on April 24th 2019
    - 35 attendees
    - 15 tribes represented; 1 Oregon tribe, 14 Washington Tribes
    - IHS, NARA, SPIPA, Oregon and Idaho Comprehensive Cancer Programs, CEDAR OHSU
- Health Data Literacy Training, Yakama WA
    - 30 attendees - Piloted policy guide
- Presented at Women's Wellness Day for Nez Perce Tribe, Lewiston
    - 283 women in attendance
    - NPAIHB presented on Cancer 101, E-cigarettes and breast feeding
- CDC Tribal Cancer Screening Workshop for Comprehensive Cancer Grantees, San Diego
    - Screening, outreach, tribal technical assistance needs, survivorship

**Technical Assistance**

- Contact with all Oregon tribes for AI/AN quit line meeting
- Follow-up on NW Tribal Cancer Action Plan Implementation application – awarded for funding
    - 13 implementation grants awarded
- Follow up with all NW tribes for recruitment to coalition
- Burns Paiute Tribe – (2) TA for TPEP grant;
- Burns Paiute Tribe (4): Klamath Tribes: (3) TA travel logistics for AI/AN Oregon Quit line Media
- CLUSI – NTCCP mini grant
- CLUSI; TA travel logistics for AI/AN Oregon Quit line Media Messaging, review TPEP
- Contact with all Oregon tribes for AI/AN quit line meeting
- Coquille (2) Discussion and planning of upcoming tobacco cessation training; type of training, trainers, date, and location**;** TA upcoming tobacco cessation training; Confirmed date and location, shared agenda**;** Planning traditional tobacco community survey at Restoration Celebration**;** July filming around traditional tobacco moved to July**;** and travel logistics for AI/AN Oregon Quit line Media Messaging Meeting
- Cow Creek: (2) Updated current Tribal TPEP activities to new Tribal TPEP temp; TA travel logistics for AI/AN Oregon Quit line Media Messaging
- Grand Ronde: TA and input on their hoodies and tee's for canoe journey promoting Quit line and the use of traditional tobacco
- Klamath: Researching tribal substance abuse patient education materials and handouts for Klamath Tribes Administrative Assistant; reach out to Grand Ronde and Warm Springs
- Quinault – TA for e-cigarette factsheets, educational materials and e-cigarette 101 presentation
- Siletz – discussion policy versus tribal resolution for housing policy
- Umatilla – (2) sent Second Wind Curriculum, outreach for Knight tribal advisory committee; new navigator, mini grant, and DPP; TA in mini grant for survivorship

- Warm Springs – (2) TA for TPEP grant, follow up from AI/AN quit line and honorarium and discussion of CPS
- Warm Springs – Submitted proposal for joint presentation upcoming HPV summit; Housing policy information
- Yakama; (3) NW tribal implementation application; coordinate "KiKi"
- Follow-up on NW Tribal Cancer Action Plan Implementation application – awarded for funding

**Special projects**

- CDC Umbrella grant AI/AN Quit line tobacco cessation
    - Scope of work – timeline, strategies, objectives outcomes
    - Budget and budget narrative
- Tobacco cessation in tribal communities: Spring 2019 Survey
    - Assist with survey communication between tribes and interviewer
    - Review and edit draft survey report
- Klamath Contract work
    - Review and edit Oregon tribe's history draft report
- American Indian Commercial Tobacco Cessation Program
    - OHA Optum NTCCP
    - Quit line data – evaluation - training
- AI/AN Oregon Quit line Media Messaging / Metro Group
    - Final invoicing for Marriott and travel reimbursement
    - Honorariums
    - Invite Tribal ADPEP coordinators to join zoom webinar follow-up
- Quarterly Prevention June Meeting
    - Set up purchase order and invoice for food order
    - Research Certified Prevention Specialist (CPS) training
- Tribal Policy Guide
    - Review and edit NW Tribal Policy History to be included in final document
    - Piloted tool kit
- Presentation at NARCH Summer Program
    - NTCCP overview and projects
- Oregon HPV Summit
    - Presentation HPV in Indian country – NTCCP
    - HPV Media presentation by Warm Springs on local media campaign
- Oregon HPV Summit Strategic Planning
    - Met with Oregon partners to develop HPV campaign for communities in Oregon
- Native America Calling: Radio talk show – discussed the dangers/harms of e-cigarettes, marketing, targeting AI/AN and youth, AI/AN adult and youth rates
- Native American Center of Excellence
    - Celebration for Wy'east Scholars – NPAIHB hosted 4 interns
- NARCH Luncheon - A key to crafting tobacco cessation interventions for cancer prevention and treatment for American Indians and Alaska Natives

- On-going follow-up with Oregon and Washington tribes on 2015 EpiCenter and PSE survey for tobacco cessation and policy for the policy resource library
- Facilitated focus group for Wy'east Pathway Scholars
- Engaged in NARCH Cancer Fellowship Courses for two weeks to build capacity for Northwest Tribal comprehensive cancer project
    - Classes on applying to NIH funding, epidemiology, cancer control program presentations and cancer control updates throughout the nation
- Developed and disseminated June Cancer Survivorship month factsheet to Northwest Tribes.

**Meetings**

- All Staff Meeting
- Project directors
- AI/AN Oregon Quit line Media Messaging Planning/Debriefing Meeting
- Cancer Fellowship Meeting
- CDC Supplement Tobacco Cessation Grant Workgroup Meeting
- Certified Prevention Specialist Training Meeting
- Collaboration with Knight Cancer Institute CEDAR program
- Conference call with CDC Project Officer
- E-cigarettes Media Pre-interview
- Emergency Preparedness – Immunization as harm reduction
    - Facilitated student focus group
- Governor's Tobacco Tax Coalition
- Governor's Tobacco Tax Coalition – submitted written testimony
- Knight Cancer Institute Collaboration
- Knight Cancer Institute Collaboration – HPV Concept Mapping meeting (2)
- Meet with CDC Project Officer (2)
- Native American Center for Excellence
    - Annual meeting -
- Northwest Native American Center of Excellence Program Coordinator
- Northwest Portland Area Dental Planning Meeting
- Optum Meeting (NTCCP, OHA, and Optum) (2)
- Oregon HPV Summit Speakers Call meeting
- Quality Improvement Meeting with Cardea
- Smoke-free Casino Follow-up Meeting (2)
- Tribal Policy Guide Meeting
- Tribal Tobacco Cessation Planning Meeting
- Wy'east Scholars mentor meeting (2)

**<u>Conference / Webinar calls</u>**

- TRUTH Initiative – Quitting in the Age of Vaping: A Special Warner Series Webinar
- OHSU Knight Cancer Center - Tribal and Rural Advisory Board
- CDC Cancer Survivor Series - NIHB

- Tribal Comprehensive Cancer
- Health Fairs as EBI –
- Oregon Health Authority – Retail Environment Assessment: Media Toolkit -
- Oregon Health Authority – Tobacco Alcohol Retail Assessment: Tribal Communities Conversations
- Oregon Health Authority – Retail Environment Assessment: Alcohol Results
- Tribal and Rural Advisory Board Meeting; Recalibration of the Board
- You are the Key to HPV Cancer Prevention (Dental)
- IHS – Up in Smoke: Potential Health Impacts of Cannabis Use During Pregnancy and Lactation
- Knight cancer scholars (2)
- National Indian Health Board – Strengthening Colorectal Cancer Screening in AI/AN
- Tribal Sovereignty and e-cigarettes: Emerging concerns
- Tribal and Rural Advisory Board Meeting; Recalibration of the Board

**Northwest Tribal Dental Support Center**
**Northwest Tribal Dental Support Center Quarterly Report**
**(April – June 2019)**

The Northwest Tribal Dental Support Center (NTDSC) is in their 19th year of funding. The overall goals of NTDSC are to provide training, quality improvement, and technical assistance to the IHS/Tribal Dental programs, and to ensure that the services of the NTDSC result in measurable improvement in the oral health status of the AI/AN people served in the Portland Area. NTDSC activities are listed in categories corresponding to the current grant objectives.

Ensure quality and efficient care will provided in Portland Area dental programs through standardization of care and implementation of public health principles to improve dental access and oral health outcomes.

- **NTDSC staff and consultants, in coordination with the Area Dental Consultant (ADC) have provided two site visits this past quarter. NTDSC consultants visited the Makah tribe (Sophie Trettevick Indian Health Center) and the Lower Elwha Indian Health Center. This makes eight site visits for this fiscal year. NTDSC has met this objective for this fiscal year.**

Expand and support clinical and community-based oral health promotion/ disease prevention initiatives in high-risk groups to improve oral health.

- The work with ARCORA (The Foundation of Delta Dental of Washington) on our Baby Teeth Matter Initiative (BTM) is continuing with eight dental programs. The third in-person meeting was at the Portland Area Dental meeting on May 16, 2019. There have been a total of three in-person meetings and one webinar this fiscal year. We have another webinar scheduled for July 24, 2019. NTDSC has completed a program manual for new programs.

- The Elder Initiative is continuing with 10 dental programs, which includes both dental staff and Elder Coordinators from various tribes. There have been a total of two in-person meetings and one webinar this fiscal year. We have another webinar scheduled for July 30, 2019. The NTDSC staff, consultants and ARCORA foundation staff met regarding this initiative to develop measureable goals and objectives.

**Implement an Area-wide surveillance system to track oral health status.**
**Data from the surveillance system will be used to identify vulnerable populations and plan/evaluate clinical and community-based prevention programs.**

- The screening of 0-5 year olds in medical and community settings is complete and survey results have been released. This is a documented decrease in dental caries and the also in the number of children needing dental treatment.

Provide continuing dental education to all Portland Area dental staff at a level that approaches state requirements.

CDE: NTDSC tracks the number of participants and CDE credits provided through the Update on Prevention Course provided during site visits, BTM and Elders Initiatives, NTDSC yearly orientation and full meeting, and the addition of the clinical MID course.

The 2019 Portland Area Dental meeting was held in Tigard, OR May 14-16, 2019. There were 121 participants who attended from 24 tribes and 28 dental programs. 17.75 CDE were offered at the 2019 Portland Area Dental meeting.

NTDSC consultants participate in email correspondence, national conference calls, and respond to all requests for input on local, Portland Area, and national issues.

NTDSC staff attended the national IHS Dental Updates conference in Albuquerque in June.

**Improving Data & Enhancing Access (IDEA-NW)/**
**Northwest Tribal EpiCenter (NWTEC) Public Health Infrastructure**

**Quarterly Board Meeting Report – July 2019**
Reporting period: April - June 2019

Victoria Warren-Mears, Principal Investigator
Sujata Joshi, Project Director
Chiao-Wen Lan, Epidemiologist
Heidi Lovejoy, Substance Use Epidemiologist
Joshua Smith, Health Communications Specialist
Karuna Tirumala, Project Biostatistician
Natalie Roese, Project Intern
Email: IdeaNW@npaihb.org

**Data reports, fact sheets, and presentations are posted to our project website as they are completed http://www.npaihb.org/idea-nw/**
**Please feel free to contact us any time with specific data requests.**
**Email: sjoshi@npaihb.org or IdeaNW@npaihb.org**
**Phone: (503) 416-3261**

**Staff Updates**

- No updates

**Current status of data linkage, analysis, and partnership activities**

*Northwest Tribal Registry (NTR) data linkages & data acquisition*

- Completed linkage with Oregon hospital discharge records 2015-2017
- Began work on prepping the Northwest Tribal Registry v. 15 file
- Obtained Washington Healthy Youth Survey data for 2018

***Dataset Cleaning and Preparation***

- Worked on cleaning and preparing the following datasets for analysis:
    - Washington hospital discharge data for 2015-2016
    - Oregon Medicaid data for 2011-2014

***Data Analysis, Visualization, and Report Preparation Projects***

- Data Reports Completed
    - Washington suicide data profile (2014-2016)
    - Oregon suicide data profile (2013-2017)
- Data Projects in Progress
    - Maternal & Child Health Data Profiles and Analyses
        - Prepared oral presentation for the 2019 CityMatCH accepted abstract entitled "Mental health and access to services among American Indians/Alaska Natives women of reproductive age"
        - Began to prepare for the 2019 APHA presentation, "Maternal substance use disorders and infant withdrawal syndromes in hospital deliveries among American Indians/Alaska natives in Washington"
        - Smoking during pregnancy analysis
            - Completed longitudinal regression model predicting smoking reduction across the pregnancy using Oregon birth certificate
            - Manuscript development
                - Complete overview of methods, results and figures distributed for comment and review by MCH Epi & Biostats
                - Final write-up of manuscript underway
    - Tobacco-related Causes of Death Analysis
        - Drafted analysis plan for CVD and tobacco use project
        - Began work on analysis and report outline development
    - Tableau Dashboards

        - Worked on developing structure for "storytelling" Tableau dashboards
        - Worked on formatting datasets for dashboard
    - Substance Use Analyses
        - Finalized slides and mock presentation for accepted abstract at 2019 CSTE, entitled "Racial disparities in substance use disorder and self-inflicted injury among American Indian and Alaska Native youth in Washington, 2011 – 2014"
        - Draft background and methods section for the CHARS 2011-2016 manuscript on substance use comorbidities

***Suicide Surveillance Project***

- Suicide Monitoring Planning Projects
    - Provided TA and support to Chehalis, Coeur d'Alene, and Shoshone Bannock Tribes
    - Held site visits with Chehalis and Shoshone Bannock Tribes

***Maternal & Child Health (MCH) Workgroup***

- Attended Oregon PRAMS Advisory Committee meeting
- Participated in National Survey on Child Health oversample meetings
- Wrote and submitted NIH R21 grant to support immunizations trainings for tribes (Native BOOST)

***NWTEC Public Health Infrastructure (TEC-PHI) Grant Activities***

- BioStat Core Meetings
    - Continued bi-weekly meetings
- Health Communications/Evaluation Specialist
    - Developed program description page for program directory
        - Developed a guidance document to aid in projects completing program descriptions
    - Created a 1 page and ½ page report brief template in Piktochart
    - Worked with Corey Began to develop male & female stencil characters for IDEA-NW visualizations
    - Continued working on adapting evaluation data collection tables to Microsoft Forms
    - Finished the Phase II IDEA-NW TECPHI evaluation plan
- Health Data Literacy Trainings
    - Provided Health Data Literacy training to approximately 25 participants at Yakama Nation
- TEC-PHI Workgroups and Meetings
    - Continued attending TEC-PHI community of practice meetings and webinars
- Other
    - Assisted Wy'east student intern (Kayla Murphy) with analysis project and poster
    - Prepared for and presented at Washington DOH and NWTEC Epi Gathering
    - Began to draft summary notes for possible NIH R21 grant application

***Data requests/Technical assistance***

- Provided data on NW AI/AN stomach cancer incidence and mortality rates to Tom Becker and Dornell Pete
- Provided information on limitations/uses of specific Washington datasets to Andrew Shogren (Suquamish Tribe)
- Provided information on linkage methods, population denominators, age-adjustment, and other issues to Alex Wu for EIS presentation
- Met with Zoe Watson (OHSU/PSU student) and provided information on common data issues/limitations for birth certificate data
- Compiled data and presented information on Northwest AI/AN youth risk factors related to suicide, substance use, and STIs for Tribal Youth Action Planning workshop
- Provided information on death data variables available and list of PRCDA counties to Meena Patil for Motor Vehicle Injury grant analyses
- Provided feedback for cancer coalition meeting flier
- Helped design a cancer survivor factsheet
- Provided feedback to Tam regarding the WEAVE tribal food campaign
- Provided feedback for OHA AI/AN targeted quit line campaign
- Reviewed and provided feedback to Jessica Leston on background section for manuscript on Persons Who Inject Drugs
- Provided asthma hospitalizations map to Jessica M. at WA DOH for grant application
- Provided maps of Northwest Tribes to Jayney Wallick at the Northwest Center for Public Health Practice
- Reviewed and provided average number of cancer deaths per year to Rosa Frutos for Cancer Survivor fact sheet
- Created Save the Date flyer for Northwest Tribal/State Data Sharing Partnership Meeting
- Checked codes for identifying motor vehicle crash deaths for Meena Patil
- Sent examples of project protocols to Sydelle Harrison for her preparation of an IRB protocol examining violent deaths in Oregon
- Sent CSTE presentation to contacts at Southern Plains Tribal Health Board and Great Plains Tribal Health Board
- Presented “Clear Communication” presentation at the Cancer Coalition update 6/27/2019
- Met with Ms. Hurtado (Warm Springs) regarding assistance in restructuring the Warm Springs health programs evaluation system and systematic data collection protocol
- Sent examples of protocols and data sharing agreement examples to Martha Salyers (North Carolina Band of Cherokee)

***Presentations & Results Dissemination***

- Presented project introduction and background at the Shoshone-Bannock suicide monitoring and prevention strategic planning meeting (4/25)
- Presented data on Northwest AI/AN youth risk factors during Tribal Youth Action Planning workshop (4/23)

- Provided information on Tribal Epidemiology Centers, NWTEC, tribal epi and misclassification during presentation to Washington DOH Epis during Epi Meet and Greet
- 2019 CSTE Annual Conference, "Racial disparities in substance use disorders and self-inflicted injury among American Indians and Alaska Native youth in Washington State" 6/3
- 2019 CSTE Annual Conference, "Who 'counts' as American Indian/Alaska Native?" 6/2
- Presented NWTEC Data Sharing Experiences during Improving Data Access and Use between Tribes, TECs, and States Webinar 6/25
- Wrote up a short article on suicide data for AI/AN in Oregon for July Health News & Notes newsletter

***Trainings Provided to Tribes/Tribal Programs***

- Provided Health Data Literacy Training to approximately 25 attendees in Yakama Nation

***Institutional Review Board (IRB) applications and approvals/Protocol development***

- Received approvals for linkage with Idaho birth and death records and release of non-cancer cause of death information from CDRI
- Submitted continuation application for linkages with Washington State CHARS and death records
- Submitted continuation application and study amendment for linkages with Washington State Cancer Registry
- Received executed contract and approval for Washington Healthy Youth Survey
- Submitted study amendment requests to Oregon Center for Health Statistics to request: 1) state file number and 2) cause of death literal fields
- Received fully executed data sharing agreement for obtaining PII data from the National Data Warehouse for the NTR

***Grant Administration and Reporting***

- Completed and submitted TEC-PHI Base and Opioid Supplement Progress Reports and Continuation applications
- Completed and submitted CDC 1803 Umbrella Project progress report for IHS/NDI Linkage Project
- Completed and submitted EpiDataMart Project progress report to Victoria for inclusion in the EpiCore continuation application

**Travel**

*Site Visits*

- Yakama Nation for Health Data Literacy Training, Toppenish, WA 4/8 – 4/10
- Swinomish Tribes for QBM and CDC Site Visit, Anacortes, WA 4/15 - /4/17
- Shoshone-Bannock Tribes for Suicide Strategic Planning Meeting, Fort 4/24 – 4/25

Hall, ID
- Chehalis Tribe for Suicide monitoring project meeting 6/21

***Linkages***
- Oregon hospital discharge data, Salem, OR 5/2

*Other*
- 2019 Council for State and Territorial Epidemiologists Annual Meeting, Raleigh, NC 6/1-6/5

**TEC-PHI Opioid Supplement**

***Coordination and Partnership Activities***
- Met with DOH Leadership to discuss partnership opportunities, especially as related to data access and incorporating linkage results
- Continued weekly strategic planning meetings to refine draft NW Tribal Opioid Strategic Agenda
- Reached out to Swinomish tribe regarding their experiences using ODMAP
- Held discussions with WA WEMSIS staff regarding an EMS overdose analysis on/near tribal lands, relevant data quality concerns, and data request process
- Held call with Assistant Fire Department Chief Llewellyn to discuss his paper on using EMS data to map opioid use in Spokane Valley, and discussed EMS data quality, gaps, and local EMS integration with other state/federal EMS databases
- Email discussions regarding ODMAP with WA DOH and IHS
- Attended WADOH Opioid Data Workgroup meeting in Tumwater, WA; this was my first time attending this workgroup and it was an excellent opportunity to meet a number of key WA opioid partners from various WA agencies as well as provide input on the Washington State Opioid Response Plan. Several key additions to the Plan discussed include:
    - Adding an additional line item activity to work with NWTEC to integrate and address AI/AN racial misclassification
    - Adding “and race” to be explored as an additional stratification in the State Comprehensive Opioid Dashboard (previously was “by age and gender” only)
    - Adding “and tribes and TECs” anytime LHJs, ACHs, and counties are mentioned
- Meeting with WADOH State Non-Infectious Disease Epidemiologist/WA Opioid Workgroup lead to discuss underway and potential state data system linkages, medical examiner education efforts and collaboration opportunities, state AI/AN opioid workgroup, NAS and other data efforts
- Coordinated with Great Plains TEC to share our respective compilations of opioid data sources and open discussion regarding collaboration opportunities
- Held phone meeting with OR Lead Research Analyst for the Alcohol and Other Drug Prevention and Education Program to discuss OR opioid and substance data, upcoming and underway opioid workgroups, and contacts for data systems

***Data Analysis, Visualization, and Report Preparation***

- Completed Washington Opioid & Drug Overdose Data Brief
- Completed Oregon polysubstance deaths analysis
- Started working in Washington ESSENCE (RHINO) data, planning overdose analysis, and researching case definitions
- Completed Oregon Opioid & Drug Overdose Data Brief
- Conducted overdose mortality analyses by Purchased/Referred Care Delivery Areas in Oregon
- Created Coquille PRCDA specific drug overdose report

***Data Requests/Technical Assistance***

- Provided opioid drug type over time slides/data to EIS officer for CSTE presentation
- Provided feedback and relevant data items for manuscript on AI/AN PWID
- Provided national, OR, and WA AI/AN methamphetamine data to IHS through Tom W.
- Provided Coquille PRCDA specific drug overdose data report to Coquille tribe
- Provided Oregon opioid/drug overdose death data to Yellowhawk Clinic

***Trainings Provided to Tribes/Tribal Programs***

- SUD Epidemiology PowerPoint was presented (by David) at the SUD/MAT Data Waiver Training in Colville, WA

***Presentations & Results Dissemination***

- Washington Opioid & Drug Overdose Data Brief was distributed at the SUD/MAT Data Waiver Training in Colville, WA
- Provided hard copy of Washington AI/AN Opioid/Overdose Data Brief to WADOH State Epidemiologist at WADOH opioid workgroup meeting & briefly discussed data/trends found
- Chiao-Wen presented at CSTE Conference on a paper that I collaborated on: *Racial disparities in substance use disorder and self-inflicted injury among American Indian and Alaska Native youth in Washington, 2011 – 2014*
- Sent WA & OR Opioid/Overdose Data Briefs to Opioid Program Coordinator and Director of NW Tribal Dental Center for distribution. They both have contacts asking for this data. Also shared with Great Planes TEC.

***Grant Administration and Reporting***

- Met with CDC in-person to discuss Year 1 accomplishments and Year 2 work plan ideas
- Developed/submitted Year 2 of grant work plan & budget, and Year 1 progress report
- Held check-in phone call with CDC to report grant updates & accomplishments
- Began compiling Performance Measure indicators to report grant activity/progress for quarters 1-3 of the grant period (Sept-May)

***Other Activities***

- Continued developing comprehensive list of relevant opioid & overdose data sources
- Distributed CSTE SUMH preliminary behavioral/opioid indicators how-to guide to BioStat Core

- Attended OPHAT Basic Training webinar to gain familiarity with data available in this system
- Discussed SUD Epidemiology presentation contents with ECHO staff
- Added three data sources to comprehensive list of opioid & overdose data sources
- Compiling list of opioid or drug overdose dashboards

***Travel***

**Site Visits**

- Yakima, WA, Health Data Literacy Training
- Swinomish, WA, April QBM and Tour of Didgwalic Wellness Center and MAT Program Tour

**Other**

- 2019 CSTE Annual Conference in Raleigh, NC 6/1-6/5
- WADOH Opioid Workgroup meeting in Tumwater, WA 6/26
- NWTEC Opioid Workgroup Strategic Agenda Planning in Troutdale, OR 6/25
- CSTE Data Sharing Partners Meeting with OR/WA/ID states & tribes in Portland, OR 6/20

Response Circles – Domestic & Sexual Violence Prevention

*Colbie Caughlan, MPH, Project Director – THRIVE, TOR, and Response Circles*
Paige Smith, Project Coordinator – THRIVE and Response Circles

**Quarterly Report: April – June 2019**

**Site Visits**

**Tribal Site Visits**

- Quarterly Board Meeting, Swinomish Tribe, Anacortes, WA – April 15-17
- Tribal State & Federal Summit: Rising to the Challenge, Confederated Tribes of the Umatilla Indian Reservation, Pendleton, OR – April 16-18
- Social Marketing Bootcamp, Confederated Tribe of Siletz Indians (CTSI), Siletz, OR – June 21-22

**Out of Area and Other Travel**

- None during this reporting period.

**Technical Assistance & Training**

During the quarter, project staff:

- Participated in 33 meetings and conference calls with program partners.

During the quarter, Response Circles (RC) staff provided or participated in the following presentations, webinars and/or trainings:

- Training (2) – Co-facilitated the Social Marketing Bootcamp for youth at CTSI and an 8-hour training around *Culturally Responsive Approaches and Resources for Survivors of Abuse in Indian Country* with StrongHearts Native Helpline.
- Booth (1): Provided media materials and information at the Missing Murdered and Indigenous Women's Event, hosted by Multnomah Co. and the Native American Youth & Family Services Association (NAYA)
- Presentation (2): Hosted webinar presentation about RC along with StrongHearts Native Helpline and hosted a presentation by StrongHearts at the THRIVE Conference for Native youth.
- Webinar (5) – Attended five webinars for DV or SA to become more knowledgeable about the topics

During the quarter, the RC project responded to over 32 phone or email requests for domestic or sexual violence prevention, or media campaign-related technical assistance, trainings, or presentations.

## Health Promotion and Disease Prevention

**Response Circles Media Campaign**: All RC promotional materials (including the almost completed updated materials) are available on the web. During this reporting month staff disseminated 5 boxes of materials to tribes and tribal organizations that requested. Materials include: posters, brochures/rack cards, and tip cards.

## Other Administrative Responsibilities

**Staff Meetings**

- EpiCenter meetings
- All-staff meetings
- Project Director meetings
- Wellness Committee – monthly meetings and events

**Publications**

- Submitted Article for Missing Murdered and Indigenous Women day for the Healthy Native Youth e-newsletter

**Reports/Grants**

- Staff submitted the DVPI Yr2 Interim Progress Report and year 3 continuation application

**Administrative Duties**

- Budget tracking and maintenance: Ongoing.
- Managed Project Invoices: Ongoing.
- Staff/Intern oversight and annual evaluations: Ongoing.
- Managed Project Subcontracts: Ongoing

THRIVE (Tribal Health: Reaching out InVolves Everyone)

*Colbie Caughlan, MPH, Project Director – THRIVE, TOR, & RC*
*Celena McCray, MPH(c), B.S.Ed., THRIVE Project Coordinator*
*Paige Smith, THRIVE & RC Project Coordinator*

**Quarterly Report: April - June 2019**

## Site Visits

**Tribal Site Visits**

- Coeur d'Alene (CDA) Tribe, Plummer, ID – April 14-15
- Swinomish Tribe, Anacortes, WA – April 15-17
- Cowlitz Tribe, Longview, WA – May 23

**Out of Area and Other Travel**

- American Association for Suicidology's (AAS) Annual Conference, Denver, CO – April 24-27
- National Indian Health Board (NIHB) Behavioral Health Conference, Albuquerque, NM – May 15-17
- New Visions Wellness visit, Bend, OR – May 17
- Henry Federal Jackson Building, Roundtable U.S. Senator Patty Murray, Seattle, WA - May 28
- Oregon Conference on Opioids + Other Drugs, Pain + Addiction Treatment, Bend, OR – May 29-31

## Technical Assistance & Training

During the quarter, project staff:

- Participated in 58 meetings and conference calls with program partners.
- Disseminated 67 packages of the suicide prevention campaign(s) for #WeNeedYouHere.

During the quarter, THRIVE provided or participated in the following presentations and trainings:

- Presentations (6)– Panel presentation on *Expanding the Inclusion of AI and AN Perspectives in Suicide Prevention* presentation at the AAS Annual Conference, 45 attendees; panel presentation on *The Opioid Epidemic: Intersecting Suicide and Substance Abuse Prevention Efforts* presentation at the AAS Annual Conf., 50 attendees; poster presentation on the *Concerning Post Webinar* poster presentation at the AAS Annual Conference, 36 attendees; and co-presented on *Healing of the Canoe* at the AAS Annual Conference, 30 attendees; Garret Lee Smith Youth Suicide Prevention State/Tribal grantees: Virtual Program Showcase webinar presented on the *Concerning Posts on Social Media webinar* training, 75 virtual attendees and; facilitated & presented at the NW Native Adolescent Health Alliance meeting, 13 participants.

- Facilitation/Training (3) – Hosted provider trainings for Marimn Health at the CDA Tribe, 8 attendees; hosted a Question Persuade Refer (QPR) for trainers at the NPAIHB offices, 36 attendees; facilitated a QPR gatekeeper training for 9 participants.
- Booth (2): Provided media materials and information at the AAS Annual Conference, 200+ attendees in Denver, CO and at the Gathering of Native Youth: Youth Movement at the University of Oregon in Eugene, OR
- Conference (1): staff hosted the 9th Annual THRIVE youth conference and served 14 tribes and had 64 kids participate and 40 chaperones, staff, and facilitators attend.

During the quarter, the THRIVE project responded to over 272 phone or email requests for suicide, bullying, Zero Suicide Model, or media campaign-related technical assistance, trainings, or presentations. Staff also received a Notice of Award for the 2019-2024 SAMHSA Garret Lee Smith Youth Suicide Prevention Grant!!

## Health Promotion and Disease Prevention

**THRIVE Media Campaign**: All THRIVE promotional materials are available on the web. Materials include: posters, informational rack and tip cards, t-shirts, radio PSAs, and Lived Experience videos.

**GLS Messages April - June:** Number/Reach of We R Native Facebook messages addressing…

- Suicide (general) = 1 posts, 0 text message, **4,400** people reached
  - Mental health = 6 posts, 0 text messages, **11,001,** people reached

## Other Administrative Responsibilities

**Staff Meetings**

- EpiCenter meetings
- All-staff meetings
- Project Director meetings
- Wellness Committee – monthly meetings and events

**Publications**

- None during this reporting period.

**Reports/Grants**

- Submitted a year 4 quarter 2 financial report for the IHS MSPI Purpose Area 2.
- Submitted quarterly reports for year 5 quarter 2 for the SAMHSA GLS grant.
- Staff submitted the MSPI Yr4 Interim Progress Report and year 5 continuation application

**Administrative Duties**

- Budget tracking and maintenance: Ongoing.
- Managed Project Invoices: Ongoing.
- Staff/Intern oversight and annual evaluations: Ongoing.
- Managed Project Subcontracts: Ongoing

## WEAVE-NW Quarterly Report

*Victoria Warren Mears, PI*
*Tam Lutz, Project Director*
*Nora Frank, Project Coordinator*
*Jenine Dankovchik, Evaluation Project Specialist*
*Ryan Sealy, Tobacco Specialist*
*Chelsea Jensen, Project Assistant*

### BACKGROUND

WEAVE-NW is a program of the Northwest Tribal Epidemiology Center, funded through the CDC's Good Health and Wellness in Indian Country (GHWIC) initiative. The overall objective is to establish or strengthen and broaden the reach and impact of effective chronic disease prevention programs that improve the health of tribal members and communities.

The project has built capacity and created lasting change through training, technical assistance and collaborative support to aid Northwest tribes in creating policy, systems and environment changes that encourage healthy lifestyles.

### Meetings (excluding internal)

**Conference/committee:** 12
**Tribal Community:** 15
**Funding Agency:** 2
**Sub-Awardee:** 0
**Community (non-tribal):** 0
**Government Partner:** 1
**Other:** 20

***Total Meetings:*** *50*

### Site Visits

| Date(s) | Tribe | Short Summary |
|---|---|---|
| 05/08/19 | Great Plain | GHWIC celebrating Women's Health series |
| 06/08/19 | Cowlitz Tribe | Grand Opening of Cowlitz Garden |
| 06/28/19 | Coquille Tribe | Assisted with data collection for Traditional Tobacco Policy Survey |

*Total number of site visits this quarter: 3*

### Presentations

*WEAVE-NW gave 4 presentations this quarter*

## Publications

*WEAVE-NW completed 2 publications this quarter*

## Professional Development

*WEAVE-NW staff completed 4 professional development activities this quarter*

## Technical Assistance Given

*WEAVE-NW responded to 15 requests for technical assistance this quarter*

## Trainings

**In-Person**

- 4/9/2019 Health Data Literacy
- 6/4/2019 2019 NW Tribal Food Sovereignty Coalition Gathering
- 6/10/2019 Peer Counselor breast feeding training

**Webinar**

- 5/3/2019 Diabetes ECHO clinic (in person at Diabetes Gathering)
- 5/9/2019 Diabetes ECHO clinic
- 6/13/2019 Diabetes ECHO clinic

*Total number of trainings given this quarter: 6*

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**Western Tribal Diabetes Project**
**Western Tribal Diabetes Quarterly Board Report**
**April-June 2019**

## Trainings

- Northwest DMS class
  - 8 attendees
  - 5 call in
- Northwest SDPI Annual Gathering
  - Live Endo Echo Session – two cases
    - Panel
    - Interactive and very successful
  - Key note – Harm Reduction
  - Diabetes – NA mindful meditation (stress reduction)
  - Best practice session – 11 Best practices of programs in attendance
  - Round tables – traditional foods, physical activity, healthy cooking, tobacco cessation, breast feeding
  - 30 participants – 25 tribes (13 WA; 9 OR, 3 ID)
  - EndoECHO follow up with travel reimbursements
- Northwest Dental Meeting
  - Tobacco cessation referral process in dental clinics
  - 121 participants, 24 tribes, 28 dental programs
- Nez Perce women and wellness day

    - Presentation Cancer 101; e-cigarettes and vaping, breast feeding
    - 283 women in attendance
- Tobacco Webinar input for AI/AN quit line Oregon
    - Feedback and discussion of creative design and messaging
    - Development of resource materials for quit line
- Tobacco Charrette for AI/AN quit line Oregon
    - 18 participants form 8 tribes, 2 tribal organizations, Chemawa
    - Development of resource materials for quit line launch and cessation
- NARA Site Visit – registry clean up, taxonomies

**Technical Assistance:**

- Ongoing for updating new program staff
- Cow Creek; TA audit from entry errors; DPP reimbursement for training
- Cowlitz,(3) TA on referral labs into the system and national conference breakout; TA entering outside labs and referrals into RPMS
- Crown Point health; (2) TA Qman and report, TA for an updated Shortcut and Reference Manual; and any updates will be on our website, and sent her the UR
- Fort Defiance Indian Health; TA to search and create register
- Four Corners Regional Health Center, sent the materials for June training
- IHS National; TA on switching registries in new system
- IHS Oklahoma City Area Office, TA removing optometry from the Audit
- InterTribal Council of Arizona; TA on NW tribal and community involvement
- Klamath; DPP reimbursement
- Lummi: TA to upload Patch 12
- Madison Fulton requesting help with community involvement here in the PacNW
- Makah, TA needed assistance with iCare
- Marimn Health – TA for capturing Dental patients
- NARA, TA on missing a patient from the Audit; dpp reimbursement
- Navajo Nation; TA on HSR – sent template and example
- Nimiipuu Health, (2)TA about taxonomies, TA on EHR
- Nooksack, TA to capture outside ASA medications
- Northern Navajo Medical Center: TA on how to set up registries, and how to remove registries.
- Northern New Mexico College Health Center; TA to get the registers to show up on DMS; and how to delete registers off account,
- Quileute, request for Excel files for the Quileute clinic for the last several years
- Samish; (2)TA for problem list for hep B vaccinations; RPMS changes
- Skokomish, (2) TA patients who don't have a dental visit in the past year and Shortcut & Reference Manual
- Spokane Tribe, (2) SOS midyear report due; TA new DC for access to registry
- Squaxin Island, TA submit her mid-year SOS RKM
- Umatilla – (2) follow up for DPP training sponsorship of Oregon DPP travel; DPP reimbursement
- Urban Inter-Tribal Center of Texas: TA to find patients that were newly diagnosed, so I sent her instructions for QMAN

- Reached out to Cow Creek, Klamath, NARA, Coquille, Chemawa all interested in attending a dpp class

**Special Projects**:

- EndoECHO proposal to present at national conference
    - Checking with national team
    - Checking with Carol and local panel
    - EndoECHO participant reimbursement – previous session
- Native Fitness August 15 and 16th 2019
    - Recruitment flyers disseminated – 30 registered
    - Outside vendor application complete
    - Meeting with Nike – Kaman is coordinator
    - Got list of contacts for all things Nike
    - Disseminated to all ADC's
    - Request for National IHS program to post flyer
- DPP – reminders to Oregon participants for reimbursement:
    - Yellowhawk DPP July
    - Recruitment of Oregon Programs
    - Strategy for learning sessions
- Native Fitness August 15 and 16th 2019
    - Recruitment flyers disseminated
    - Registration in place
    - Contractors NAFC – in progress ideas for workshops
    - Hotel set up for NF 16
- Recruited two SPDI grantees in the Portland Area to lead two breakout sessions at the National Diabetes Conference in August
- Recruited Cow Creek staff to present at the June Endo ECHO, and she said she would.
- Printed all the Shortcut & Reference Manuals and packets for the June DMS training, sent an email to all the ADCs for them to forward them to their Areas, and sent out confirmation emails and added participants to the database
- DPP – reminders to Oregon participants for reimbursement:
    - Klamath, Siletz, Cow Creek, Umatilla, NARA,
    - Recruitment for June Coquille and Klamath
    - Strategy for learning sessions

**Partnerships and collaborations**

- Washington State Dental Association (ARCOA)
    - Discussion of collaboration tribal dental clinics / diabetes
- Governor's work group for Oregon tobacco tax
    - Tribes and tribal programs will receive 10% of the tax package
    - Public testimony – submitted testimony
- Oregon Prevention Coordinators Meeting
    - Disseminated agenda
    - Presentation and resource material from other projects
- Oregon Prevention Coordinators Meeting
    - Presentation NPAIHB

    - CPS discussion
- Diabetes ECHO – Cow Creek presentation
    - 15 attendees
    - Took the clinical notes and submitted for review
- WyEast Scholars – food insecurity, nutrition, and obesity
    - 2 check in meetings
    - Attendance at WyEast graduation
    - Submission of final poster board
- Native American Center for Excellence (2 check in calls)
    - Annual retreat – accomplishment and next year strategies
    - Successes, areas for growth or improvement, and creating more effective communication
- Graphic support –
    - Food Sovereignty flyer, registration and booklet
- Wrote article for Health News & Notes
- Preparing for DMS breakout session for the national diabetes conference in August
- Graphic support –
    - NPAIHB quarterly newsletter
    - Food Sovereignty Conference

**Meetings and Conferences**

- NPAIHB All-Staff Meeting (3)
- WTDP and Cancer Staff Meeting
- Project directors meeting (3)
- EndoECHO session meeting
- Meeting with Washington DOH Leadership
- NPAIHB Veteran's Committee Meeting, Apr 16
- NPAIHB QBM
    - Staff Veterans Committee
- NPAIHB Communication and Social Media Workgroup
- Diabetes Data Workgroup Meeting (2)

**Conference Calls:**

- OHA – Optum AI/AN Quit line
- Metropolitan Group – wrap up and two webinars for feedback
- SDPI grant review webinar
- Obesity Coalition Leadership Meeting – bylaws and membership
- Diabetes Coordinators Meeting - review of 2019 ADA Standards of Medical Carea

## Cancer Prevention and Control Research in AI/AN

**April-June Quarterly Report**

**Cancer Prevention and Control Research in AI/ANs**
**Tom Becker, PI**
**Victoria Warren-Mears, Director**
**Tom Weiser, Medical Epidemiologist**
**Ashley Thomas, Program Manager**
**Jacqueline Left Hand Bull**

The Tribal Researchers Cancer Control Fellowship Program has successfully completed our two-week summer training with our second cohort. The training, held June 16-28, 2019. The cancer control fellows were able to increase proficiency and build new skills in the areas of research design and grant writing, cancer prevention and control, epidemiology, cancer survivorship, and several site-specific cancers. The one-week fall training is coming together very well. We were able to get our fellows and instructors registered and their travel has all been booked. All nine fellows from cohort two and eight fellows from cohort one will attend the fall follow-up training in Calgary. Our second cohort of fellows have completed their pre-course skills evaluations and pre-tests, all submitted to our evaluator. Our first cohort of fellows have been presenting at national conferences and we have been tracking those dissemination efforts.

Tribal Opioid Response (TOR) Consortium
*Colbie Caughlan, MPH, Project Director – THRIVE, TOR, & RC*
*Megan Woodbury, Opioid Project Coordinator*

**Quarterly Report: April – June 2019**

### Site Visits

**Tribal Site Visits**

- Swinomish Tribe, Anacortes, WA – April 15-17
- Hoh Tribe, Forks, WA – June 20

**Out of Area and Other Travel**

- TOR Technical Assistance Meeting hosted by the National American Indian & Alaska Native Addiction Technology Transfer Center (ATTC), Mystic Lake, MN – April 10-12
- White Earth Harm Reduction Conference, Mahnomen, MN – April 28-30
- National Indian Health Board's 10th Annual Tribal Public Health Summit, Albuquerque, NM – May 13-15
- Oregon Conference on Opioids + Other Drugs, Pain + Addiction Treatment, Bend, OR – May 29-31

## Technical Assistance & Training

During the quarter, project staff:

- Participated in 42 meetings and conference calls with program partners.
- Hosted 1 video conference call around the TOR Consortium grant for the 22 consortium tribes, 11 TOR Consortium attendees.
- Attended 7 webinars during the reporting period: *De-escalating the Opioid Crisis: An Overview of Promising Prevention Strategies Parts 1 & 2; Compassion Fatigue Online Series: The Opioid Epidemic Parts 1, 2 & 4*; *Native Women with Substance Use Disorders are Different* and; *Survivors, Stress and Substance Abuse: Examining the Connection Between Trauma and Substance Use* by the TOR technical assistance provider, Addiction Technology Transfer Center (ATTC) and; the NASEM (National Academies of Science, Engineering, and Medicine) Public Meeting 3: *Committee on Examination of the Integration of Opioid and Infectious Disease Prevention Efforts in Select Programs*
- Trainings (2): Opioid Overdose Kit practice training at NPAIHB and another training at the Hoh Tribe, 35 attendees, Forks, WA.

During the quarter, the TOR consortium project responded to over 109 phone or email requests for opioid and substance use disorder prevention, education, medication, grant requirements, etc.

## Health Promotion and Disease Prevention

The TOR Consortium staff work closely with many other Opioid Prevention projects at the NPAIHB and together these projects continue to disseminate a monthly Substance Use Disorder e-newsletter which monthly. Staff have decided to only host monthly calls for the TOR consortium partners and not connect them to any Community of Learning webinars.

Staff provided the first Opioid Overdose Kit training to a Tribe in the Northwest and received very positive reviews. The training is currently one hour long and staff will pare it down to a 5-min training for booths and short interactions next month. Over 75 Narcan Opioid Overdose kits will disseminated for this Tribe.

## Other Administrative Responsibilities

**Staff Meetings**

- EpiCenter meetings
- All-staff meetings
- Project Director meetings
- Wellness Committee – monthly meetings and events

**Publications**

- None during this reporting period.

**Reports/Grants**

- Staff submitted the TOR year 2 continuation application to SAMHSA during this reporting period.
- Staff submitted the TOR year 1 progress report for Sept. 30, 2018 – March 31, 2019 to SAMHSA during this reporting period.

**Administrative Duties**

- Budget tracking and maintenance: Ongoing.
- Managed Project Invoices: Ongoing.
- Staff/Intern oversight and annual evaluations: Ongoing.
- Managed Project Subcontracts: Ongoing

**Enhancing Asthma Control for Children in AI/AN communities**

*Enhancing Control of Childhood Asthma in AI/AN Communities*

"Asthma Project"

**1st Quarter Activity Report**

April – June 2019

**Staff:**

Mattie Tomeo-Palmanteer – Asthma Project Coordinator
Celeste Davis- Asthma Project Director

**Technical Assistance via telephone/email**

- Ongoing communication with NPAIHB Epi Center Director.
- Celeste & Mattie – continue to provide support to site 1: Indian Health Service, Yakama Service Unit and site 2: Nimiipuu Health Clinic
- Ongoing communication (telephone, email, presentations, and the NPAIHB newsletter) to recruit additional sites to evaluate the *Enhancing Control of Childhood Asthma in AI/AN Communities* project.

**Reporting**

April

- Completed National Institutes of Health (RPPR) report due 01-June-19- now.
- SIRS Report information was gathered by Mattie to ensure Ashley was provided with needed information to submit on time.

***Updates***

Asthma Project.

- Mattie is preparing a site coordinator power point training module and has ordered supplies and incentives for Nimiipuu Health site two to begin participation early July. This includes getting letters of support from Nez Perce Tribal Council and approval from the PAIRB to join the study.
- Mattie and Victoria Warren-Mears met with Joe Cladouhos and Dr. at the April QBM to review the drafted MOA and Data Sharing Agreement.

***Challenges/Opportunities/Milestones***

- Mattie worked together with PI and Project Director to submit the SIRS Report for the National Institutes of Health annual report. This includes fine-tuning the encumbrance's budget and the justification budget.
- Celeste and Mattie worked together with the Yakama site team to plan a Community Advisory Committee meeting. In addition, Mattie provided recruitment outreach at the Yakama Nation Tribal School Dance Away Diabetes Pow-wow. Flyers at many public locations within the Yakama Reservation were posted.
- Follow up calls to the February site recruitment email that outlined site participation benefits sent to Tribal Health Directors and Clinical Directors have started with Clinics that meet the qualifications to participate.
- A protocol modification that includes a telephone and Public Service Announcement (PSA) script for participant outreach received approval by the PAIRB. Additionally, all documents to add in site two (Nimiipuu Health) were uploaded, reviewed, modified and approved by PAIRB.
- Tom and Mattie to support recruitment of additional site additions contacted the Tribal Clinical Health Directors from Yellowhawk Clinic, Warm Springs Clinic, and Chehalis Tribal Health Clinic. Yellowhawk and Chehalis responded and are reviewing the draft MOA templates, a conference call will be scheduled in the next couple of weeks after the 4th of July Holiday.
- Yakama Site one, is starting preparation for pharmaceutical training and home visiting modules to share with additional sites in the near future.
- Mattie is working on creating Trello Program team storage set up for the working documents and ongoing module toolkit training curriculum storage.
- Evaluation planning meetings are occurring to ensure objectives are met.
- Data RPMS login issues occurred and were fixed within the Indian Health Service IT Department 25-June-19.
- An excel database (to hold participant questionnaires) was developed by Nancy Bennet. Practice data storage usage is being tested for usage.

***Meetings/Trainings***

- All Staff Meetings attended by Mattie and Tom for April, May, and June-19
- Indian Day Pow-Wow planning meeting 17-May-19.
- Asthma project meeting with the evaluator and all project staff 13-June-19.
- Mattie and Tom attended NARCH guest speaker series OHSU Tobacco Cessation presentation 25-June-19.
- Mattie attended the Clean Air Spaces: Fire Smoke Episodes Webinar 13-June-2019.
- Data System Development meeting with Mattie and Nancy Bennett 25-June-19.

***Site Visits***

- Yakama Pilot Site Visit and supplies delivery to Environmental Health Officer from Mattie 26-April-19.
- Mattie provided a site visit at the Yakama Indian Health Service Unit to give an update to the Community Advisory Committee 22-April-19.
- Mattie attended the 2019 NW Tribal Food Sovereignty Coalition conference to provide support in Skokomish Washington 03-June-19.

***Upcoming Calls/Presentations/Meetings/Travel***

- Tom Becker presented at the Indian Health Services Clinical Directors Meeting to recruit additional Asthma Project Sites 1-May-19
- Yakama Community Advisory Committee Asthma Update Presentation. 23-May-19.
- Celeste and Mattie attended the NW Tribal Asthma Project conference call team meeting facilitated by the EPA. 17-May-2019.

***Other communications***

- None

***Publications***

- Article for NPAIHB's MCH focused newsletter was submitted by Celeste 22-June-19.

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Northwest Tribal Juvenile Justice Alliance

Stephanie Craig Rushing, PhD, MPH, Principal Investigator
Danica Love Brown – Behavioral Health Manager – Choctaw
Contractor-Juliette Markin, NPC

**Quarterly Report** 2019

## Program Development, Planning and Training

**Overview:** To inform the planning process, the NPAIHB and NPC Research will create and administer data collection tools to identify available data sources and Juvenile Justice best and promising practices in use regionally and nationally. Mixed-methods data collection will include:

- meeting minutes,
- stakeholder surveys,
- key informant interviews, and
- reviews of the published literature.

The decision-making process will take into consideration cultural-relevance for the NW Tribes, evidence of effectiveness, cost effectiveness, and scalability.

Our DOJ study will address critical health and safety topics in AI/AN communities, will extend the limited knowledge base surrounding best practices to improve outcomes for AI/AN teens

and young adults, and will generate guidelines and tools tailored to the unique needs and cultural assets present in the lives of AI/AN youth. Effective practices, programs, and policies will be packaged by the NPAIHB for dissemination to the NW Tribes and Juvenile Justice programs nationwide. Intervention materials will be made available free-of-charge, on the www.HealthyNativiveYouth.org website.

**Meetings – Conference Calls – Presentations – Trainings**

- NIJ Tribal Research Capacity Building Grant meeting-June 21, 2019
- Zoom-NW TJJA Alliance Kick off June 19, 2019
- Stakeholder Focus Group-THRIVE Conference June 27, 2019

**Out of Area Tribal Visits**

- N/A

**Technical Assistance Requests**

- N/A

## Project Overview

**Overview:** In response to the **Tribal-Researcher Capacity Building Grant** opportunity, issued by the U.S. Department of Justice (DOJ) and the National Institute of Justice (NIJ), the NPAIHB will form a new inter-tribal workgroup – *the **NW Tribal Juvenile Justice Alliance (NW TJJA)***. The group will meet over 18 months to collaboratively design a research study to evaluate and disseminate juvenile justice best practices for AI/AN youth in the Pacific Northwest, aligning with DOJ research priorities.

Due to a range of historical, social, environmental, and structural factors, American Indian and Alaska Native (AI/AN) youth are overrepresented in juvenile justice systems. To improve outcomes for AI/AN youth, OJJDP prevention, intervention, and recidivism programs must be responsive to their unique worldview and social context. Unfortunately, research and data to guide DOJ system improvements for Native youth are limited.

The inclusive, iterative process will ensure all research partners actively weigh in on and contribute to research decisions.

## Surveillance and Research

**Study:** The need for this inclusive, strategic planning process is significant. While AI/AN youth in the region experience disproportionate rates of juvenile justice involvement, no planning body is presently convening decision-makers to elevate these important health and safety research questions in AI/AN community. The goal is to establish Tribal-researcher partnerships to:

1. Identify, test and expand best practices that improve Juvenile Justice systems for Tribes in the Pacific Northwest,
2. Ensure that non-Native justice systems are improving life outcomes for AI/AN youth who interact with their services,

3. Build tribal capacity to access and utilize data that support quality improvement at the community-level, and
4. Create and administer data collection tools that will identify **Data Sources** that could inform our understanding of Juvenile justice disparities or concerns for our NW Tribes.

**Research Study Tasks**

- Recruitment of NWTJJA advisory group members
- NPC Final draft of study questions
- Literature review
- Resource Mapping of services in Pacific Northwest Tribal communities

## Other Administrative Responsibilities

**Publications-Peer Review Presentations**

**Reports/Grants Submitted**

**Administrative Duties**

- Budget tracking and maintenance: Ongoing
- Managed Project Invoices: Ongoing
- Managed Project Subcontracts: Ongoing
- Staff oversight and annual evaluation: Ongoing

**Overview**

The Northwest Portland Area Indian Health Board has a high level of office automation and extensive information services. The staff uses desktop computers, laptops, PDAs and office equipment that require periodic maintenance and upgrades. This is in addition to 11 servers and other electronic equipment housed in a secure and temperature-controlled server room. The Board also has a 24 station training room using Dell PCs and Microsoft Terminal Server technology. The purchase of technical equipment, configuration, and maintenance is handled by the department director and the network administrator. The Electronic Health Record – RPMS training and support is now a part of the IT Department and its activities will be part of this report.

**Strategic Priorities by Functional Area**

**Meetings Attended:**

- Management Group Meeting
- Project Directors Meeting
- All Staff Meeting
- eMARs Project conference call meeting(s)
- Weekly Area Informaticist call
- EHR Office Hours (weekly)
- EPCS for RPMS Alpha Testing calls bi-weekly
- Portland Area CAC call (monthly)
- Washington HCA-BHA Monthly Tribal Meeting
- Indian Day Planning mtg.
- Safety Committee Meeting
- IHS MACRA Work Group – weekly
- IHS National Pharmacy Council meeting (monthly)
- IHS National Council of Informatics (monthly)
- IHS HOPE Committee meeting (monthly)
- IHS Partnership Meeting – Spokane, WA
- TribalNet Health IT Board planning meeting (monthly)
- Indian Day Planning mtg.
- IHS ISAC meeting
- IHS Southwest Regional Pharmacy Conference

**Conferences and Trainings Supported/Provided:**

- ECHO Hepatitis C sessions – (minimum 3 per month)
- EHR Office Hours weekly
- Advanced TIU wit IHS
- April Quarterly Board Meeting
- RPMS /IHS 3rd Party Billing and Accounts Receivable Training

- 2019 Portland Area Dental Meeting
- IHS EHR Integrated Behavioral Health – e-learning
- RPMS / IHS Training for Diabetes
- 2019 IHS Dental Updates Continuing Dental Education Conference
- 9th Annual Thrive Conference

**Presentations**:

- American Indian Health Commission EHR Workshop – "Current Landscape of Electronic Health Records in Indian Country" – May 8 in Spokane, Washington.
- Narcan Training for staff – select group
- Hepatitis C Reminders – on national OIT EHR Office Hours

**NPAIHB Activity:**

- Implemented new screen time out policy via GPO, to lock computer screens after 20 min
- Procured new server to replace our old Primary Domain Controller
- Procured new server that will be a new print server (in progress)
- Procured new server that will be our new DHCP server (in progress)
- Troubleshooting EHR – helpdesk activities daily
- Planning deployment of Hepatitis C new reminders suite for universal screening and tracking
- HOPE Committee – Technical Assistance workgroup
    - developing guidance on documentation of PDMP checking and how to monitor that in RPMS
    - Substance abuse screening tools – development and research on how to disseminate to RPMS users
    - Measures discussion/development on substance abuse screenings
- National Pharmacy Council Communications Committee - organizing and initiating, developing pages on max.gov, development of content for IHS Pharmacy public webpage
- Precept ASHP accredited Informatics rotation for IHS Pharmacy Residents
- Work with Sarah Sullivan on survey of EHR use for NW Tribes
- Development work for hepatocellular cancer RPMS EHR Reminder
- HOPE Committee 4PS screening tool documentation development for RPMS
- HOPE Committee – documentation development for auricular acupuncture partnership with Veteran's Administration as pain treatment adjuvant
- Integrated Behavioral Health for RPMS EHR training course planning
- Troubleshooting EHR – helpdesk activities daily
- New CAC training – Nisqually
- HOPE Committee – Technical Assistance workgroup

  - developing guidance on documentation of PDMP checking and how to monitor that in RPMS
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- Development work for hepatocellular cancer RPMS EHR Reminder
- HOPE Committee 4PS screening tool documentation development for RPMS
- Retired old BACKUP EXEC server, and Implemented new backup server that uses VEEAM
- Purchased space on the Amazon Glacier cloud for a future backup repository (in progress)
- Attended WIN 10 Administration/Deployment class
- Implemented new VPN solution for full time employees
- Procured new server that will act as a WSUS server for centralized windows updates (in progress)
- Did a massive "spring cleaning" and recycled lots of old equipment
- Signed on to 5 year maintenance contract for our new Shoretel phone system
- Implementing new online password reset tool (in process)
- Troubleshooting EHR – helpdesk activities daily
- Planning deployment of Hepatitis C new reminders suite for universal screening and tracking
- HOPE Committee – Technical Assistance workgroup
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- Development work for hepatocellular cancer RPMS EHR Reminder
- HOPE Committee – documentation development for auricular acupuncture partnership with Veteran's Administration as pain treatment adjuvant
- Integrated Behavioral Health for RPMS EHR training course support and planning

# Indian Health Service
## Portland Area Director's Update

**Dean M Seyler - Area Director**
**July 16, 2019**
Thunder Valley Casino Resort
NPAIHB Quarterly Board Meeting

## Indian Health Service
## Portland Area

**Portland Area P.L. 93-638 ISDEAA Orientaion**

- July 23 – 24
- 8:00AM to 4:30PM
- Embassy Suites by Portland Airport
- Questions? Call Rena Macy (503) 414-7792 or e-mail at rena.macy@ihs.gov

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## Indian Health Service
## Portland Area

- **Area Staff Changes**
  - CAPT Thomas Weiser, MD – Acting CMO
  - CAPT Marcus Martinez, Director, Office of Environmental Health and Engineering
  - Ashley Tuomi – Director, Office of Clinical Support
  - CDR Roney Won – Acting Area Diabetes Consultant
  - Currently Advertising for:
    - Area Chief Medical Officer
    - CEOs at Wellpinit and Warm Springs Service Units
    - Clinical Directors at Ft. Hall and Warm Springs Service Units
    - Area Diabetes Consultant

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# Indian Health Service
# Portland Area

**Tribal Leader Letters**

- July 5, 2019 – Tribal Leaders invited to provide updates to Facilities Master Plan
- July 3, 2019 – New appointments and updates to the IHS senior leadership team.
- June 21, 2019 – Consultation and Confer session on the Opioid Grant Program
- June 7, 2019 – Deadline extended on CHAP comment period
- May 24, 2019 – Update on IHS Sanitation Deficiency System
- May 15, 2019 – PRC Tribal Consultation results
- May 8, 2019 – Initiate Tribal Consultation on draft CHAP Policy
- April 23, 2019 – FY19 Small Ambulatory Program
- www.ihs.gov/newsroom/triballeaderletter/



# Indian Health Service
# Portland Area

- **Portland Area IHS FY 2022 Budget Formulation Meeting**
  - Thursday, November 14, 2019
  - Embassy Suites Portland Airport
  - **Tribal Representatives for Portland**
    - Andrew Joseph, The Confederated Tribes of the Colville Reservation
    - Steve Kutz, Cowlitz Indian Tribe
  - **Technical Support Team**
    - CAPT Arnett, PAIHS, Executive Officer
    - Nichole Swanberg, PAIHS, Director, Division of Financial Management
    - Joe Finkbonner, NPAIHB, Executive Director
    - Laura Platero, NPAIHB, Policy Analyst



# Indian Health Service
# Portland Area

## FY18 Catastrophic Health Emergency Fund

- **Status as of June 25, 2019**
  - 79 total cases
  - 53 amendments
  - $3,277,045.00 in reimbursements
  - $66,291.49 pending reimbursements
  - 98% Reimbursed
  - **FY18 CHEF Balance: $ 582,067.00**

## Indian Health Service
## Portland Area

### FY19 Catastrophic Health Emergency Fund

- **Status as of June 25, 2019**
  - 21 total cases
  - 2 amendments
  - $547,964.00 in reimbursements
  - $35,765.82 pending reimbursement
  - 93% reimbursed to date



## Indian Health Service
## Portland Area

### CHEF Online Tool

- Fully automated paperless process for identifying, documenting and submitting CHEF cases for reimbursement.
- Implemented for Federal PRC Programs on May 1, 2019
- Tribal programs have the option to opt-in/opt-out
- Area Office is currently onboarding interested Tribal sites. If your site is interested, please contact:
  - Peggy Ollgaard, Director, Division of Business Operations
  - (503) 414-5598
  - Peggy.Ollgaard@ihs.gov



## Indian Health Service
## Portland Area

**Office of Environmental Health & Engineering (OEH&E)**
**Staffing Highlights:**

- CAPT Marcus Martinez, P.E., OEH&E Director Effective August 1.
- Jeffrey Esteban is an Environmental Engineer for the Olympic District Office, Effective June 23.
- Samantha Handrock Transferred to Yakama Field Office June 9. She is the New Environmental Engineer.
- Scotty Riddle is the New Project Accountant for OEHE, Effective April 14.

# Indian Health Service
# Portland Area

**Transitions in Division of Sanitation Facilities Construction (SFC):**

CAPT Mathew J. Martinson, SFC Director transferred to EPA

- Served as the Director, Division of Sanitation Facilities Construction for Over 6½ Years.
- As of July 1, Branch Chief at EPA Region 10 in Seattle, Overseeing Drinking Water, Infrastructure and Clean Water Act Permitting.

CDR Craig Haugland, P.E., will Serve as Acting Director Until the Position is Filled on a Permanent Basis.

- Project Engineer from the Port Angeles Field Office.
- 30-years Engineering and Project Management Experience



# Indian Health Service
# Portland Area

**Office of Environmental Health & Engineering (OEH&E)**
**Staffing Highlights (continued):**

- ***Acting Division Director for Sanitation Facilities Construction***
  - *CDR Craig Haugland, P.E., Acting Director, craig.haugland@ihs.gov*
- ***Spokane District and Fort Hall Field Office (Eastern Washington, Idaho)***
  - *CDR Steve Sauer, P.E., BCEE, District Engineer, steve.sauer@ihs.gov*
- ***Olympic District (Washington, West of the Cascade Mountains)***
  - *CDR Roger Hargrove, P.E., District Engineer, roger.hargrove@ihs.gov*
- ***Oregon District (Oregon Tribes + Yakama Field Office)***
  - *LT Derek Hancey, P.E., Supervisory Environmental Engineer, derek.hancey@ihs.gov*
- ***District Utility Consultant (Area-wide coverage)***
  - *CDR Ben Chadwick, P.E., District Engineer (Utility Consulting) - Arrives July 22nd*



# Indian Health Service
# Portland Area

- **FY 19 Facilities Appropriation Update**
  - Backlog of Essential Maintenance, Alteration, and Repair (BEMAR)
    - $1.7M is Reserved for Tribal Facilities
    - Only Previously Reported Facility Deficiencies Are Eligible
    - DHFE Sent Request for Additional Info to THD's on Tribal Priorities, Due June 28th
    - PAFAC Assist with Prioritization; Final Fund Allocation by End of the FY
  - Small Ambulatory Program (SAP)
    - Applications Were Due June 28th
    - $2.0M Max Award
    - Timeline for Award Determination not Yet Established, Applicants will be Notified
  - Joint Venture Construction Program
    - New Announcement Under Consideration in Near Future, Nothing Official
    - If Interested, Focus on Getting Projects "Shovel Ready" (Site, Funding, Preliminary Design)

## Indian Health Service
## Portland Area

CMO Updates:

- Recent Special General Memos
  - SGM 19-01 Assuring Access to Medication Assisted Treatment for Opioid Use Disorder
  - SGM 19-02 Hepatitis C Universal Screening and Treatment
- Other
  - Circular 19-03 Wait Times for Primary Care Visits in IHS Direct Care Facilities

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## Indian Health Service
## Portland Area

Medical Epidemiologist Updates

- Immunizations
  - State-led Tribal Immunization Summits
  - Updates to RPMS
- Measles
  - Highest number of cases in 1 year since measles declared eliminated in the US in 2000
  - Recent outbreaks in WA, OR and 1st cases in ID in 20 yrs
  - No Tribal communities or facilities involved so far

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INDIAN HEALTH SERVICE · PHS · 1955 ·

Our Mission… to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

Our Goal… to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

Our Foundation… to uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

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# *NPAIHB Legislative & Policy Update*

**NPAIHB Quarterly Board Meeting**
**Hosted by: California Rural Indian Health Board**
**Lincoln, CA**
**July 16, 2019**

## Report Overview

1. Hot Topics
2. Legislation
3. Future IHS Appropriations & Budget Formulation
4. New & Pending Federal Policies
5. Litigation
6. Upcoming National/Regional Meetings

## Hot Topics

- *Texas v. United States* - Threat to the ACA/IHCIA
- House Appropriations for IHS and HHS
- SDPI Reauthorization and Funding
- Lower Health Care Costs/Surprise Billing
- CMS Work Requirements

## Legislation

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## FY 2020 Labor HHS Education Appropriations

- On 6/19/19, House passed four-bill FY 2020 appropriations package (226 to 203)
  - HHS: $99.4 billion (+$8.9 billion above FY 2019 enacted level)
    - NIH: $41.1 billion (+2 billion)
    - CDC: $8.3 billion (+$938 million)
    - SAMHSA: $5.9 billion (+129 million)
    - HRSA: $7.6 billion (+$485 million)
    - CMS: $4 billion (+$315 million)
    - ACF: $27.9 billion (+$4.7 billion)
    - ACL: $2.3 billion (+$180 million)
    - Office of the Secretary: $550 million (+$5 million)
- Senate Bill Status: Not released; testimony submitted

## FY 2020 House Labor HHS Education Appropriations- Indian programs

- CDC:
  - Good Health and Wellness in Indian Country- $21m (level)
- SAMHSA:
  - Tribal Opioid Response Grants-$50m (level)
  - Medication Assisted Treatment Grants for Tribes-$10m (level)
  - AI/AN Zero Suicide Program-$2.2m
  - AI/AN Suicide Prevention-$2.9m
- ACL:
  - Native American Nutrition and Supportive Services-$37.2m (+$3m)
  - Native American Caregiver Support Services-$12m (+$2m)
- HRSA
  - NHSC Loan Repayment Program to individuals who work for I/T/Us-$15m

## FY 2020 Interior IHS Appropriations Summary

- National Tribal Budget Formulation Workgroup recommended over $7 billion for IHS for FY 2020 (36% increase over FY 2017 enacted level).
- President Released Budget on 3/11/19
  - $82.6m increase above FY 2019 for services and facilities (1.7%) or $115 m (2%) increase overall above 2019 enacted level
- House Bill Status:
  - On 6/25/19, House passed Interior appropriations bill (with 4 others).
    - $6.3 billion or $537m above FY 2019 enacted level
- Senate Bill Status: Not released; testimony submitted

## FY 2020 Interior IHS Appropriations- President & House

| | FY 2019 Enacted | Pres Req. FY 2020 | House Bill FY 2020 | Enacted vs. House Bill |
|---|---|---|---|---|
| Clinical Svcs | $3,739,961 | $3,996,963 | $4,120,282 | +$380,321 |
| Prev Health | 174,742 | 118,257 | 181,062 | +$6,320 |
| Other Svcs | 188,487 | 171,321 | 255,526 | +67,039 |
| **Total Services** | **4,103,190** | **4,286,541** | **4,556,870** | **+453,680** |
| Facilities | 878,806 | 803,026 | 964,121 | +85,315 |
| **Total w/o CSC** | **$4,981,996** | **$5,089,567** | **$5,520,991** | **+$538,995** |
| CSC | 822,227 | 820,000 | 820,000 | -2,227 |
| **Total w/CSC** | **$5,804,223** | **$5,909,567** | **$6,340,991** | **+$536,768** |

Advance Appropriations: Committee directs IHS to examine its existing processes and determine what changes are needed to develop and manage an advance appropriation and report to the Committee within 180 days of enactment of this Act on the processes needed and whether Congressional authority is required in order to develop the processes.

## FY 2020 IHS Clinical Services- President & House

| | FY 2019 Enacted | Pres Req. FY 2020 | House Bill FY 2020 | Enacted vs. House Bill |
|---|---|---|---|---|
| H&HC* | $2,147,343 | $2,363,278 | $2,420,568 | +273,235 |
| EHR | 0 | 25,000 | 25,000 | +25,000 |
| Dental | 204,672 | 212,369 | 227,562 | +22,890 |
| MH | 105,281 | 109,825 | 125,332 | +20,051 |
| Alcohol/SA | 245,566 | 246,034 | 280,151 | +34,485 |
| PRC | 964,819 | 968,177 | 969,479 | +4,660 |
| IHCIF | 72,280 | 72,280 | 72,280 | |
| **Totals:** | **$3,739,961** | **$3,996,963** | **$4,120,282** | **+$380,321** |

*H&HC Highlights: includes $20m for CHAP expansion; $4m increase for DV prevention; $2m increase for TECs; $17m increase for 105(l) leases; $25m for HIV/HCV treatment and prevention

## FY 2020 IHS Preventative Health- President & House

| | FY 2019 Enacted | Pres Req. FY 2020 | House Bill FY 2020 | Enacted vs. House |
|---|---|---|---|---|
| PH Nursing | $89,159 | $92,084 | $95,307 | +$6,148 |
| Health Educ* | 20,568 | 0 | 20,669 | +101 |
| CHRs* | 62,888 | 24,000 | 62,913 | +$25 |
| Immun AK | 2,127 | 2,173 | 2,173 | +46 |
| **Totals:** | **$174,742** | **$118,257** | **$181,062** | **+$6,320** |

*Health Education & CHRs: House bill includes increases for both line items.

## FY 2020 IHS Other Services- President & House

| | FY 2019 Enacted | Pres Req. FY 2020 | House Bill FY 2020 | Enacted vs. House Bill |
|---|---|---|---|---|
| Urban Health | $51,315 | $48,771 | $81,000 | +$29,685 |
| IHP* | 57,363 | 43,612 | 90,656 | +33,293 |
| Tribal Mngt | 2,465 | 0 | 2,521 | +56 |
| Direct Ops | 71,538 | 74,131 | 75,385 | +3,847 |
| Self Gov | 5,806 | 4,807 | 5,964 | +158 |
| **Totals:** | **$188,487** | **$171,321** | **$255,526** | **+67,039** |

*IHP Highlight: Bill language provides $50m for the loan repayment program

## FY 2020 IHS Facilities- President & House

| | FY 2019 Enacted | Pres Req. FY 2020 | House Bill FY 2020 | Enacted vs. House Bill |
|---|---|---|---|---|
| M&I | $167,527 | $168,568 | $174,336 | +$6,809 |
| Sanitation | 192,033 | 193,252 | 193,577 | +1,544 |
| HC Fac Const* | 243,480 | 165,810 | 304,290 | +60,810 |
| Fac & Envir. | 252,060 | 251,413 | 266,831 | +14,771 |
| Equipment | 23,706 | 23,983 | 25,087 | +1,381 |
| **Totals:** | $878,806 | $803,026 | $964,121 | +85,315 |

*Health Care Facilities Construction: Includes $10m for Green Infrastructure.
Joint Venture Construction Program: Committee urges the Service to consult with tribes to determine and open competitions on a regular cycle of between three to five years.

## Other Directives in House Bill

- 105(l) Leases:
  - Report required within 90 days on treatment of 105(l) leases like CSC and estimated costs in current and next fiscal year.
- Electronic Health Records (EHR):
  - Must provide notice at least 90 days before funds are obligated or expended by IHS; and directive to look at VA system.
- VA MOU:
  - Urges IHS to look at performance measures related to MOUs.
- Electronic Dental Records (EDR):
  - Directs IHS to include EDR in its assessment.

## Advanced Appropriations Bills for BIA/BIE/IHS and IHS only

- **S. 229 & H.R. 1122 – Advanced Appropriations for BIA and BIE at DOI and IHS at HHS.**
  - Senate Bill introduced by Sen. Tom Udall (D-NM) on 1/25/19.
  - House Bill introduced by Rep. Betty McCollum (D-MN-4) on 2/8/19.
  - **Status**: Both referred to respective House and Senate Committees.
- **H.R. 1135 –Advanced Appropriations for IHS.**
  - House Bill introduced by Rep. Don Young (R-AK- At Large) on 2/8/19; referred to Committees.
  - Senate Bill anticipated to be introduced.
  - **Status**: In House Committees.

## Special Diabetes Program for Indians Reauthorization

SDPI expires September, 2019. Several bills to reauthorize:

- **H.R. 2328- Community Health Investment, Modernization, and Excellence Act of 2019** (Rep. Tom O'Halleran (D-AZ)-4 years at $150m)
  - **Status**: 7/11/19- House E&C Health Markup
- **H.R. 2668 – Special Diabetes Program Reauthorization Act of 2019** (Rep. Diana DeGette (D-CO)-5 years at $200m)
  - **Status**: 6/4/19- House E&C Health Subcommittee Hearing
- **H.R. 2680 – Special Diabetes Programs for Indians Reauthorization Act of 2019** (Rep. Tom O'Halleran (D-AZ)- 5 years at $200m)
  - **Status**: 6/4/19-House E&C Health Subcommittee Hearing
- **H.R. 2700 – Lowering Prescription Drug Costs and Extending Community Health Centers and Other Health Priorities Act** (Rep. Michael Burgess (R-TX)- 1 year extension at $150m)
  - **Status**: 6/26/19- In Committees
- **S. 192 - Community and Public Health Programs Extensions Act)** (Sen. Lamar Alexander (R-TN) – 5 years at $150m)
  - **Status**: 1/18/19- In HELP Committee
- **S. 1895- Lowering Health Care Costs Act** (Sen. Lamar Alexander (R-TN) – 5 years at $150m)
  - **Status**: 7/8/19- Placed on Senate Leg Calendar

## Indian Health Professions Bills

- **H.R. 3340- Tribal Healthcare Careers Act**
  - Introduced by Jimmy Gomez (D-CA) on 6/19/19
  - Provides a set-aside of funds for Indian populations under the health profession opportunity grant program under Section 2008 of the Social Security Act.
  - **Status**: Referred to Ways & Means
- **H.R. 3343- Technical Assistance for Health Grants Act**
  - Introduced by Daniel Kildee (D-MI) on 6/19/19
  - Provides for technical assistance under health profession opportunity grant program under section 2008 of Social Security Act.
  - **Status**: Referred to Ways & Means

## Other Indian Specific Health & DOI Bills

- **Pay Our Doctors Act (H.R. 195)**
  - **Status**: In Committee
- **Native American Suicide Prevention Act of 2019 (S. 467 & H.R. 1191)**
  - **Status:** In House and Senate Committees
- **Assessment of the Indian Health Service Act (S. 498)**
  - **Status:** In Committee
- **Urban Indian Health Parity Act (S. 1180/H.R. 2316)**
  - **Status:** In House and Senate Committees
- **PROGRESS for Indian Tribes Act (S. 209 & H.R. 2031)**
  - **Status**: Passed Senate on 6/17/19; In House Committee

## Opioid Bills

- **Comprehensive Addiction Resources Emergency Act of 2019 (CARE) (S. 1365 & H.R. 2569)**
  - Provides emergency assistance to states, territories**, tribal nations**, and local areas affected by the opioid epidemic, and financial assistance, for the development, organization, coordination and operation of more effective and efficient systems for the delivery of essential services to individuals with substance use disorder and their families.
  - **S. 1365**- Introduced by Sen. Elizabeth Warren (D-MA) on 5/8/19.
    - **Status**: In HELP Committee
  - **H.R. 2569**- Introduced by Rep. Elijah Cummings (D-MD) on 5/8/19.
    - **Status**: 5/13/19-Referred to Indigenous Peoples of the United Status Subcommittee (Natural Resources)
- **Examining Opioid Treatment Infrastructure Act of 2019 (H.R. 1303)**
  - **Status**: In Committee

## Other Health Bills

- **Lower Health Care Costs Act (S. 1895)**-Sen. Alexander Lamar (R-TN)
  - Purpose is to lower health care costs, extend community health centers and SDPI
    - **Status:** 7/8/19: Placed on Senate Legislative Calendar
- **Aligning 42 CFR Part 2 with HIPAA**
  - **Protecting Jessica Grub's Legacy Act (S. 1012)**-Sen. Joe Manchin (D-WV)
    - **Status**: 4/3/19-In HELP Committee
  - **Overdose Prevention and Patient Safety Act (H.R. 2062)**-Rep. Earl Blumenauer (D-OR)
    - **Status**: 4/3/19-In E&C Committee
- **PrEP Assistance Program Act (H.R. 1643) & PrEP Coverage Access and Coverage Act (S. 1926)**
  - **Status:** In House and Senate Committees

## Veterans' Bills

- **Tribal HUD-VASH Act of 2019 (S. 257)**
  - **Status**: 6/27/19-Passed Senate; Referred to House Committee on Financial Services
- **Veterans Improved Access and Care Act of 2019 (S. 450)**
  - **Status**: 5/22/19-Senate VA Hearings
- **Department of Veterans Affairs Tribal Advisory Committee Act of 2019 (S. 524 & H.R. 2791)**
  - **Status**: 5/22/19-Senate VA Hearings; 5/16/19-Referred to House Committee on VA Affairs
- **Commander John Scott Veterans Mental Health Improvement Act of 2019 (S. 785)**
  - **Status**: 5/22/19-Senate VA Hearings
- **Tribal Veterans Health Care Enhancement Act (S. 1001)**
  - **Status**: 5/22/19-Senate VA Hearings

## DV & Missing AI/AN Bills

- **Violence Against Women's Act of 2019 (H.R. 1585)**
  - **Status:** 4/4/19-Passed House; 4/10/19-Placed on Senate Legislative Calendar
- **Not Invisible Act (S. 982 & H.R. 2438)**
  - **Status:** 6/19/19- SCIA; 5/10/19-Referred to Indigenous People's of the U.S. Subcommittee
- **Studying the Missing and Murdered Indian Crisis Act of 2019 (S. 336)**
  - **Status:** 2/5/19- SCIA

# Future IHS Appropriations & Budget Formulation

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## FY 2021 IHS Budget Formulation

- National Tribal Budget Formulation Workgroup met on March 14-15, 2019 in Washington D.C. and recommended full funding for IHS at $37.61 billion to be phased in over 12 years.
- For FY 2021, a total of $9.1 billion for IHS is requested. Includes:
  - $257 m for full funding of current services
  - $413 m for binding fiscal obligations
  - $2.7 b for program increases (46% above FY 2019 enacted level)
  - And more!

## FY 2021 IHS Budget Formulation Cont'd

- Other recommendations for IHS:
  - Support preservation of Medicaid, IHCIA and Indian-specific provisions of the ACA.
  - Fund critical infrastructure investments (Health IT/HCFC)
  - Exempt Tribes from Sequestration
  - Support Advance Appropriations
  - Allow federally-operated health facilities and IHS headquarters to use federal dollars efficiently and adjust programmatic funds flexibly across accounts at the local level
  - Support funding of tribes outside of grants based system.
  - Permanently authorize SDPI and increase funding to $200 m per year plus annual inflationary increases.
  - Take a adequate steps to fully address 105(l) leasing obligations and work proactively with Congress to ensure its full payment as an indefinite appropriation.
- Available at: https://www.nihb.org/legislative/budget_formulation.php

## FY 2022 IHS Budget Formulation

- National Tribal Budget Formulation Workgroup (NTBFW) met on June 27-28 in Reno, Nevada.
- Workgroup decided to request full funding now (not 12 year phased in funding).
  - An analysis will be conducted to determine what that amount is.
- Recommendation for FY 2022 will be based on NTBFW request for FY 2021, plus 30%.
- Portland Area Budget Formulation Meeting for FY 2022 is November 14, 2019 in Portland, Oregon- location TBD.

## New & Pending Federal Policies

HHS STAC Meeting, Phoenix, AZ, May, 2019

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## Executive Orders

- **Improving Price and Quality Transparency in American Health Care to Put Patients First**-Issued 6/24/19
  - Within 60 days, HHS Secretary must issue a proposal to require hospitals to post standard charge information
  - Within 90 days, Secretaries of HHS, Treasury and Labor to issue a proposal to require providers, issuers and plans to facilitate access to information that tells patients about expected out-of-pocket costs before they receive care
- **Evaluating and Improving the Utility of Federal Advisory Committees**
  - Directs agencies to terminate at least 1/3 of its current committees established under 9(a)(2) of FACA, including other committees.
  - Agencies must send OMB a list of all their advisory committees and recommendations on which ones to eliminate by August 1.
  - OMB has one month to take recommendations to President
  - **We understand that no tribal advisory committees will be impacted at IHS or HHS (per IHS leadership)**

## Pending Responses from HHS

- **HHS Office of National Coordinator (ONC) 21st Century Cures Act and CMS Interoperability, Information Blocking and the ONC Health IT Certification Program**; issued 3/4/19; comments due 6/3/19; comments submitted
- **HHS Office of HIV/AIDS and Infectious Disease Policy STD Federal Action Plan;** issued 5/3/19; comments due 6/3/19; expected June, 2020
- **HHS RFI on National HIV/AIDS Strategy and National Viral Hepatitis Action Plan**; issued 2/8/19; comments submitted; expected June, 2020
- **HHS Pain Management Best Practices Inter-Agency Task Force Draft Report on Pain Management Best Practices**; issued 12/31/18
- **HHS Tribal Consultation Policy**; DTLL 10/22/18; comments submitted
- **HHS Draft Strategy to Reduce Regulatory and Administrative Burden of Health IT and EHRs**; comments submitted
- **Disbanding of the OMH AI/AN Health Resource Advisory Committee (HRAC)**

## CMS Nondiscrimination in Health and Health Education Programs or Activities

- Issued: 6/14/19; comments due 8/13/19
- In May 2016, OCR HHS published a final rule (2016 Rule) that sought to codify nondiscrimination requirements and set forth new standards for implementing Section 1557 of the Affordable Care Act (ACA), particularly with respect to the prohibition of discrimination on the basis of sex.
- HHS interpreted that Congress did not intend for Section 1557 of the ACA to prohibit discrimination based on gender identity and termination of pregnancy.
- Senate Health Committee ranking Democrat Patty Murray (WA) and 30 Democratic Senate colleagues are demanding HHS withdraw its recent proposed rule that scales back the protections under Section 1557.
- The Senators want HHS to explain its reasoning for removing protections for transgender individuals, women who have terminated pregnancy and people with limited English proficiency by July 18th.

## Pending Responses and/or Ongoing Issues with CMS

- **CMS Medicaid and CHIP Managed Care Proposed Rule** - comments submitted 1/28/19.
- **CMS Work Requirements**
- **CMS Four Walls Limitation- FAQs**
- **CMS Decision on Appeal of Washington DHAT SPA**

## National Institutes of Health

- Tribal consultation on three initiatives:
  - Tribal Consultation on NIH Intellectual Property Rights in Biomedical Research; comments due 8/22/19.
  - Request for Comments on NIH Draft Policy on Data Sharing Management; DTLL 4/17/19; comments due 8/22/19.
  - Tribal Consultation and Listening Session on the All of Us Research Program; comments/testimony due 8/31/19.
    - Feedback received through the tribal consultation and other public engagement efforts will result in a plan for working with Tribal Nations.
    - More info available at: https://allofus.nih.gov/about/all-us-tribal-engagement

## Recent IHS DTLLs

- **Invitation to Provide Updated Facility Master Plans and/or Identified Health Care Facility Needs to Local IHS Area Facilities Program Director for Possible Inclusion in the 2021 IHS and Tribal Health Care Facilities Needs Assessment Report to Congress**; DTLL 7/5/19; data due on 12/31/19
- **Update on New Appointments and Updates to the Indian Health Service Senior Leadership Team**; DTLL 7/3/19

## Recent IHS DTLLs Cont'd

- **Initiation of Tribal Consultation and Urban Confer on Developing IHS Opioid Grant Program to Distribute the FY 2019 Opioid Funding**; DTLL 7/5/19; comments due 8/1/19
  - Related to $10m for Special Behavioral Health Program for Indians FY 2019 appropriation
- **Update on Sanitation Deficiency System-A Guide for Reporting Sanitation Deficiencies for AI/AN Homes and Communities;** DTLL 5/24/19.
  - IHS Facilities Appropriations Advisory Board reviewed comments and provided recommendations
- **Results of Tribal Consultation on the Indian Health Manual Part 2, Chapter 3-PRC**; DTLL on 5/15/19.
  - PRC Workgroup was advised of changes

## Pending IHS Responses

- **Tribal Consultation on Community Health Aide Program Interim Policy**; DTLL on 5/8/19; comments due 7/8/19; comments submitted.
  - IHS Community Health Aide Program (CHAP) Workgroup to review comments
- **Tribal Consultation on Long and Short Term Options for Meeting ISDEAA 105(l) Requirements**; DTLL on 3/12/19; comments submitted.
  - IHS technical workgroup trying to determine costs
- **Update on the Mechanism to Distribute Behavioral Health Initiative Funding**; DTLL on 12/11/18; comments submitted.
  - IHS National Tribal Advisory Committee (IHS NTAC) provided a recommendation to RADM Weahkee.
- **Contract Support Costs – Indian Health Manual, Chapter 3 CSC**, rescission of 97/3 split language; DTLL 4/13/18; comments submitted.
  - CSC Workgroup Tribal Chairman, Andy Joseph, Jr., requested an update; IHS close to finalizing a decision & meeting in Aug/Sept

## HRSA UPDATES

- HRSA Shortage Designation Modernization Project (SDMP) will update existing Auto-HPSA designation scores in August 2019 through an online portal.
- New Auto-HPSA scores will be applicable to the 2020 National Health Service Corp application cycle.
  - Clinics will be able to update their HPSA score in the online portal after the national rollout.
  - Clinics should collect and submit facility-specific data and supplemental data to increase scores in replacement of the ACS data.
  - HRSA and IHS are working to identify data sources to assist in increasing scores for I/T/Us prior to national rollout.
- June 25 Webinar: Auto-HPSA Portal Training for I/T/Us.
  - Webinar recordings available at: https://bhw.hrsa.gov/sdmp
- Apply for the NHSC Rural Community Loan Repayment Program Grant Application through July 18

## VA Updates

- VA DTLL: Requests comments on implementation of VA MISSION Act; DTLL on 4/16/19; Comments submitted 6/10/19.
- VA and White House launched a Veteran Suicide Prevention Task Force to create a roadmap to empower veterans and end the national tragedy of suicide (PREVENTS Executive Order)
  - Inclusion of a community integration and collaboration proposal, a national research strategy and an implementation strategy.
- VA extends Agent Orange presumption to Blue Water Navy Veterans who served offshore of the Republic of Vietnam between 1962 and 1975 to be eligible for disability compensation benefits.

# Litigation

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## *Texas v. United States*
### Challenge to Affordable Care Act

- On December 14, 2018, Judge Reed O'Conner (USDC ND Texas) held:
  - That the individual mandate enacted as part of the ACA is unconstitutional because it cannot be justified under Congress' taxing power (Congress reduced tax penalty to $0).
  - The entire ACA must be invalidated because the individual mandate is not severable and essential to the ACA's operation.
- If ACA struck down, ICHIA would also be struck down.
- Appealed to USCA for the the Fifth Circuit.
- 483 tribes and tribal organizations(including NPAIHB) joined an amicus brief.
- On March 25, 2019, a coalition of states intervened in the case in order to defend the ACA while Department of Justice filed a two-sentence letter with the court announcing that the U.S. had changed its position in the litigation.
- On July 9, 2019, a three-panel judge in the Fifth Circuit heard oral arguments.
- Ruling expected in the coming months.

## *Brackeen v. Bernhardt*
### Challenge to ICWA

- On 10/5/18, Judge Reed O'Conner (USDC ND Texas) ruled that ICWA is unconstitutional in Brackeen v. Zinke.
- Found that *Morton v. Mancari* rule does not apply because ICWA extends to Indians who are not members of tribes.
- ICWA struck down in violation of equal protection.
- Appealed to USCA for the Fifth Circuit and now titled, *Brackeen v. Bernhardt*.
- Many tribes and tribal organizations (including NPAIHB) joined the amicus brief.
- On March 13, 2019, oral argument occurred before a panel of 3 judges.
- Decision pending in Fifth Circuit.

## Opioid Litigation

- All federal court lawsuits have been combined in multi-district litigation under Federal District Judge Dan A. Polster (USDC-ND Ohio)
- Over 100 tribes and tribal organizations joined 1,000 state and local governmental plaintiffs in the litigation.
- Tribal Amicus Brief: 448 tribes and tribal organizations signed on and provided statements of interest (NPAIHB, ATNI, NCAI, and NIHB).
- **Status**:
  - Two Tribal Cases selected as bellweather cases ---Muscokee (Creek) Nation and Blackfeet Tribe.
  - On June 13, 2019, Judge Polsner issued a Motion Opinion and Order ruling on the Motions to Dismiss.
  - The Order adopts most of the recommendations by Magistrate David Ruiz recommending to the court that the Motions to Dismiss be denied with respect to the vast majority of tribes' claims.
  - In the multidistrict litigation, plaintiffs continue to pursue a settlement.

## Upcoming National/Regional Meetings

HHS Annual Tribal Budget Consultation, Washington, DC

## July-September 2019

- TSGAC Quarterly Meeting, July 16-19, Washington, D.C
- MMPC/TTAG Meeting, July 23-25, Washington, D.C.
- 16th Annual DSTAC Meeting, July 30-31, Albuquerque, NM
- Region X Opioid Summit, August 6-9, Vancouver, WA
- 2019 Diabetes in Indian Country Conference, August 6-9, Oklahoma City, OK
- Center for State, Tribal, Local and Territorial Support (CSTLTS), CDC/ATSDR Tribal Advisory Committee (TAC) Meeting and 19th Biannual Tribal Consultation; August 13-14, Cherokee, NC (Testimony Due: 7/19/19)
- NCAI Impact Days, September 10-11, Washington, D.C.
- TSGAC Strategy Session, September 10-11, Washington, D.C.
- HHS STAC Meeting, September 12-13, Washington, D.C.

## September-October 2019

- NIHB National Tribal Health Conference, September 16-19, Temecula, CA
- IHS TSGAC Quarterly Meeting, October 2-3, Washington, D.C.
- ATNI Fall Convention, October 7-10, Suquamish
- PRC Workgroup Meeting, October 15-17, Washington, D.C.
- NCAI Annual Convention, October 20-25, Albuquerque, NM
- Quarterly Board Meeting, October, 21-24, Pendleton, OR

## Discussion and Questions

HHS Secretary's Tribal Advisory Committee Meeting, Fairbanks, AK

**Northwest Portland Area Indian Health Board**
**Indian Health Legislation: 116th Congress**
**Dated: June 11th, 2019**

| Bill No. | Title | Description | Sponsor | Committee(s) | Status |
|---|---|---|---|---|---|
| H.R. 195<br>Introduced:<br>1/3/19 | Pay our Doctors Act of 2019 | Provides full-year appropriations for the Indian Health Service in the event of a partial lapse in appropriations, and for other purposes. | Mullin (R-OK)<br>*Simpson (R-ID), Bonamici (D-OR), Kilmer (D-WA)* | Appropriations | In Committee |
| S. 192<br>Introduced:<br>1/18/19 | Community and Public Health Programs Extensions Act | Provides for funding extensions through 2024 for: Special Diabetes Program, Community Health Centers, National Health Service Corps, and Teaching Health Centers that operate GME programs. | Alexander (R-TN)<br>*Murray (D-WA)* | HELP | In Committee |
| S. 209<br>Introduced:<br>1/24/19<br><br>H.R. 2031<br>Introduced:<br>4/2/19 | PROGRESS for Indian Tribes Act | Amends the Indian Self-Determination and Education Assistance Act (ISDEAA) to establish and further self-governance by Indian Tribes under DOI. | Hoeven (R-ND)<br>*Cantwell (D-WA)*<br><br>Haaland (D-NM)<br>*Heck (D-WA), Kilmer (D-WA)* | Indian Affairs<br><br>Natural Resources | 6/27/19- Passed Senate<br>4/29/19- Reported without amendment through Indian Affairs; placed on Senate Legislative Calendar<br><br>4/30/19- Natural Resources referred to Indigenous Peoples of the United States Subcommittee |
| S. 257<br>Introduced:<br>1/29/19 | Tribal HUD-VASH Act of 2019 | Provides rental assistance for homeless or at-risk Indian veterans, and for other purposes. | Tester (D-MT)<br>*Cantwell (D-WA)* | Indian Affairs | 6/27/19- Passed Senate<br>3/28/19- Placed on Senate Legislative Calendar under General Orders; Indian Affairs- Reported by Sen. Hoeven without amendment |

| Bill No. | Title | Description | Sponsor | Committee(s) | Status |
|---|---|---|---|---|---|
| S. 336<br>Introduced:<br>2/5/19<br><br>H.R. 2029<br>Introduced:<br>4/2/19 | Studying the Missing and Murdered Indian Crisis Act of 2019 | Directs the Comptroller General of the United States to submit a report on the response of law enforcement agencies to report on missing or murdered Indians. | Tester (D-MT)<br><br>Gallego (D-AZ)<br>*Bonamici (D-OR)* | Indian Affairs<br><br>Judiciary, Natural Resources, | In Committee<br><br>4/23/19- Natural Resources refers to Indigenous Peoples of the United States Subcommittee<br>5/15/19- Judiciary refers to Crime, Terrorism, and Homeland Security Subcommittee |
| H.R. 1046<br>Introduced:<br>2/7/19<br><br>S. 337<br>Introduced:<br>2/7/19 | Medicare Negotiation and Competitive Licensing Act of 2019 | Amends the Social Security Act to require the Secretary of HHS to negotiate prices of prescription drugs furnished under part D of the Medicare program. | Doggett (D-TX)<br>*DeFazio(D-OR),*<br>*Bonamici (D-OR),*<br>*Blumenauer (D-OR),*<br>*Jayapal (D-WA),*<br><br>Brown (D-OH) | Energy and Commerce, Ways and Means<br><br>Finance | In Committee |
| H.R. 1135<br>Introduced:<br>2/8/19 | Indian Health Service Advance Appropriations Act of 2019 | Amends ICHIA to authorize advance appropriations for HIS by providing 2-fiscal years budget authority | Young (R-AK)<br>*Kilmer (D-WA)*<br>*Heck (D-WA)* | Budget, Energy and Commerce and Natural Resources | 3/13/19- Natural Resources referred to Indigenous Peoples of the United States Subcommittee |
| S. 229<br>Introduced:<br>1/25/19<br><br>H.R. 1128<br>Introduced:<br>2/8/19 | Indian Programs Advance Appropriations Act | Provides advance appropriations authority for certain accounts of the BIA and BIE of the DOI and the IHS of HHS. | Udall (D-NM)<br>*Merkley (D-OR),*<br>*Wyden (D-OR)*<br><br>McCollum (D-MN) | Budget<br><br>Budget, Energy and Commerce and Natural Resources | In Committee |

| Bill No. | Title | Description | Sponsor | Committee(s) | Status |
|---|---|---|---|---|---|
| | | | *Kilmer (D-WA), Herrera Beutler (R-WA), Simpson (R-ID), Heck (D-WA)* | | 2/28/19- Natural Resources referred to Indigenous Peoples of the United States Subcommittee |
| S. 450<br>Introduced: 2/12/19 | Veterans Improved Access and Care Act of 2019 | To require the Secretary of Veterans Affairs to carry out a pilot program to expedite the onboarding process for new medical providers of the Department of Veterans Affairs and to reduce the duration of the hiring process for such medical provider. | Gardner (R-CO) | Veterans' Affairs | 5/22/19 -Committee on Veterans' Affairs Hearing held. |
| S. 467<br>Introduced: 2/13/19<br><br>H.R. 1191<br>Introduced: 2/13/19 | Native American Suicide Prevention Act of 2019 | Amends section 520E of the Public Health Service Act to require States and their designees receiving grants for development and implementation of statewide suicide early intervention and prevention strategies to collaborate with each Federally recognized Indian tribe, tribal organization, urban Indian organization, and Native Hawaiian health care system in the State. | Warren (D-MA)<br>*Merkley (D-OR)*<br><br>Grijalva (D-AZ)<br>*Blumenauer (D-OR)* | HELP<br><br>Energy and Commerce | In Committee<br><br>In Committee |
| S. 498<br>Introduced: 2/14/19 | Assessment of the Indian Health Service Act of 2019 | Calls for the Secretary of HHS to contract an assessment of IHS' health care delivery systems and financial management process of IHS facilities to improve care for patients. | Rounds (R-SD) | Indian Affairs | In Committee |

# 3A

| Bill No. | Title | Description | Sponsor | Committee(s) | Status |
|---|---|---|---|---|---|
| H.R. 1303 Introduced: 2/15/19 | Examining Opioid Treatment Infrastructure Act of 2019 | Requires Comptroller General of the United States to examine, among other things, the availability of residential and outpatient treatment programs to AI/AN. | Foster (D-IL) | Energy and Commerce, Natural Resources | 3/8/19- Natural Resources referred to Indigenous Peoples of the United States Subcommittee |
| S. 524 Introduced: 2/24/19 | Department of Veterans Affairs Tribal Advisory Committee Act of 2019. | Establishes a VA Tribal Advisory Committee to provide advice and guidance to the Secretary on matters relating to Indian tribes, tribal organizations and Native American veterans. | Tester (D-MT) | Veterans Affairs | In Committee<br>5/22 Veterans Affairs held a hearing about the bill |
| H.R. 1585 Introduced 3/7/19 | Violence Against Women Reauthorization Act of 2019 | Reauthorizes Violence Against Women's Act of 1994 | Bass (D-CA),<br>*DeFazio (D-OR),*<br>*Blumenauer (D-OR),*<br>*Bonamici (D-OR),*<br>*Schrader (D-OR),*<br>*Schrier (D-WA),*<br>*Larsen (D-WA),*<br>*Kilmer (D-WA),*<br>*Jayapal (D-WA),*<br>*Heck (D-WA),*<br>*DelBene (D-WA),*<br>*Smith (D-WA)* | Whole House | 4/4/19- Passed House<br>4/8/19- Received in Senate<br>4/10/19- On Senate Legislative Calendar. |
| H.R. 1643 Introduced: 3/8/19 | PrEP Assitance Program Act | Establishes a Grant Program under HHS to provide grants to tribes, states and territories for pre-exposure prophylaxis (PrEP) programs. | Watson-Coleman (D-NJ)<br>*Blumenauer (D-OR)* | Energy and Commerce | In Committee |
| S. 785 Introduced: 3/31/19 | Commander John Scott Hannon Veterans Mental Health Improvement Act of 2019 | Improves mental health care, eases transition from recently separated veterans, increases community engagement through grants. | Tester (D-MT)<br>*Murray (D-WA),*<br>*Merkley (D-OR),* | Veterans' Affairs | 5/22 Committee on Veterans' Affairs Hearing held. |

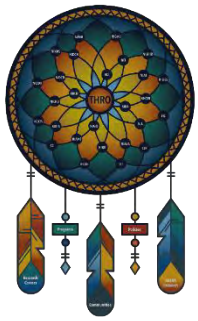
| Bill No. | Title | Description | Sponsor | Committee(s) | Status |
|---|---|---|---|---|---|
| S. 982<br>Introduced<br>4/2/2019<br><br>H.R. 2438<br>Introduced:<br>5/1/19 | Not Invisible Act | Establishes an advisory committee on violent crimes and would establish best practices for law enforcement on combatting the missing and murdered AI/ANs epidemic. | Cortez Masto (D-NV)<br><br>Haaland (D-NM)<br>*Kilmer (D-WA), Smith (D-WA), Heck (D-WA), DelBene (D-WA), Larsen (D-WA), Bonamici (D-OR), DeFazio (D-OR)* | Indian Affairs<br><br>Natural Resources<br>Judiciary | 06/19/19- Considered by Senate Committee on Indian Affairs<br><br>05/10/19- Natural Resources referred to Indigenous Peoples of the United States Subcommittee |
| S. 1001<br>Introduced:<br>4/3/19 | Tribal Veterans Health Care Enhancement Act | Amends the Indian Health Care Improvement Act to allow the Indian Health Service to cover the cost of a copayment of an Indian or Alaska Native veteran receiving medical care or services from the Department of Veterans Affairs, and for other purposes. | Thune (R-SD) | Indian Affairs | In Committee |
| H.R. 2062<br>Introduced:<br>4/3/19<br><br>S. 1012<br>Introduced:<br>4/3/19 | Overdose Prevention and Patient Safety Act<br><br>Protecting Jessica Grub's Legacy Act | Aligns 42 CFR Part 2 with HIPAA to protect the privacy of patients with substance use disorders. Prevents discrimination based on medical records and provides penalties for violations. | Blumenauer (D-OR)<br>*Bonamici (D-OR), DelBene (D-WA), Larsen (D-WA), Walden (R-OR), DeFazio (D-OR), Kilmer (D-WA)*<br><br>Manchin (D-WV)<br>*Merkley (D-OR)* | Energy and Commerce<br><br>HELP | In Committee<br><br>In Committee |
| S. 1180<br>Introduced:<br>4/11/19<br><br>H.R. 2316<br>Introduced: | Urban Indian Health Parity Act | A bill to extend the full Federal medical assistance percentage to urban Indian organizations. | Udall (D-NM)<br>*Merkley (D-OR), Murray (D-WA)*<br><br>Lujan (D-NM) | Finance<br><br>Energy and Commerce | In Committee<br><br>In Committee |

| Bill No. | Title | Description | Sponsor | Committee(s) | Status |
|---|---|---|---|---|---|
| 4/12/19 | | | *Blumenauer (D-OR), DelBene (D-WA), Jayapal (D-WA), Smith (D-WA), Heck (D-WA), Bonamici (D-OR)* | | |
| S. 1213 Introduced 4/11/19 | Consumer Health Insurance Protection Act of 2019 | Introduces consumer protections on par with Medicare and Medicaid requirements for private insurers. Protects against high premiums and limits insurance company profits. | Warren (D-MA) | Finance | In Committee |
| S. 1307 Introduced: 5/2/19<br><br>H.R. 2494 Introduced 5/2/19 | Tribal Nutrition Improvement Act of 2019 | Amends the Richard B. Russell National School Lunch Act and the Child Nutrition Act of 1966 to improve nutrition in tribal areas, and for other purposes. | Udall (D-NM)<br><br>Haaland (D-NM)<br>*Kilmer (D-WA)* | Agriculture, Nutrition and Forestry<br><br>House Education and Labor | In Committee |
| S. 1329 Introduced: 5/6/19<br><br>H.R. 2549 Introduced 5/7/19 | AI/ AN CAPTA | Requires that equitable distribution of assistance include equitable distribution in Indian tribes and tribal organizations and to increase amounts reserved for allotment to Indian tribes and tribal organizations under certain circumstances, and to provide for a Government Accountability Office report on child abuse and neglect in American Indian tribal communities. | Warren (D-MA)<br>*Merkley (D-OR)*<br><br>Grijalva (D-AZ) | Indian Affairs<br><br>Education and Labor, Natural Resources | In Committee<br><br>05/16/19- Natural Resources referred to Indigenous Peoples of the United States Subcommittee |

# 3A

| Bill No. | Title | Description | Sponsor | Committee(s) | Status |
|---|---|---|---|---|---|
| S. 1365<br>Introduced:<br>5/8/19<br><br>H.R. 2569<br>Introduced:<br>5/8/19 | Comprehensive Addiction Resources Emergency Act of 2019 (CARE) | To Provide emergency assistance to States, territories, Tribal nations, and local areas affected by the opioid epidemic and to make financial assistance available to States, territories, Tribal nations, local areas, and public or private nonprofit entities to provide for the development, organization, coordination, and operation of more effective and cost efficient systems for the delivery of essential services to individuals with substance use disorder and their families | Warren(D-MA)<br><br>Cummings (D-MD)<br>*Bonamici (D-OR), Blumenauer (D-OR), Jayapal (D-WA), Kilmer (D-WA)* | HELP<br><br>Energy and Commerce, Natural Resources, Judiciary | In Committee<br><br>05/13/19- Natural Resources referred to Indigenous Peoples of the United States Subcommittee |
| H.R. 2680<br>Introduced:<br>5/10/19 | Special Diabetes Programs for Indians Reauthorization Act of 2019 | Reauthorizes special programs for Indians for providing services for prevention and treatment of diabetes, and for other purposes | O'Halleran (D-AZ) | Energy and Commerce | In Committee |
| HR 3340<br>Introduced:<br>6/19/19 | Tribal Healthcare Careers Act | To provide a set-aside of funds for Indian populations under the health profession opportunity grant program under section 2008 of the Social Security Act. | Gomez (D-CA) | Ways and Means | In Committee |
| H.R. 3343<br>Introduced:<br>6/19/19 | Technical Assistance for Health Grants Act | To provide for technical assistance under the health profession opportunity grant program under section 2008 of the Social Security Act. | Kildee (D-MI) | Ways and Means | In Committee |

| Bill No. | Title | Description | Sponsor | Committee(s) | Status |
|---|---|---|---|---|---|
| S. 1895 Introduced: 6/19/19 | Lower Health Care Costs Act | To lower healthcare costs. | Lamar (R-TN) | HELP | 6/26/19- Ordered Reported and sent to Senate |
| S. 1926 Introduced: 6/20/2019 | PrEP Access and Coverage Act | To increase access to pre-exposure prophylaxis to reduce the transmission of HIV | Harris (D-CA) | HELP | In Committee |



## Tribal Health Research Office

Division of Program Coordination, Planning, & Strategic Initiatives
Office of the Director, National Institutes of Health (NIH)

# NIH *All of Us* Research Program

## What is precision medicine and why is it important?

- Precision medicine is health care that is based on you as an individual. It takes into account factors like where you live, what you do, and your family health history: it is medicine tailored to you.
- Researchers are learning more and more about resilience and how both common, chronic diseases – as well as those that are rare – may be prevented and treated with strategies that will work best for individuals.
- The more people that are included in a study, the more powerful the study is to identify and understand the causes of health and illness. This kind of power cannot be achieved unless individuals decide to share their data for research.

## What is the *All of Us* Research Program?

- *All of Us* is a national research resource funded by NIH that will be open to all kinds of researchers. Instead of focusing on just one disease or condition, it will support research on a wide variety of health conditions.
- *All of Us* aims to engage a community of 1 million or more participants that reflects the diversity of America, including many people who haven't taken part in medical research before. They will share different kinds of information over time that will help researchers learn what prevention and treatments work for different individuals and communities.
- *All of Us* is intended to last for decades, so researchers may better understand what causes changes in health over time.
- Research using *All of Us* participant data has not yet begun; the research database may be open as soon as Winter 2019.

## What does participation in the *All of Us* Research program entail?

- Participants will be asked to share information about their health, family, home, and work; access to electronic health records; basic physical measurements; and biological samples, like blood and urine. The program will ask participants periodically to provide additional information.
- Participants' information may be accessed for many different studies. At this time, there is no option for participants to opt out of specific research studies (e.g. a specific study proposed by a researchers) nor is there a way to specify that their data be used only in specific kinds of research (e.g. environmental research only).

- Participants may withdraw from the program at any time. If they withdraw, their data will not be used for any future research but cannot be removed from research that is ongoing or has already taken place.

## How does *All of Us* protect participant data?

- *All of Us* removes participants' names and other direct identifiers (like Social Security number) from their information and replaces them with a code.
- Access to data is tiered according to sensitivity. Researchers seeking access will be required to register, verify their identity, take *All of Us*' training in ethical research, and sign a data use agreement, promising not to identify participants. Researchers also must provide a description of their research project for the program to post publicly.
- While no data platform can guarantee a security breach will not occur, *All of Us* partners with top-tier security experts to help constantly improve its systems to mitigate those risks.
- At this time, the *All of Us* public data browser does not include racial/ethnic identity or Tribal affiliation; AI/AN-specific information will be visible only after consultation and using feedback received through this process.

## How can Tribal Nations work with *All of Us*?

- *All of Us* is engaged in a Tribal consultation process and seeking input from Tribal leaders on the best way to work with Tribal Nations. Dates for consultation events and listening sessions may be accessed at: https://allofus.nih.gov/about/all-us-tribal-engagement
- The *All of Us* Research Program's consultation efforts and questions are being guided by the report of the *All of Us* Tribal Collaboration Working Group, which may be accessed at https://allofus.nih.gov/about/who-we-are/tribal-collaboration-working-group-all-us-research-program-advisory-panel.
- Feedback received through the Tribal consultation and other public engagement efforts will result in a plan for working with Tribal Nations. Feedback may be provided in person at events, as well as through email, call/text, or mail. Contact information for the *All of Us* Research Program Tribal Engagement team may be found at https://allofus.nih.gov/about/all-us-tribal-engagement.

## *All of Us* Resources

- *All of Us* Tribal Engagement website: https://allofus.nih.gov/about/all-us-tribal-engagement
- 2018 Tribal Collaboration Working Group report: https://allofus.nih.gov/about/who-we-are/tribal-collaboration-working-group-all-us-research-program-advisory-panel
- *All of Us* Research Program study protocol and lay summary: https://allofus.nih.gov/about/all-us-research-program-protocol
- *All of Us* website for potential participants: https://www.joinallofus.org
- *All of Us* Research Hub, including the Data Browser: https://www.researchallofus.org/

DEPARTMENT OF HEALTH & HUMAN SERVICES

3C
Public Health Service

Indian Health Service
Rockville MD 20857

JUL 05 2019

Dear Tribal Leader:

The Secretary of the Department of Health and Human Services (HHS) is required to submit to Congress every 5 years an updated report of Indian Health Service (IHS) and Tribal health care facilities' needs (25 U.S.C. § 1631 et seq.). The next report is due in 2021. The report includes renovation and expansion needs identified by Tribes, Tribal Organizations, and the IHS. The IHS is requesting your assistance in identifying potential facility needs.

The report is updated in close collaboration with the Facilities Appropriation Advisory Board, and assistance from the Facilities Needs Assessment Workgroup. The report estimates cost and space requirements across Indian Country using the same consistent methodology and data sources as in the previous reports. To view the report, "2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress," please visit the IHS Web site at https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf.

The report is neither a funding request nor a priority system. It is an estimate of need for planning level use.

I invite you to provide updated Facility Master Plans and/or other identified health care facility needs to your local IHS Area Facilities Program Director for possible inclusion in the 2021 IHS and Tribal Health Care Facilities' Needs Assessment Report to Congress.

Because of the extensive lead time needed to complete the draft and clearance process for the report, I am asking that you please provide your data by no later than December 31, 2019. If you have questions please contact your IHS Area Facilities Program Director (see enclosure).

Sincerely,

/Michael D. Weahkee/

RADM Michael D. Weahkee, MBA, MHSA
Assistant Surgeon General, U.S. Public Health Service
Principal Deputy Director

Enclosure: IHS Facility Program Directors

# IHS Facility Program Directors

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DEPARTMENT OF HEALTH & HUMAN SERVICES

3D
Public Health Service

Indian Health Service
Rockville MD 20857

JUN 19 2019

Dear Tribal Leader and Urban Indian Organization Leader:

I am writing to initiate Tribal Consultation and Urban Confer on developing an Indian Health Service (IHS) Opioid Grant Program to distribute the Fiscal Year (FY) 2019 opioid funding. The Consolidated Appropriations Act, 2019 (Public Law 116-6), provided a $10 million increase in the Alcohol and Substance Abuse Program budget line to better combat the opioid epidemic by creating a Special Behavioral Health Pilot Program (SBHPP), modeled after the Special Diabetes Program for Indians.

The explanatory statement further instructs the IHS that the SBHPP be developed in coordination with the Substance Abuse and Mental Health Services Administration to award grants for: 1) supporting the development, documentation, and sharing of locally designed and culturally appropriate prevention, treatment, recovery, and aftercare services for mental health and substance use disorders in American Indian and Alaska Native communities, and 2) providing services and technical assistance to grantees to collect and evaluate performance of the program.

During the formal Tribal Consultation and Urban Confer sessions, I invite you to provide feedback on the following:

- Which priorities need to be considered in developing grant program objectives and goals to address opioid prevention, treatment, and recovery?
- What are the associated national outcomes with each of the priorities identified?
- How can the IHS demonstrate effectiveness using data and evaluation methods?
- What distribution formula or methodology should be utilized in the selection and award process?

To frame these sessions, the IHS Division of Behavioral Health (DBH) will host learning sessions that will share the summary of previous opioid listening sessions and further explain grant distribution options currently in use within the IHS Office of Clinical and Preventive Services. To find proposed dates and locations of Tribal Consultation and Urban Confer sessions, please visit https://www.ihs.gov/dbh/consultationandconfer/.

I encourage you to participate in following virtual Tribal Consultation and Urban Confer sessions that will be hosted by the IHS DBH, in partnership with the IHS Opioid Coordinating Group, and the Heroin, Opioids, and Pain Efforts (HOPE) Committee through August 1, 2019:

**Virtual Tribal Consultations**

- Monday, June 24, 2019 from 3:00 p.m. - 5:00 p.m. (ET)
- Adobe Connect: https://ihs.cosocloud.com/vtc
- Conference Call-in line: (800) 832-0736; Room Number *4571119 #

**Virtual Tribal Consultations**

- Tuesday, July 9, 2019 from 2:00 p.m. - 4:00 p.m. (ET)
- Adobe Connect: https://ihs.cosocloud.com/vtc
- Conference Call-in line: (800) 832-0736; Room Number *4571119 #

**Virtual Urban Confer**

- Wednesday June 26, 2019 from 2:00-4:00 p.m. ET
- Adobe Connect: https://ihs.cosocloud.com/vtc
- Conference Call-in line: (800) 832-0736; Room Number *4571119 #

Written comments will be accepted through the duration of the Tribal Consultation and Urban Confer comment period. **The deadline to provide comments is Thursday, August 1, 2019.**

Send comments by e-mail to: consultation@ihs.gov or urbanconfer@ihs.gov

**Subject Line: IHS FY 2019 Opioid Grant Funds**

Send comments by postal mail to:
RADM Michael D. Weahkee
Principal Deputy Director
Indian Health Service
5600 Fishers Lane, Mail Stop: 08E86
Rockville, MD 20857

**Attention: IHS FY 2019 Opioid Grant Funds**

I look forward to your input and recommendations on developing an IHS Opioid Grant Program to address the opioid epidemic.

Thank you for your support and partnership in addressing important behavioral health issues in the communities we serve. If you have questions about the process for submitting a comment on the FY 2019 Opioid Grant Funding Tribal Consultation and Urban Indian Organization Confer, please directly contact Ms. Michele Muir-Howard, DBH, IHS, by telephone at (301) 443-2038, or by e-mail at michele.muir-howard@ihs.gov.

Sincerely,

/ Michael D. Weahkee /
RADM Michael Weahkee, MBA, MHSA
Assistant Surgeon General, U.S. Public Health Service
Principal Deputy Director

DEPARTMENT OF HEALTH & HUMAN SERVICES

3E
Public Health Service

Indian Health Service
Rockville MD 20857

MAY 24 2019

Dear Tribal Leader:

I am writing to update you on the Tribal Consultation for the Indian Health Service (IHS) *Sanitation Deficiency System – A Guide for Reporting Sanitation Deficiencies for American Indian and Alaska Native Homes and Communities* (commonly known as the "SDS Guide").

By letter dated July 2, 2018, I initiated Tribal Consultation on proposed updates to the SDS Guide, which is used to establish the processes by which IHS Areas collect and report the current sanitation deficiencies affecting American Indian and Alaska Native (AI/AN) homes and communities. At the request of Tribes, I extended the comment period through September 14, 2018, to provide additional time for comments. During the comment period, 41 responses were received that included 71 unique comments on the SDS Guide. I want to thank the Tribes and Tribal Organizations that took the time to review and provide comments on the document.

On March 20, 2019, the IHS Office of Environmental Health and Engineering (OEHE) met with the IHS Facilities Appropriation Advisory Board (FAAB) in Rockville, Maryland, to discuss the results of the Tribal Consultation and to receive feedback on the finalization of the SDS Guide. At the meeting, the IHS OEHE provided the FAAB with a summary of the comments received, and the FAAB requested additional time to review the comments in detail. Following the meeting, two conference calls were held to discuss the comments and proposed responses. I want to thank the FAAB members for their active engagement and feedback.

A summary of the comments received during Tribal Consultation and how the IHS incorporated them into the updated SDS Guide can be found under the Links header at https://www.ihs.gov/dsfc/resources/. IHS based these responses on a thorough review of the statutory requirements, program policy, and input from the FAAB. The comments are provided with limited modifications to remove identifying information and to group similar comments together.

The IHS OEHE plans to issue the updated SDS Guide for use in the 2020 SDS reporting cycle. The updated SDS Guide will be posted under the Documents header at the above-stated link by September 30, 2019.

If you have additional questions, please contact RADM Mark Calkins, Director, Division of Sanitation Facilities Construction, IHS, by telephone at (301) 443-1046 or by e-mail at mark.calkins@ihs.gov.

Sincerely,

/Michael D. Weahkee/

RADM Michael D. Weahkee, MBA, MHSA
Assistant Surgeon General, U.S. Public Health Service
Principal Deputy Director

| The following is a summary of changes to the PRC Chapter as a result of Tribal consultation | | |
|---|---|---|
| **Draft PRC Chapter Section** | **Draft PRC Chapter Section language before Tribal Consultation** | **PRC Chapter Section language after Tribal Consultation** |
| 2-3.1 Introduction –<br><br>Removed reference to when funds are depleted to another section of the chapter as requested (GAO recommendation) addition of B. Scope<br><br>Impact: Clarity on rule | 2-3.1 INTRODUCTION<br><br>A. Purpose. This revised chapter publishes the policy, procedures, and guidance for the effective management of the Indian Health Service (IHS) Purchased/Referred Care (PRC) Program. The authority to manage the operation of the PRC Program is delegated to the greatest degree possible, within the limits of available funds, to Area Directors and Chief Executive Officers (CEO). In the event PRC funds are depleted, PRC payment for services must be denied or deferred and the CEO must notify the Area Director. | A. Purpose. This revised chapter publishes the policy, procedures, and guidance for the effective management of the Indian Health Service (IHS) Purchased/Referred Care (PRC) Program. The authority to manage the operation of the PRC Program is delegated to the greatest degree possible, within the limits of available funds, to Area Directors and Chief Executive Officers (CEO).<br><br>B. Scope. In accordance with 42 C.F.R. 136.3, this chapter contains operating procedures to assist officers and employees in carrying out their responsibilities, and are not regulations establishing program requirements which are binding upon members of the general public. |
| 2-3.1 Introduction –<br><br>E. Acronyms – addition of (10) CMS<br><br>Impact: Clarity and definition | (8) CDSR – Core Data Set Requirement<br>(9) DCC – Division of Contract Care | (9) CDSR – Core Data Set Requirement<br>(10) CMS – Centers for Medicare and Medicaid Services<br>(11) DCC – Division of Contract Care |
| 2-3.1 Introduction –<br><br>E. Acronyms – addition of (24) ORAP and (32) U.S.<br><br>Impact: Clarity and definition | (24) PRCO – Purchased/Referred Care Officer<br>(25) RCIS – Referred Care Information System<br>(26) RPMS – Resource and Patient Management System<br>(27) UFMS – Unified Financial Management System<br>(28) U.S.C. – United States Code | (24) ORAP – Office of Resource Access and Partnerships<br>(28) PRCO – Purchased/Referred Care Officer<br>(29) RCIS – Referred Care Information System<br>(30) RPMS – Resource and Patient Management System<br>(31) UFMS – Unified Financial Management System<br>(32) U.S. - United States<br>(33) U.S.C. – United States Code |
| 2-3.1 Introduction –<br><br>F. Definitions –<br>(1) Alternate Resources – small wordsmithing changes<br><br>Impact: Clarity | (1) Alternate Resources. Alternate resources are any Federal, State, local, or private source of coverage for which the patient is eligible. Such resources include health care providers and institutions and health care programs for the payment of health services including but not limited to programs under the Social Security Act (i.e., Medicare and Medicaid, Children's Health Insurance Program), other Federal health care programs, State and | (1) Alternate Resources. Alternate resources means health care resources other than those of the Indian Health Service. Such resources include health care providers and institutions, and health care programs for the payment of health services including but not limited to programs under titles XVIII or XIX of the Social Security Act (i.e., Medicare, Medicaid), State or local health care programs, and private insurance. |

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| (2) Appropriate Ordering Official – additional language for clarity<br><br>Impact: Clarity | local health care programs, Veterans Health Administration and private insurance.<br><br>(2) Appropriate Ordering Official. The person, with documented delegated procurement authority, who signs the purchase order authorizing the obligation of PRC funds. | (2) Appropriate Ordering Official. Appropriate ordering official means, unless otherwise specified by contract with the health care facility or provider, the ordering official for the purchased/referred care delivery area in which the individual requesting PRC or on whose behalf the services are requested, resides. |
| 2-3.1 Introduction –<br><br>F. Definitions –<br>(10) Medical Referral – additional language for clarity<br><br>Impact: Clarity<br><br>(11) Purchased/ Referred Care Delivery Area – additional language and citation for clarity<br><br>Impact: Clarity | (10) Medical Referral. A referral for health care services that is not authorized for payment by PRC.<br><br>(11) Purchased/Referred Care Delivery Area. The Purchased/Referred Care Delivery Area (PRCDA) is the geographic area within which PRC will be made available by the IHS and Tribes. | (16) Medical Referral. A referral for health care services that is not authorized for payment by PRC. A medical referral that becomes authorized for PRC becomes a PRC referral.<br><br>(18) Purchased/Referred Care Delivery Area. The PRCDA means the geographic area within which PRC services will be made available by the IHS to members of an identified Indian community who reside in the area, subject to the provisions of 42 C.F.R. § 136 Subpart C. |
| 2-3.1 Introduction –<br><br>F. Definitions – Descendent of a Tribal Member – omitted not used in the chapter<br><br>Impact: None/should not be used | (16) Descendent of a Tribal Member. An individual biologically descended from an enrolled member of the Tribe.<br><br>(22) Notification of a Claim. For the purposes of part 136, and also 25 U.SC. 1621s and 1646, the submission of a claim that meets the requirements of 42 CFR 136.24 | Omitted per consultation request<br><br>(20) Notification of a Claim (see 42 C.F.R. § 136.202) For the purposes of part 136, and also 25 U.SC. § 1621s and 1646, the submission of a claim that meets the requirements of 42 C.F.R. § 136.24.<br><br>a. Such claims must be submitted within the applicable time frame specified by 42 C.F.R. § 136.24, or if applicable, 25 U.S.C. § 1646, and include information necessary to determine |

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| (21) Notification of a Claim – addition of citations<br><br>Impact: Clarity on rule/citations | | the relative medical need for the services and the individual's eligibility.<br><br>b. The information submitted with the claim must be sufficient to:<br>(i) Identify the patient as eligible for IHS services (e.g., name, address, home or referring service unit, Tribal affiliation),<br><br>(ii) Identify the medical care provided (e.g., the date(s) of service, description of services), and<br><br>(iii) Verify prior authorization by the IHS for services provided (e.g., IHS purchase order number or medical referral form) or exemption from prior authorization (e.g., copies of pertinent clinical information for emergency care that was not prior-authorized). |
| 2-3.1 Introduction –<br><br>F. Definitions –<br>(24) Reservation added the phrase, including former reservations in Oklahoma, which was mistakenly left out of the revised chapter<br><br>Impact: None/Clarity, 43 U.S.C. 1601 et seq. already defines this. | (25) Reservation. Any Federally-recognized Indian Tribe's reservation, pueblo, colony, Indian allotments, or Rancheria, including Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 *et seq*).<br><br>(29) Tribal Health Director. The Director of a Tribally-operated program, or his/her designee, authorized to make decisions on payment of PRC funds pursuant to a Pub. L. 93-638 contract.<br><br>(31) Tribally-Operated Program. A program operated by a Tribe or Tribal organization that has contracted under Pub. L. 93-638 to provide a PRC program. | (23) Reservation. Any Federally-recognized Indian Tribe's reservation, pueblo, colony, including former reservations in Oklahoma, Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 *et seq*), and Indian allotments.<br><br>Omitted per consultation request<br><br>(27) Tribal Health Program. The term "tribal health program" means an Indian Tribe or Tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided |

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| Tribal Health Director – omitted not used in the chapter<br><br>Impact: Clarity/outdated term<br><br>(29) Tribal Health Program – Replaced Tribally-Operated Program and added language for clarity<br><br>Impact: None/Clarity<br><br>(30) Tribal Organization – added definition as requested by consultation<br><br>Impact: Defines and adds Tribal Organization | | for in, a contract or compact with the Service under the ISDEAA (25 U.S.C. § 5301 *et seq*).<br><br>(29) Tribal Organization. Tribal Organization means the recognized governing body of any Indian Tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities: Provided, that in any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian Tribe, the approval of each such Indian Tribe shall be a prerequisite to the letting or making of such contract or grant. |
| 2-3.1 Introduction –<br><br>F. Definitions –<br>(31) Tribal Self-Insurance – added a statement on stop loss<br><br>Impact: Clarity and prescriptive, on Tribal Self Insurance, Cost saving to PRC Funds | (32) Tribal Self-Insurance. A health plan that is funded solely by a Tribe or Tribal organization and for which the Tribe or Tribal organization assumes the burden of payment for health services covered under the plan either directly or through an administrator. Any portion of the plan that is reinsured will not be considered Tribal Self-Insurance. | (30) Tribal Self-Insurance. A health plan that is funded solely by a Tribe or Tribal organization and for which the Tribe or Tribal organization assumes the burden of payment for health services covered under the plan either directly or through an administrator. Any portion of the cost of care that is the responsibility of a reinsurer or stop loss plan will not be considered Tribal Self-Insurance. |
| 2-3.3 Purchased/Referred Care Delivery Area | A. Purchased/Referred Care Delivery Area (PRCDA). Currently the IHS provides services under regulations in effect on September 15, 1987 republished at 42 CFR Part 136, Subparts A-C, and may be changed only in accordance with the Administrative Procedures Act (5 | A. Purchased/Referred Care Delivery Area (PRCDA). Currently the IHS provides services under regulations in effect on September 15, 1987 republished at 42 CFR Part 136, Subparts A-C, and may be changed only in accordance with the Administrative Procedures Act (5 |

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| C. Established PRCDAs – omitted the link to the web site as requested<br><br>Impact: None – changes to link have caused confusion. | U.S.C. 553). 42 CFR Part 136, Subpart C defines a PRCDA as the geographic area within which PRC will be made available to members of an identified Indian community who reside in the PRCDA. It should be clearly understood that residence within a PRCDA by a person who is within the scope of the Indian health program, as set forth in 42 CFR 136.12, creates no legal entitlement to PRC but only potential eligibility for services.<br><br>C. Established Purchased/Referred Care Delivery Areas. Established PRCDA are listed in the *Federal Register* (FR) Notices. The current PRCDA *Federal Register* Notice can be found on the IHS PRC Web site: http://www.ihs.gov/PRC/documents/PRCDA_FEDERAL_REGISTER_NOTICE_June_21_2007.doc | U.S.C. 553). IHS personnel should understand and be able to explain that residence within a PRCDA by a person who is within the scope of the Indian health program, as set forth in 42 CFR 136.12 creates no legal entitlement to PRC but only potential eligibility for services.<br><br>C. Established Purchased/Referred Care Delivery Areas. Established PRCDA are listed in the *Federal Register* (FR) Notices. The current PRCDA *Federal Register* Notice can be found on the IHS PRC Web site. Deleted Link |
| 2-3.4 Redesignation of a PRCDA<br>C. Requirements – (1) added citations for consultation<br><br>Impact: None/Clarity on rule | (1) The Area PRC Officer will analyze the request and will recommend acceptance or rejection of the request to the Area Director. For tribally-managed programs, analysis will be coordinated with the Area Tribal Project Officer for contracted programs or Self-Governance Coordinator for compacted programs. If another Tribe(s) is affected by the PRCDA designation/re-designation there must be consultation by the Area with the affected Tribe(s). | (1) The Area PRC Officer will analyze the request and will recommend acceptance or rejection of the request to the Area Director. For tribally-managed programs, analysis will be coordinated with the Area Tribal Project Officer for contracted programs or Self-Governance Coordinator for compacted programs. The Area is required to consult in accordance with 42 C.F.R. § 136.23(b). |
| 2-3.5 Persons to Whom PRC Will be Provided –<br><br>C. Insufficient Funds – (1) and (2) changed the format as requested – GAO recommendation<br><br>Impact: None/Clarity | C. Insufficient Funds. When funds are insufficient to provide the volume of purchased/referred care indicated as needed by the population residing in a PRCDA, priorities for service shall be determined on the basis of relative medical need. Manual Exhibit 2-3-B demonstrates the process for determining the disposition for a patient being considered for PRC funding. In the event that all PRC funds are depleted, referrals will be denied PRC payment or deferred. Medical referrals will still be made based on services needed by the patient. However, no payment or | C. Insufficient Funds. When funds are insufficient to provide the volume of PRC services indicated as needed by the population residing in a PRCDA, priorities for service shall be determined on the basis of relative medical need.<br><br>(1) Manual Exhibit 2-3-B demonstrates the process for determining the disposition for a patient being considered for PRC funding. |

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| | promise of payment can be made when there are no funds available. The Service Unit CEO will notify the Area Director when PRC funds are insufficient. | (2) In the event that all PRC funds are depleted, referrals will be denied PRC payment or deferred. Medical referrals will still be made based on services needed by the patient. However, no payment or promise of payment can be made when there are no funds available. The Service Unit CEO will notify the Area Director when PRC funds are insufficient or depleted. |
| 2-3.5 Persons to Whom PRC Will be Provided –<br><br>D. Services – removed the link to the Medical Priorities and provided a Manual Exhibit<br><br>Impact: None – changes to link have caused confusion. | D. Any expenditure of PRC funds is limited to services that are medically indicated. See the Medical Priority list for services that may be included and those specifically excluded. The listing for PRC Medical Priorities can be found at the PRC Web site: http://www.ihs.gov/PRC/index.cfm?module=PRC_requirements_priorities_of_care | D. Services. Any expenditure of PRC funds is limited to services that are medically indicated. See the Medical Priority list for services that may be included and those specifically excluded. The listing for PRC Medical Priorities can be found in Manual Exhibit 2-3-B. The listing for PRC Dental Levels of Care can be found in Manual Exhibit 2-3-C. |
| 2-3.6 Eligibility Requirements<br><br>A. Documentation Added Manual Exhibit 2-3-E<br>B. Eligibility –<br>• added a citation and removed – must be eligible for direct care<br><br>Impact: None, Clarify and conform to regulation language. | Eligibility. Eligibility for PRC is governed by 42 CFR 136.23. The PRC program is not an entitlement program and thus, when funds are insufficient to provide the volume of PRC needed, services shall be determined on the basis of relative medical need in accordance with established medical priorities [42CFR 136.23(e)]. To be eligible for PRC, an individual:<br>(1) must be eligible for direct care as defined in 42 CFR 136.12; and either<br>(2) reside within the U.S. on a Federally-recognized Indian reservation; or<br>(3) reside within a PRCDA and;<br>a. are members of the Tribe or Tribes located on that reservation; or<br>b. maintain close economic and social ties with that Tribe or Tribes. | A. Documentation. An AI/AN claiming eligibility for PRC has the responsibility to furnish the CEO with verifiable documentation to substantiate the claim. Each facility should establish a policy on documentation.<br><br>B. Eligibility. Eligibility for PRC is governed by 42 CFR 136.23. The PRC program is not an entitlement program and thus, when funds are insufficient to provide the volume of PRC needed, services shall be determined on the basis of relative medical need in accordance with established medical priorities [42CFR 136.23(e)]. To be eligible for PRC, an individual must be eligible for direct care as defined in 42 C.F.R. § 136.12 and either:<br><br>(1) reside within the U.S. on a Federally-recognized Indian reservation; or<br>(2) reside within a PRCDA and; |

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| | | a. are members of the Tribe or Tribes located on that reservation; or<br>b. maintain close economic and social ties with that Tribe or Tribes. |
| 2-3.6 Eligibility Requirements<br><br>added language for clarity<br><br>Impact: None/Clarity<br><br>Changed BIA to BIE | (1) Full time student programs such as high school, college (undergraduate and graduate) vocational, technical, or other academic education, during their attendance and normal school breaks. The service unit where the student was eligible for PRC prior to leaving for school is responsible for the student. These students remain eligible after the completion of the courses of study up to 180 days. After 180 days has elapsed the student is no longer eligible for PRC. | (1) Full time student programs such as high school (except for BIE Boarding Schools), college (undergraduate and graduate) vocational, technical, or other academic education, during their attendance and normal school breaks. The service unit where the student was eligible for PRC prior to leaving for school is responsible for the student. These students remain eligible after the completion of the courses of study up to 180 days. After 180 days has elapsed the student is no longer eligible for PRC.<br><br>(2) At all BIE Boarding Schools, PRC is provided for students during their full-time attendance, by the Area where the boarding school is located. Included are BIA off-reservation schools such as: |
| 2-3.6 Eligibility Requirements<br>Page 20<br>F. Persons in Custody – added language and citations for clarity<br><br>Impact: None/Clarity | F. Persons in Custody. The cost of medical and related health services for eligible beneficiaries in custody of (non-Indian) law enforcement agencies is not the responsibility of the IHS, but is the responsibility of that particular agency. Persons in the custody of Indian law enforcement agencies will be considered eligible on the same basis as other beneficiaries of the Service. IHS does not provide the same health services in each area served and services provided will depend upon the facilities and services available (42 CFR 136.11(c)). | F. Persons in Custody. The cost of medical and related health services for eligible beneficiaries in custody of non-Indian law enforcement agencies is not the responsibility of the IHS, but is the responsibility of that particular agency. Persons in the custody of Bureau of Indian Affairs or tribal law enforcement agencies, including custodial services provided through contract, shall be eligible for services provided through the IHS, on the same basis, and for the same level of care, as other beneficiaries. IHS does not provide the same health services in each area served and services provided will depend upon the facilities and services available (42 C.F.R. § 136.11(c)). |
| 2-3.7 Purchased/Referred Care Medical Priorities | Regulations [42 CFR 136.23(e)] permit the establishment of priorities based on relative medical need when funds are insufficient to provide the volume of PRC indicated as needed | Regulations, 42 C.F.R. § 136.23(e), permit the establishment of priorities based on relative medical need when funds are insufficient to provide the volume of PRC indicated as needed |

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| Removed the link and added Manual Exhibit for Medical Priorities<br><br>Impact: None – changes to link have caused confusion. | by the population residing in a PRCDA. The IHS medical and dental priorities health priorities are found on the PRC Web site: https://www.ihs.gov/PRC/index.cfm?module=PRC_requirements_priorities_of_care | by the population residing in a PRCDA. The IHS medical and dental priorities health priorities are found Manual Exhibits 2-3-B and 2-3-C. |
| 2-3.8 Payor of Last Resort Requirements<br><br>A. (3) Removed the reference to charity programs<br><br>Impact: None/Clarity | (3) The AI/AN would be eligible for alternate resources under State or local law or regulation but for the Indian's eligibility for PRC or other health services, from the IHS or IHS programs. Note; a "charity program" is not considered an alternate resource if the provider of services is absorbing the full cost of the care, but the charity program would be an alternate resource if the provider of services receives reimbursement for the costs of providing such care. | (3) The AI/AN would be eligible for alternate resources under State or local law or regulation but for the Indian's eligibility for PRC or other health services, from the IHS or IHS programs. |
| 2-3.8 Payor of Last Resort Requirements<br>D. (1) Failure to follow alternate resources – changed from 10 to 30 days as requested<br><br>Impact: None, was in original language. i.e. did not want it changed to 10 days. | (1) When the patient willfully or intentionally fails to apply or fails to complete an alternate resource application. The facility staff will provide written notice to patients that if an alternate resource application is not completed, or if the patient does not contact the facility staff for assistance in completing the application within 10 days after the receipt of the notice, a PRC denial letter will be issued. If an alternate resource program issues a denial because the applicant failed to apply or failed to complete the application and the PRC file is well documented with attempts to assist the applicant, the PRC office should issue a PRC denial to the patient and a copy should be forwarded to the provider. | (1) When the patient willfully or intentionally fails to apply or fails to complete an alternate resource application. The facility staff will provide written notice to patients that if an alternate resource application is not completed, or if the patient does not contact the facility staff for assistance in completing the application within 30 days after the receipt of the notice, a PRC denial letter will be issued. If an alternate resource program issues a denial because the applicant failed to apply or failed to complete the application and the PRC file is well documented with attempts to assist the applicant, the PRC office should issue a PRC denial to the patient and a copy should be forwarded to the provider. |
| 2-3.8 Payor of Last Resort Requirements<br>G. Alternate Resources – | G. Alternate Resources. All IHS or Tribal facilities that are available and accessible to an individual are considered alternate resources. Other alternate resources to pay for private sector services would include, but not be | G. Alternate Resources. All IHS or Tribal facilities that are available and accessible to an individual must be used before PRC. IHS considers the list of alternate resources included in 42 C.F.R. § 136.61(c) to be exemplary and not |

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|---|---|---|
| **Draft PRC Chapter Section** | **Draft PRC Chapter Section language before Tribal Consultation** | **PRC Chapter Section language after Tribal Consultation** |
| Added, must be used before PRC and added language for clarity added statement that - IHS considers insurance purchased under 25 U.S.C. § 1642 to be an alternate resource under the payor of last resort rule<br><br>Impact: None, Clarify and conform to regulation language. | limited to, Medicare, Medicaid, Vocational Rehabilitation, Children's Rehabilitative Services, Local or Private Insurance, State Programs and Crime Victims Act. Also see 42 CFR 136.61(c). A charity or indigent care program offered by a provider of services is not considered an alternate resource if the provider of services is absorbing the full cost of the care, but the charity or indigent care program will be considered an alternate resource if it receives reimbursement for the costs of providing such care from state resources or other institutions | exhaustive, other alternate resources to pay for private sector services would include, but not be limited to, Veterans programs, Vocational Rehabilitation, Children's Rehabilitative Services, Local or Private Insurance, State Programs and Crime Victims Act. See 42 C.F.R. § 136.61(c). IHS considers insurance purchased under 25 U.S.C. § 1642 to be an alternate resource under the payor of last resort rule. A charity or indigent care program offered by a provider of services is not considered an alternate resource if the provider of services is absorbing the full cost of the care, but the charity or indigent care program will be considered an alternate resource if it receives reimbursement for the costs of providing such care from state resources or other institutions. |
| 2-3.8 Payor of Last Resort Requirements<br>G. Alternate Resources – Added, Individuals who receive funding to purchase health care coverage shall be required to use such funds to purchase health care purposes and such funds will be considered an alternate resource<br><br>Impact: None/Clarity<br><br>H. Added, Exception to the IHS Payor of Last Resort Rule – Tribal Self-Insurance with language on | I. Exception to the IHS Payor of Last Resort: Tribal Self-Insurance Plans. For purposes of IHS administered PRC programs, the Agency will not consider tribally-funded self-insured health plans to be alternate resources for purposes of the IHS' Payor of Last Resort Rule. | Individuals who receive funding to purchase health care coverage shall be required to use such funds for health care purposes and such coverage shall be considered an alternate resource.<br><br>H. Exception to the IHS Payor of Last Resort – Tribal Self-Insurance Plans. For purposes of IHS administered PRC programs, the Agency will not consider tribally-funded self-insured health plans to be alternate resources for purposes of the IHS' Payor of Last Resort Rule. IHS will assume that a Tribe does not wish for its self-insured plan to be an alternate resource for purposes of PRC and IHS will treat the plan accordingly, once IHS receives documentation to show that the plan is tribal self-insurance. IHS will only treat the Tribe's plan as an alternate resource for purposes of PRC if either of the following occurs:<br><br>(1) IHS has not received documentation to show that the plan is tribal self-insurance, or |

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|---|---|---|
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| requirements as a new section under the topic (1) and (2)<br><br>Impact: Allows Tribal Self Insurance to be payor of Last Resort, Cost Saving to Tribal Self Insurance Programs, however off set by Federal PRC programs. | | (2) IHS receives a tribal resolution from the Tribe's governing body, which clearly states that the Tribe would like IHS to treat the self-insured plan as an alternate resource for purposes of PRC.<br><br>REMINDER: This process applies to IHS operated PRC programs. Tribes and Tribal organizations operating PRC programs may choose to follow this coordination process, or they may adopt a different process for addressing this issue.<br><br>To the extent any Tribal self-insurance plan has reinsurance or stop loss insurance from which claims are paid by entities other than the Tribe or Tribal organizations, such reinsurance or stop loss insurance shall not be considered Tribal self-insurance; provided that the fact that a Tribal self-insurance plan has reinsurance or stop loss insurance does not mean that the Tribal self-insurance shall be considered an alternate resource. |
| 2-3.8 Payor of Last Resort Requirements<br>J. Added Medicaid Coordination as a separate section under the topic<br><br>Impact: None/Clarity<br><br>K. Added Coordination of Other Benefits (Non-Medicaid) as a separate section under the topic<br><br>Impact: None/Clarity | AI/ANs with Medicaid who have ever received a service (e.g., a primary care, dental, behavioral health visit etc.) from the Indian Health Service, tribal health programs, or through a PRC referral are exempt from cost-sharing which includes copayments or coinsurance for Medicaid services. Therefore, there is no cost to the PRC program for Medicaid services provided. AI/ANs can self-attest that they have ever received services from IHS or a tribal health program.<br><br>J. Coordinating Benefits with Health Care Coverage Purchased under 25 U.S.C. 1642 ("sponsorship"). IHS considers sponsorship through indemnity to be an alternate resource under the payer of last resort rule. | J. Medicaid Coordination. AI/ANs with Medicaid who have ever received a service (e.g., a primary care, dental, behavioral health visit etc.) from the Indian Health Service, tribal health programs, or through a PRC referral are exempt from cost-sharing which includes copayments or coinsurance for Medicaid services. Therefore, there is no cost to the PRC program for Medicaid services provided. AI/ANs can self-attest that they have ever received services from IHS or a tribal health program.<br><br>K. Coordination of Other Benefits (Non-Medicaid). When an alternate resource is identified that will require the IHS to pay a portion of the medical care costs, IHS will obligate the funds for the estimated balance, after alternate resource payment, with corresponding distribution of the form. In these situations, the obligating document, must clearly indicate that payment |

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| | | will not be processed and disbursed unless and until the provider has billed and received payment from the alternate resource. An explanation of benefits (EOB) or, in cases of denial from the alternate resource, a copy of the denial notice for the record. |
| 2-3.9 Authorization for Purchase/Referred Care –<br><br>C. PRC rates for services provided by Medicare participating hospitals – In the event a hospital is balance billing patients after PRC payment – omitted (iii), (iv) and (v) as requested<br><br><u>Impact</u>: None omitted were under the authority of CMS | (1) PRC Rates for services furnished by Medicare-Participating Hospitals - 42 CFR 136 Subpart D Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173), requires hospitals and critical access hospitals to participate in PRC programs. Section 506 directed the Secretary to set forth a payment methodology, payment rates, and admission practices through regulation for the PRC services provided by Medicare-participating hospitals. Any payments made under the PRC program are considered payment in full and the patients must not be billed for any remaining balance. See 42 CFR 482.29, 42 CFR 136.30 and also 25 U.S.C. 1621u.<br>a. In the event a hospital is balance billing patients after PRC payment.<br>(i) Notify the hospital of the law, if the hospital refuses to comply.<br>(ii) Notify the Area PRC Officer who will notify the Regional CMS Native American Contact (NAC).<br>(iii) The NAC will notify the CMS Survey and Certification Division.<br>(iv) The Survey and Certification Division will contact the hospital and allow them to have a 90 day corrective action plan to remedy the infraction.<br>(v) After 90 days if the action has not been remedied, CMS will pull the hospital's CMS certification. | (1) PRC Rates for services furnished by Medicare-Participating Hospitals - 42 CFR 136 Subpart D Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173), requires hospitals and critical access hospitals to participate in PRC programs. Section 506 directed the Secretary to set forth a payment methodology, payment rates, and admission practices through regulation for the PRC services provided by Medicare-participating hospitals. Any payments made under the PRC program are considered payment in full and the patients must not be billed for any remaining balance. See 42 CFR 482.29, 42 CFR 136.30 and also 25 U.S.C. 1621u.<br><br>a. In the event a hospital is balance billing patients after PRC payment.<br><br>(i) Notify the hospital of the law, if the hospital refuses to comply.<br><br>(ii) Notify the Area PRC Officer who will notify the Regional CMS Native American Contact (NAC). |

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| 2-3.10 Electronic Signatures Corrected the name of Pub. L. 106-229<br><br>Impact: None/Clarity rule | A. Electronic Signature for PRC Purchase Order. Pub. L. 106-229 (Electronic Signature Act) provides for the use of electronic signatures. The electronic signature promotes the use of electronic contract formation, signatures, and record keeping in private commerce by establishing legal equivalence between: | A. Electronic Signature for PRC Purchase Order. Pub. L. 106-229 (Electronic Signatures in Global and National Commerce Act) provides for the use of electronic signatures. The electronic signature promotes the use of electronic contract formation, signatures, and record keeping in private commerce by establishing legal equivalence between: |
| 2-3.11 Payment Denials and Appeals –<br>E. Tribal Appeal Process – Title I and V Programs –<br>(1) added, IHS will use Tribal Medical Priorities if provided<br><br>Impact: Allows IHS to adjudicate appeals within Tribal Medical Priorities | (1) The Area Director and the Director, IHS, will utilize the IHS regulations and interpretations, not Tribal criteria and interpretations, to adjudicate claims. The IHS utilizes its medical priorities and policies to adjudicate IHS PRC claims. | (1) The Area Director and the Director, IHS, will follow the IHS regulations and interpretations to adjudicate claims but will adopt tribal standards for close economic and social ties, medical priority and high cost case management, as applicable. |
| 2-3.12 Management of Purchased/Referred Care Fund<br><br>This was an addition to the Chapter to meet a GAO recommendation<br><br>Impact: Ability to increase staffing in PRC | B. Use of PRC Funds for Staff Administering the PRC Program. PRC funds may be used for staff administrating the PRC program at administrative levels, including for the support of HQ and Area positions. PRC funds may be used for staff at the service unit level PRC programs as long as the following conditions are met:<br><br>(1) The PRC program is purchasing care beyond Medical Priority II and using funds for PRC staff does not preclude payment for Priority II throughout the year; and<br><br>(2) The PRC program reports the following information to the Area Director annually: the medical priority level the program is purchasing; the number, grade level and salary of full or part time employees supported by PRC funds; and the | B. Use of PRC Funds for Staff Administering the PRC Program. PRC funds may be used for staff administrating the PRC program at administrative levels, including for the support of HQ and Area positions. PRC funds may be used for staff at the service unit level PRC programs as long as the following conditions are met:<br><br>(1) The PRC program is purchasing care beyond Medical Priority II and using funds for PRC staff does not preclude payment for Priority II throughout the year; and<br><br>(2) The PRC program reports the following information to the Area Director annually: the medical priority level the program is purchasing; the number, grade level and salary of full or part time employees supported by PRC funds; and the number of any |

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| | number of any denied and deferred services for Priority II care; and<br><br>(3) The Area Director reports by October 10, annually to the Director, DCC, ORAP, for each Area Service Unit, the following information: medical priority level each program is purchasing; the number, grade level and salary of full or part time employees supported by PRC funds; and the number of denied and deferred services for Priority II care. | denied and deferred services for Priority II care; and<br><br>(3) The Area Director reports by October 10, annually to the Director, DCC, ORAP, for each Area Service Unit, the following information: medical priority level each program is purchasing; the number, grade level and salary of full or part time employees supported by PRC funds; and the number of denied and deferred services for Priority II care. |
| 2-3.21 Prompt Action on Payment of Claims Also Known As The PRC "Five-Day Rule"<br>Omitted Notification of a Claim as requested as it was duplicated information already provided earlier in the chapter<br><br><u>Impact</u>: None Duplicative | B. Notification of a Claim. For the purposes of part 136, and also 25 U.S.C. 1621s and 1646, the submission of a claim that meets the requirements of 42 CFR 136.24.<br><br>(1) Such claims must be submitted within 72 hours after the beginning of treatment for the condition or after admission to a health care facility notify the appropriate ordering official of the fact of the admission or treatment, together with information necessary to determine the relative medical need for the services and the eligibility of the Indian for the services.<br>(2) The information submitted with the claim must be sufficient to:<br>a. Identify the patient as eligible for IHS services (e.g., name, address, home or referring service unit, Tribal affiliation),<br>b. Identify the medical care provided (e.g., the date(s) of service, description of services), and<br>c. Verify prior authorization by the IHS for services provided (e.g., IHS purchase order number or medical referral form) or exemption from prior authorization (e.g., copies of pertinent clinical information for | |

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| | emergency care that was not prior-authorized). | |
| 2-3.21 Prompt Action on Payment of Claims Also Known As The PRC "Five-Day Rule"<br><br>B. Failure to Timely Respond – added language for clarity<br><br><u>Impact:</u> None/Clarity | C. Failure to Timely Respond. If IHS fails to respond to a notification of a claim as defined in 2-3.21A, IHS shall accept the claim as a valid claim for PRC services. | B. <u>Failure to Timely Respond</u>. If IHS fails to respond to a notification of a claim that contains the information required by 42 C.F.R. § 136.24, IHS shall accept the claim as a valid claim for PRC services. The Notification of a Claim must include sufficient information so that IHS may make a decision about a claim. IHS will not adjudicate a Notification of a Claim that does not contain the information from the individual, or as applicable, the provider or supplier, necessary to make a decision. |

# *NPAIHB Legislative & Policy Update*

**NPAIHB Quarterly Board Meeting**

**Hosted by: California Rural Indian Health Board**

**Lincoln, CA**

**July 16, 2019**

# Report Overview

1. Hot Topics
2. Legislation
3. Future IHS Appropriations & Budget Formulation
4. New & Pending Federal Policies
5. Litigation
6. Upcoming National/Regional Meetings

# Hot Topics

- *Texas v. United States* - Threat to the ACA/IHCIA
- House Appropriations for IHS and HHS
- SDPI Reauthorization and Funding
- Lower Health Care Costs/Surprise Billing
- CMS Work Requirements

# Legislation

# FY 2020 Labor HHS Education Appropriations

- On 6/19/19, House passed four-bill FY 2020 appropriations package (226 to 203)
  - HHS: $99.4 billion (+$8.9 billion above FY 2019 enacted level)
    - NIH: $41.1 billion (+2 billion)
    - CDC: $8.3 billion (+$938 million)
    - SAMHSA: $5.9 billion (+129 million)
    - HRSA: $7.6 billion (+$485 million)
    - CMS: $4 billion (+$315 million)
    - ACF: $27.9 billion (+$4.7 billion)
    - ACL: $2.3 billion (+$180 million)
    - Office of the Secretary: $550 million (+$5 million)
- Senate Bill Status: Not released; testimony submitted

# FY 2020 House Labor HHS Education Appropriations- Indian programs

- CDC:
  - Good Health and Wellness in Indian Country- $21m (level)
- SAMHSA:
  - Tribal Opioid Response Grants-$50m (level)
  - Medication Assisted Treatment Grants for Tribes-$10m (level)
  - AI/AN Zero Suicide Program-$2.2m
  - AI/AN Suicide Prevention-$2.9m
- ACL:
  - Native American Nutrition and Supportive Services-$37.2m (+$3m)
  - Native American Caregiver Support Services-$12m (+$2m)
- HRSA
  - NHSC Loan Repayment Program to individuals who work for I/T/Us-$15m

# FY 2020 Interior IHS Appropriations Summary

- National Tribal Budget Formulation Workgroup recommended over $7 billion for IHS for FY 2020 (36% increase over FY 2017 enacted level).
- President Released Budget on 3/11/19
  - $82.6m increase above FY 2019 for services and facilities (1.7%) or $115 m (2%) increase overall above 2019 enacted level
- House Bill Status:
  - On 6/25/19, House passed Interior appropriations bill (with 4 others).
    - $6.3 billion or $537m above FY 2019 enacted level
- Senate Bill Status: Not released; testimony submitted

# FY 2020 Interior IHS Appropriations- President & House

| | FY 2019 Enacted | Pres Req. FY 2020 | House Bill FY 2020 | Enacted vs. House Bill |
|---|---|---|---|---|
| Clinical Svcs | $3,739,961 | $3,996,963 | $4,120,282 | +$380,321 |
| Prev Health | 174,742 | 118,257 | 181,062 | +$6,320 |
| Other Svcs | 188,487 | 171,321 | 255,526 | +67,039 |
| **Total Services** | **4,103,190** | **4,286,541** | **4,556,870** | **+453,680** |
| Facilities | 878,806 | 803,026 | 964,121 | +85,315 |
| **Total w/o CSC** | **$4,981,996** | **$5,089,567** | **$5,520,991** | **+$538,995** |
| CSC | 822,227 | 820,000 | 820,000 | -2,227 |
| **Total w/CSC** | **$5,804,223** | **$5,909,567** | **$6,340,991** | **+$536,768** |

Advance Appropriations: Committee directs IHS to examine its existing processes and determine what changes are needed to develop and manage an advance appropriation and report to the Committee within 180 days of enactment of this Act on the processes needed and whether Congressional authority is required in order to develop the processes.

# FY 2020 IHS Clinical Services- President & House

| | FY 2019 Enacted | Pres Req. FY 2020 | House Bill FY 2020 | Enacted vs. House Bill |
|---|---|---|---|---|
| H&HC* | $2,147,343 | $2,363,278 | $2,420,568 | +273,235 |
| EHR | 0 | 25,000 | 25,000 | +25,000 |
| Dental | 204,672 | 212,369 | 227,562 | +22,890 |
| MH | 105,281 | 109,825 | 125,332 | +20,051 |
| Alcohol/SA | 245,566 | 246,034 | 280,151 | +34,485 |
| PRC | 964,819 | 968,177 | 969,479 | +4,660 |
| IHCIF | 72,280 | 72,280 | 72,280 | |
| **Totals:** | **$3,739,961** | **$3,996,963** | **$4,120,282** | **+$380,321** |

*H&HC Highlights: includes $20m for CHAP expansion; $4m increase for DV prevention; $2m increase for TECs; $17m increase for 105(l) leases; $25m for HIV/HCV treatment and prevention

# FY 2020 IHS Preventative Health- President & House

| | FY 2019 Enacted | Pres Req. FY 2020 | House Bill FY 2020 | Enacted vs. House |
|---|---|---|---|---|
| PH Nursing | $89,159 | $92,084 | $95,307 | +$6,148 |
| Health Educ* | 20,568 | 0 | 20,669 | +101 |
| CHRs* | 62,888 | 24,000 | 62,913 | +$25 |
| Immun AK | 2,127 | 2,173 | 2,173 | +46 |
| **Totals:** | **$174,742** | **$118,257** | **$181,062** | **+$6,320** |

*Health Education & CHRs: House bill includes increases for both line items.

# FY 2020 IHS Other Services- President & House

| | FY 2019 Enacted | Pres Req. FY 2020 | House Bill FY 2020 | Enacted vs. House Bill |
|---|---|---|---|---|
| Urban Health | $51,315 | $48,771 | $81,000 | +$29,685 |
| IHP* | 57,363 | 43,612 | 90,656 | +33,293 |
| Tribal Mngt | 2,465 | 0 | 2,521 | +56 |
| Direct Ops | 71,538 | 74,131 | 75,385 | +3,847 |
| Self Gov | 5,806 | 4,807 | 5,964 | +158 |
| **Totals:** | **$188,487** | **$171,321** | **$255,526** | **+67,039** |

*IHP Highlight: Bill language provides $50m for the loan repayment program

# FY 2020 IHS Facilities- President & House

| | FY 2019 Enacted | Pres Req. FY 2020 | House Bill FY 2020 | Enacted vs. House Bill |
|---|---|---|---|---|
| M&I | $167,527 | $168,568 | $174,336 | +$6,809 |
| Sanitation | 192,033 | 193,252 | 193,577 | +1,544 |
| HC Fac Const* | 243,480 | 165,810 | 304,290 | +60,810 |
| Fac & Envir. | 252,060 | 251,413 | 266,831 | +14,771 |
| Equipment | 23,706 | 23,983 | 25,087 | +1,381 |
| **Totals:** | $878,806 | $803,026 | $964,121 | +85,315 |

*Health Care Facilities Construction: Includes $10m for Green Infrastructure.

Joint Venture Construction Program: Committee urges the Service to consult with tribes to determine and open competitions on a regular cycle of between three to five years.

# Other Directives in House Bill

- 105(l) Leases:
  - Report required within 90 days on treatment of 105(l) leases like CSC and estimated costs in current and next fiscal year.
- Electronic Health Records (EHR):
  - Must provide notice at least 90 days before funds are obligated or expended by IHS; and directive to look at VA system.
- VA MOU:
  - Urges IHS to look at performance measures related to MOUs.
- Electronic Dental Records (EDR):
  - Directs IHS to include EDR in its assessment.

# Advanced Appropriations Bills for BIA/BIE/IHS and IHS only

- **S. 229 & H.R. 1122 – Advanced Appropriations for BIA and BIE at DOI and IHS at HHS.**
  - Senate Bill introduced by Sen. Tom Udall (D-NM) on 1/25/19.
  - House Bill introduced by Rep. Betty McCollum (D-MN-4) on 2/8/19.
  - **Status**: Both referred to respective House and Senate Committees.
- **H.R. 1135 –Advanced Appropriations for IHS.**
  - House Bill introduced by Rep. Don Young (R-AK- At Large) on 2/8/19; referred to Committees.
  - Senate Bill anticipated to be introduced.
  - **Status**: In House Committees.

# Special Diabetes Program for Indians Reauthorization

SDPI expires September, 2019. Several bills to reauthorize:

- **H.R. 2328- Community Health Investment, Modernization, and Excellence Act of 2019** (Rep. Tom O'Halleran (D-AZ)-4 years at $150m)
  - **Status**: 7/11/19- House E&C Health Markup
- **H.R. 2668 – Special Diabetes Program Reauthorization Act of 2019** (Rep. Diana DeGette (D-CO)-5 years at $200m)
  - **Status**: 6/4/19- House E&C Health Subcommittee Hearing
- **H.R. 2680 – Special Diabetes Programs for Indians Reauthorization Act of 2019** (Rep. Tom O'Halleran (D-AZ)- 5 years at $200m)
  - **Status**: 6/4/19-House E&C Health Subcommittee Hearing
- **H.R. 2700 – Lowering Prescription Drug Costs and Extending Community Health Centers and Other Health Priorities Act** (Rep. Michael Burgess (R-TX)- 1 year extension at $150m)
  - **Status**: 6/26/19- In Committees
- **S. 192 - Community and Public Health Programs Extensions Act)** (Sen. Lamar Alexander (R-TN) – 5 years at $150m)
  - **Status**: 1/18/19- In HELP Committee
- **S. 1895- Lowering Health Care Costs Act** (Sen. Lamar Alexander (R-TN) – 5 years at $150m)
  - **Status**: 7/8/19- Placed on Senate Leg Calendar

# Indian Health Professions Bills

- **H.R. 3340- Tribal Healthcare Careers Act**
  - Introduced by Jimmy Gomez (D-CA) on 6/19/19
  - Provides a set-aside of funds for Indian populations under the health profession opportunity grant program under Section 2008 of the Social Security Act.
  - **Status**: Referred to Ways & Means
- **H.R. 3343- Technical Assistance for Health Grants Act**
  - Introduced by Daniel Kildee (D-MI) on 6/19/19
  - Provides for technical assistance under health profession opportunity grant program under section 2008 of Social Security Act.
  - **Status**: Referred to Ways & Means

# Other Indian Specific Health & DOI Bills

- **Pay Our Doctors Act (H.R. 195)**
  - **Status**: In Committee
- **Native American Suicide Prevention Act of 2019 (S. 467 & H.R. 1191)**
  - **Status:** In House and Senate Committees
- **Assessment of the Indian Health Service Act (S. 498)**
  - **Status:** In Committee
- **Urban Indian Health Parity Act (S. 1180/H.R. 2316)**
  - **Status:** In House and Senate Committees
- **PROGRESS for Indian Tribes Act (S. 209 & H.R. 2031)**
  - **Status**: Passed Senate on 6/17/19; In House Committee

# Opioid Bills

- **Comprehensive Addiction Resources Emergency Act of 2019 (CARE) (S. 1365 & H.R. 2569)**
  - Provides emergency assistance to states, territories**, tribal nations**, and local areas affected by the opioid epidemic, and financial assistance, for the development, organization, coordination and operation of more effective and efficient systems for the delivery of essential services to individuals with substance use disorder and their families.
  - **S. 1365**- Introduced by Sen. Elizabeth Warren (D-MA) on 5/8/19.
    - **Status**: In HELP Committee
  - **H.R. 2569**- Introduced by Rep. Elijah Cummings (D-MD) on 5/8/19.
    - **Status**: 5/13/19-Referred to Indigenous Peoples of the United Status Subcommittee (Natural Resources)
- **Examining Opioid Treatment Infrastructure Act of 2019 (H.R. 1303)**
  - **Status**: In Committee

# Other Health Bills

- **Lower Health Care Costs Act (S. 1895)-**Sen. Alexander Lamar (R-TN)
  - Purpose is to lower health care costs, extend community health centers and SDPI
    - **Status:** 7/8/19: Placed on Senate Legislative Calendar
- **Aligning 42 CFR Part 2 with HIPAA**
  - **Protecting Jessica Grub's Legacy Act (S. 1012)**-Sen. Joe Manchin (D-WV)
    - **Status**: 4/3/19-In HELP Committee
  - **Overdose Prevention and Patient Safety Act (H.R. 2062)**-Rep. Earl Blumenauer (D-OR)
    - **Status**: 4/3/19-In E&C Committee
- **PrEP Assistance Program Act (H.R. 1643) & PrEP Coverage Access and Coverage Act (S. 1926)**
  - **Status:** In House and Senate Committees

# Veterans' Bills

- **Tribal HUD-VASH Act of 2019 (S. 257)**
  - **Status**: 6/27/19-Passed Senate; Referred to House Committee on Financial Services
- **Veterans Improved Access and Care Act of 2019 (S. 450)**
  - **Status**: 5/22/19-Senate VA Hearings
- **Department of Veterans Affairs Tribal Advisory Committee Act of 2019 (S. 524 & H.R. 2791)**
  - **Status**: 5/22/19-Senate VA Hearings; 5/16/19-Referred to House Committee on VA Affairs
- **Commander John Scott Veterans Mental Health Improvement Act of 2019 (S. 785)**
  - **Status**: 5/22/19-Senate VA Hearings
- **Tribal Veterans Health Care Enhancement Act (S. 1001)**
  - **Status**: 5/22/19-Senate VA Hearings

# DV & Missing AI/AN Bills

- **Violence Against Women's Act of 2019 (H.R. 1585)**
  - **Status:** 4/4/19-Passed House; 4/10/19-Placed on Senate Legislative Calendar
- **Not Invisible Act (S. 982 & H.R. 2438)**
  - **Status:** 6/19/19- SCIA; 5/10/19-Referred to Indigenous People's of the U.S. Subcommittee
- **Studying the Missing and Murdered Indian Crisis Act of 2019 (S. 336)**
  - **Status:** 2/5/19- SCIA

# Future IHS Appropriations & Budget Formulation

# FY 2021 IHS Budget Formulation

- National Tribal Budget Formulation Workgroup met on March 14-15, 2019 in Washington D.C. and recommended full funding for IHS at $37.61 billion to be phased in over 12 years.
- For FY 2021, a total of $9.1 billion for IHS is requested. Includes:
  - $257 m for full funding of current services
  - $413 m for binding fiscal obligations
  - $2.7 b for program increases (46% above FY 2019 enacted level)
  - And more!

# FY 2021 IHS Budget Formulation Cont'd

- Other recommendations for IHS:
  - Support preservation of Medicaid, IHCIA and Indian-specific provisions of the ACA.
  - Fund critical infrastructure investments (Health IT/HCFC)
  - Exempt Tribes from Sequestration
  - Support Advance Appropriations
  - Allow federally-operated health facilities and IHS headquarters to use federal dollars efficiently and adjust programmatic funds flexibly across accounts at the local level
  - Support funding of tribes outside of grants based system.
  - Permanently authorize SDPI and increase funding to $200 m per year plus annual inflationary increases.
  - Take a adequate steps to fully address 105(l) leasing obligations and work proactively with Congress to ensure its full payment as an indefinite appropriation.
- Available at: https://www.nihb.org/legislative/budget_formulation.php

# FY 2022 IHS Budget Formulation

- National Tribal Budget Formulation Workgroup (NTBFW) met on June 27-28 in Reno, Nevada.
- Workgroup decided to request full funding now (not 12 year phased in funding).
  - An analysis will be conducted to determine what that amount is.
- Recommendation for FY 2022 will be based on NTBFW request for FY 2021, plus 30%.
- Portland Area Budget Formulation Meeting for FY 2022 is November 14, 2019 in Portland, Oregon- location TBD.

# New & Pending Federal Policies

HHS STAC Meeting, Phoenix, AZ, May, 2019

# Executive Orders

- **Improving Price and Quality Transparency in American Health Care to Put Patients First**-Issued 6/24/19
  - Within 60 days, HHS Secretary must issue a proposal to require hospitals to post standard charge information
  - Within 90 days, Secretaries of HHS, Treasury and Labor to issue a proposal to require providers, issuers and plans to facilitate access to information that tells patients about expected out-of-pocket costs before they receive care
- **Evaluating and Improving the Utility of Federal Advisory Committees**
  - Directs agencies to terminate at least 1/3 of its current committees established under 9(a)(2) of FACA, including other committees.
  - Agencies must send OMB a list of all their advisory committees and recommendations on which ones to eliminate by August 1.
  - OMB has one month to take recommendations to President
  - **We understand that no tribal advisory committees will be impacted at IHS or HHS (per IHS leadership)**

# Pending Responses from HHS

- **HHS Office of National Coordinator (ONC) 21st Century Cures Act and CMS Interoperability, Information Blocking and the ONC Health IT Certification Program**; issued 3/4/19; comments due 6/3/19; comments submitted
- **HHS Office of HIV/AIDS and Infectious Disease Policy STD Federal Action Plan;** issued 5/3/19; comments due 6/3/19; expected June, 2020
- **HHS RFI on National HIV/AIDS Strategy and National Viral Hepatitis Action Plan**; issued 2/8/19; comments submitted; expected June, 2020
- **HHS Pain Management Best Practices Inter-Agency Task Force Draft Report on Pain Management Best Practices**; issued 12/31/18
- **HHS Tribal Consultation Policy**; DTLL 10/22/18; comments submitted
- **HHS Draft Strategy to Reduce Regulatory and Administrative Burden of Health IT and EHRs**; comments submitted
- **Disbanding of the OMH AI/AN Health Resource Advisory Committee (HRAC)**

# CMS Nondiscrimination in Health and Health Education Programs or Activities

- Issued: 6/14/19; comments due 8/13/19
- In May 2016, OCR HHS published a final rule (2016 Rule) that sought to codify nondiscrimination requirements and set forth new standards for implementing Section 1557 of the Affordable Care Act (ACA), particularly with respect to the prohibition of discrimination on the basis of sex.
- HHS interpreted that Congress did not intend for Section 1557 of the ACA to prohibit discrimination based on gender identity and termination of pregnancy.
- Senate Health Committee ranking Democrat Patty Murray (WA) and 30 Democratic Senate colleagues are demanding HHS withdraw its recent proposed rule that scales back the protections under Section 1557.
- The Senators want HHS to explain its reasoning for removing protections for transgender individuals, women who have terminated pregnancy and people with limited English proficiency by July 18th.

# Pending Responses and/or Ongoing Issues with CMS

- **CMS Medicaid and CHIP Managed Care Proposed Rule** - comments submitted 1/28/19.
- **CMS Work Requirements**
- **CMS Four Walls Limitation- FAQs**
- **CMS Decision on Appeal of Washington DHAT SPA**

# National Institutes of Health

- Tribal consultation on three initiatives:
  - Tribal Consultation on NIH Intellectual Property Rights in Biomedical Research; comments due 8/22/19.
  - Request for Comments on NIH Draft Policy on Data Sharing Management; DTLL 4/17/19; comments due 8/22/19.
  - Tribal Consultation and Listening Session on the All of Us Research Program; comments/testimony due 8/31/19.
    - Feedback received through the tribal consultation and other public engagement efforts will result in a plan for working with Tribal Nations.
    - More info available at: https://allofus.nih.gov/about/all-us-tribal-engagement

# Recent IHS DTLLs

- **Invitation to Provide Updated Facility Master Plans and/or Identified Health Care Facility Needs to Local IHS Area Facilities Program Director for Possible Inclusion in the 2021 IHS and Tribal Health Care Facilities Needs Assessment Report to Congress**; DTLL 7/5/19; data due on 12/31/19
- **Update on New Appointments and Updates to the Indian Health Service Senior Leadership Team**; DTLL 7/3/19

# Recent IHS DTLLs Cont'd

- **Initiation of Tribal Consultation and Urban Confer on Developing IHS Opioid Grant Program to Distribute the FY 2019 Opioid Funding**; DTLL 7/5/19; comments due 8/1/19
  - Related to $10m for Special Behavioral Health Program for Indians FY 2019 appropriation
- **Update on Sanitation Deficiency System-A Guide for Reporting Sanitation Deficiencies for AI/AN Homes and Communities;** DTLL 5/24/19.
  - IHS Facilities Appropriations Advisory Board reviewed comments and provided recommendations
- **Results of Tribal Consultation on the Indian Health Manual Part 2, Chapter 3-PRC**; DTLL on 5/15/19.
  - PRC Workgroup was advised of changes

# Pending IHS Responses

- **Tribal Consultation on Community Health Aide Program Interim Policy**; DTLL on 5/8/19; comments due 7/8/19; comments submitted.
  - IHS Community Health Aide Program (CHAP) Workgroup to review comments
- **Tribal Consultation on Long and Short Term Options for Meeting ISDEAA 105(l) Requirements**; DTLL on 3/12/19; comments submitted.
  - IHS technical workgroup trying to determine costs
- **Update on the Mechanism to Distribute Behavioral Health Initiative Funding**; DTLL on 12/11/18; comments submitted.
  - IHS National Tribal Advisory Committee (IHS NTAC) provided a recommendation to RADM Weahkee.
- **Contract Support Costs – Indian Health Manual, Chapter 3 CSC**, rescission of 97/3 split language; DTLL 4/13/18; comments submitted.
  - CSC Workgroup Tribal Chairman, Andy Joseph, Jr., requested an update; IHS close to finalizing a decision & meeting in Aug/Sept

# HRSA UPDATES

- HRSA Shortage Designation Modernization Project (SDMP) will update existing Auto-HPSA designation scores in August 2019 through an online portal.
- New Auto-HPSA scores will be applicable to the 2020 National Health Service Corp application cycle.
  - Clinics will be able to update their HPSA score in the online portal after the national rollout.
  - Clinics should collect and submit facility-specific data and supplemental data to increase scores in replacement of the ACS data.
  - HRSA and IHS are working to identify data sources to assist in increasing scores for I/T/Us prior to national rollout.
- June 25 Webinar: Auto-HPSA Portal Training for I/T/Us.
  - Webinar recordings available at: https://bhw.hrsa.gov/sdmp
- Apply for the NHSC Rural Community Loan Repayment Program Grant Application through July 18

# VA Updates

- VA DTLL: Requests comments on implementation of VA MISSION Act; DTLL on 4/16/19; Comments submitted 6/10/19.
- VA and White House launched a Veteran Suicide Prevention Task Force to create a roadmap to empower veterans and end the national tragedy of suicide (PREVENTS Executive Order)
  - Inclusion of a community integration and collaboration proposal, a national research strategy and an implementation strategy.
- VA extends Agent Orange presumption to Blue Water Navy Veterans who served offshore of the Republic of Vietnam between 1962 and 1975 to be eligible for disability compensation benefits.

# Litigation

# *Texas v. United States*
# Challenge to Affordable Care Act

- On December 14, 2018, Judge Reed O'Conner (USDC ND Texas) held:
  - That the individual mandate enacted as part of the ACA is unconstitutional because it cannot be justified under Congress' taxing power (Congress reduced tax penalty to $0).
  - The entire ACA must be invalidated because the individual mandate is not severable and essential to the ACA's operation.
- If ACA struck down, ICHIA would also be struck down.
- Appealed to USCA for the the Fifth Circuit.
- 483 tribes and tribal organizations(including NPAIHB) joined an amicus brief.
- On March 25, 2019, a coalition of states intervened in the case in order to defend the ACA while Department of Justice filed a two-sentence letter with the court announcing that the U.S. had changed its position in the litigation.
- On July 9, 2019, a three-panel judge in the Fifth Circuit heard oral arguments.
- Ruling expected in the coming months.

# *Brackeen v. Bernhardt*
# Challenge to ICWA

- On 10/5/18, Judge Reed O'Conner (USDC ND Texas) ruled that ICWA is unconstitutional in Brackeen v. Zinke.
- Found that *Morton v. Mancari* rule does not apply because ICWA extends to Indians who are not members of tribes.
- ICWA struck down in violation of equal protection.
- Appealed to USCA for the Fifth Circuit and now titled, *Brackeen v. Bernhardt*.
- Many tribes and tribal organizations (including NPAIHB) joined the amicus brief.
- On March 13, 2019, oral argument occurred before a panel of 3 judges.
- Decision pending in Fifth Circuit.

# Opioid Litigation

- All federal court lawsuits have been combined in multi-district litigation under Federal District Judge Dan A. Polster (USDC-ND Ohio)
- Over 100 tribes and tribal organizations joined 1,000 state and local governmental plaintiffs in the litigation.
- Tribal Amicus Brief: 448 tribes and tribal organizations signed on and provided statements of interest (NPAIHB, ATNI, NCAI, and NIHB).
- **Status**:
  - Two Tribal Cases selected as bellweather cases ---Muscokee (Creek) Nation and Blackfeet Tribe.
  - On June 13, 2019, Judge Polsner issued a Motion Opinion and Order ruling on the Motions to Dismiss.
  - The Order adopts most of the recommendations by Magistrate David Ruiz recommending to the court that the Motions to Dismiss be denied with respect to the vast majority of tribes' claims.
  - In the multidistrict litigation, plaintiffs continue to pursue a settlement.

# Upcoming National/Regional Meetings

HHS Annual Tribal Budget Consultation, Washington, DC

# July-September 2019

- TSGAC Quarterly Meeting, July 16-19, Washington, D.C
- MMPC/TTAG Meeting, July 23-25, Washington, D.C.
- 16th Annual DSTAC Meeting, July 30-31, Albuquerque, NM
- Region X Opioid Summit, August 6-9, Vancouver, WA
- 2019 Diabetes in Indian Country Conference, August 6-9, Oklahoma City, OK
- Center for State, Tribal, Local and Territorial Support (CSTLTS), CDC/ATSDR Tribal Advisory Committee (TAC) Meeting and 19th Biannual Tribal Consultation; August 13-14, Cherokee, NC (Testimony Due: 7/19/19)
- NCAI Impact Days, September 10-11, Washington, D.C.
- TSGAC Strategy Session, September 10-11, Washington, D.C.
- HHS STAC Meeting, September 12-13, Washington, D.C.

# September-October 2019

- NIHB National Tribal Health Conference, September 16-19, Temecula, CA
- IHS TSGAC Quarterly Meeting, October 2-3, Washington, D.C.
- ATNI Fall Convention, October 7-10, Suquamish
- PRC Workgroup Meeting, October 15-17, Washington, D.C.
- NCAI Annual Convention, October 20-25, Albuquerque, NM
- Quarterly Board Meeting, October, 21-24, Pendleton, OR

# Discussion and Questions


HHS Secretary's Tribal Advisory Committee Meeting, Fairbanks, AK

# California Rural Indian Health Board (CRIHB) & Northwest Portland Area Indian Health Board (NPAIHB) Joint 15th Biennial Board of Directors Meeting

**July 15-18, 2019**
**Thunder Valley Resort, Lincoln, CA**

## AGENDA

**MONDAY, JULY 15, 2019**

| | |
|---|---|
| 8:00 AM – 9:00 AM | REGISTRATION |
| 9:00 AM – 2:30 PM | JOINT TRIBAL GOVENMENTS CONSULTATION COMMITTEE (TGCC) AND PROGRAM DIRECTORS MEETING – ROOM A |
| 2:30 PM – 5:00 PM | TGCC MEETING CONTINUED – ROOM A |
| 2:30 PM – 5:00 PM | PROGRAM DIRECTORS BREAKOUT – SIERRA ROOM |
| 9:00 AM – 11:00 AM | NPAIHB CHAP BOARD ADVISORY MEETING – ROOMS D & E |
| 2:00 PM – 5:00 PM | NPAIHB TRIBAL HEALTH DIRECTORS MEETING – ROOM E |
| 4:30 PM – 5:00 PM | CRIHB BYLAWS AND POLICY COMMITTEE – HOTEL BOARD ROOM |
| 5:00 PM – 5:30 PM | CRIHB GRIEVANCE AND COMPLIANCE MEETING – ROOM A |
| 5:30 PM – 6:00 PM | CRIHB PERSONNEL COMMITTEE – ROOM A |
| 4:00 PM – 7:00 PM | YOUTH CONFERENCE - ROOMS D & E |
| 7:00 PM – 9:00 PM | WELCOME/MEET AND GREET (HORS D'OEUVRE PROVIDED) – THUNDER VALLEY POOL |

**TUESDAY, JULY 16, 2019**

| | |
|---|---|
| 8:00 AM – 9:00 AM | REGISTRATION |
| 8:00 AM – 3:30 PM | YOUTH CONFERENCE – CRIHB OFFICE |
| 8:30 AM – 9:00 AM | CRIHB CREDENTIALS COMMITTEE |
| 9:00 AM – 3:00 PM | CRIHB BOARD OF DIRECTORS MEETING – ROOM A |
| 9:00 AM – 3:00 PM | NPAIHB BOARD MEETINGS – ROOMS D & E |
| 4:00 PM – 7:00 PM | OPENING RECEPTION (TRANSPORTATION AND DINNER PROVIDED) – CRIHB OFFICE |

**WEDNESDAY, JULY 17, 2019**

| | |
|---|---|
| 8:00 AM – 9:00 AM | REGISTRATION |
| 8:00 AM – 5:00 PM | YOUTH CONFERENCE – CRIHB OFFICE |
| 8:30 AM – 4:45 PM | JOINT BOARD OF DIRECTORS MEETING – ROOM A |
| 12:00 PM – 1:30 PM | PROVIDED BUFFET LUNCH – ROOM A |
| 4:45 PM – 5:30 PM | PUBLIC HEALTH ACCREDITATION OPEN SESSION – ROOM A |
| 6:00 PM – 7:00 PM | CRIHB BOARD/CEO DIALOGUE DINNER – CLOSED SESSION – SIERRA ROOM |

**THURSDAY, JULY 18, 2019 (CHECKOUT DATE)**

| | |
|---|---|
| 8:00 AM – 10:00 AM | PROVIDED BREAKFAST BUFFET – ROOM A |
| 8:00 AM – 3:00 PM | YOUTH CONFERENCE – CRIHB OFFICE |
| 8:30 AM – 5:00 PM | JOINT BOARD OF DIRECTORS MEETING – ROOM A |

# *JOINT BOARD OF DIRECTORS MEETING (ROOM A)*

**Thunder Valley Resort, Lincoln, CA**
**Wednesday, July 17, 2019**
**AGENDA**

| | | |
|---|---|---|
| 8:30 a.m. | Call to Order<br>Invocation | Andy Joseph, NPAIHB Board Chair<br>Lisa Elgin, CRIHB Board Chair |
| 9:00 a.m. | Welcoming Remarks & Introductions | Andy Joseph, NPAIHB Board Chair<br>Joe Finkbonner, NPAIHB Executive Director<br>Lisa Elgin, CRIHB Board Chair<br>Mark LeBeau, PhD, CRIHB Chief Executive Officer |
| 9:30 a.m. | National Indian Health Board (NIHB) Update | Stacy Bohlen, NIHB Executive Director |
| 10:00 a.m. | **BREAK** | |
| 10:15 a.m. | Indian Health Services (IHS) Update | Dean Seyler, Portland Area IHS Director<br>Beverly Miller, California Area IHS Director |
| 11:15 a.m. | CMS Update | Lane Terwilliger, CMS Division of Tribal Affairs |
| 12:00 p.m. | **BUFFET LUNCH** | **Provided** |
| 1:30 p.m. | EpiCenter Director Update | Victoria Warren-Mears, PhD, NPAIHB EpiCenter Director<br>Vanesscia Cresci, CRIHB Research & Public Health Director |
| 2:15 p.m. | Telehealth | Dr. Thomas Kim, CRIHB Medical Director |
| 3:00 p.m. | **BREAK** | |
| 3:15 p.m. | Office of Tribal Government Relations Veterans Affairs Update | Terry Bentley, Tribal Government Relations Specialist (confirmed)<br>Kara Hawthorne, Program Manager, VA IHS/THP Reimbursement Agreement Program |
| 3:45 p.m. | Community Health Aide Program & Dental Health Aide Therapist | Sue Steward, CHAP Project Director<br>Christina Peters, Tribal Community Health Provider Project Director |
| 4:45 p.m. | **Listening Session: Tribal Input to Public Health Accreditation (snacks provided for participants)** | Joe Finkbonner, NPAIHB Executive Director<br>Kaye Bender, Public Health Accreditation Board President & Chief Executive Officer |
| 5:30 p.m. | **RECESS** | |
| 6:00 p.m. | **CRIHB Board/CEO Dialogue** | Sierra Room – CLOSED SESSION |

# *JOINT BOARD OF DIRECTORS MEETING (ROOM A)*

**Thunder Valley Resort, Lincoln, CA**
**Thursday, July 18, 2019**
**AGENDA**

| | | |
|---|---|---|
| 8:00 a.m. – 10:00 a.m. | **Buffet Breakfast** | **Provided** |
| 8:30 a.m. | Call to Order<br>Invocation | Andy Joseph, NPAIHB Board Chair<br>Lisa Elgin, CRIHB Board Chair |
| 8:45 a.m. | Legislation Update | Geoff Strommer, Partner<br>Hobbs Straus Dean & Walker, LLP |
| 9:30 a.m. | **BREAK** | |
| 9:45 a.m. | Extension for Community Healthcare Outcomes (ECHO) Clinic | Jessica Leston, HIV/HCV/STI Clinic Service Director –and/or-<br>David Stephens, ECHO Clinic Director |
| 10:30 a.m. | Joint Multifaceted Opioid Initiatives | Vanesscia Cresci, CRIHB Research & Public Health Director<br>Daniel Domaguin, CRIHB Behavioral Health Clinical Manager<br>Colbie Caughlan, NPAIHB Project Director - THRIVE, TOR, & Response Circles<br>John Stephens, CEO didg$^{w}$álič Wellness Center |
| 12:00 p.m. | **LUNCH** | **On Your Own** |
| 1:30 p.m. | Youth Presentations | CRIHB & NPAIHB |
| 2:00 p.m. | Native Census Update | Lindsay McCovey, US Census Tribal Partnership Specialist<br>Shana Radford, US Census Tribal Partnership Specialist |
| 2:15 p.m. | Joint Resolutions<br>• Purchased/Referred Care (CRIHB)<br>• Full Funding Request (CRIHB)<br>• Advanced Appropriations (NPAIHB)<br>• Mandatory IHS Appropriations (CRIHB)<br>• Tribal Medicaid Reimbursement (NPAIHB) | CRIHB & NPAIHB |
| 3:00 p.m. | **BREAK** | |
| 3:15 p.m. | Joint Resolutions Cont.<br>• Opioid set asides, HR6157 (CRIHB)<br>• Future Opioid Funding? (NPAIHB)<br>• National Child Stress Initiative (CRIHB)<br>• SDPI (NPAIHB)<br>• Opposing NIH A Track Elimination (NPAIHB)<br>• Support VA Bill SB524 (CRIHB) | CRIHB & NPAIHB |
| 4:30 p.m. | Joint Board Photographs | |
| 4:45 p.m. | Closing Remarks | Board of Directors |
| 5:00 p.m. | **ADJOURN** | **Safe Travels** |

National Indian Health Board

## NATIONAL INDIAN HEALTH BOARD UPDATE TO CRIHB/NPAIHB JOINT BOARD MEETING

JULY 17, 2019

Stacy A. Bohlen, Chief Executive Officer
National Indian Health Board

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Thank you for your support, CRIHB!

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## Culture Night
## Presented by
## California Rural Indian Health Board
## Tuesday, September 17th, 2019
## Pechanga Resort and Casino

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## Annual Heroes in Health Awards Gala
## September 18th, 2019, 6 PM – 9 PM
## Event Lawn, Pechanga Resort and Casino

***Come join the National Indian Health Board for an event honoring national and regional champions in Indian Health.***

***NIHB received over 85 nominations for 44 awards. Winners will be notified by the end of this week!***

Master of Ceremonies,
Reno Franklin
Former Chairman, NIHB
*Stewarts Point Rancheria*

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National Indian Health Board

## Be a Conference Partner!
## Here's Why…

- Advance appropriations for the Indian Health Service;
- Keeping the Special Diabetes Program for Indians funded – which expires in September;
- Protecting Native Veteran's health care;
- Winning tribal funding carve outs; like; Tribal opioid response funding/direct Tribal HIV funding;
- Protecting the Indian Health Care Improvement Act from legal threats;
- Winning considerable increases for the Good Health and Wellness Program in Indian Country – even though the President's budget zeroed the program out every year;
- Conducting the Annual, Year-Long Native Youth Health Policy Fellowship: NIHB builds future leaders.

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National Indian Health Board

## NIHB is Hiring!

- Director of Congressional Relations
- Congressional Relations Associate
  - Focus on Communications & Oral Health
- Public Health Project Coordinator
- Public Health Project Associate
- Event and Meeting Manager

Email jobs@nihb.org!

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National Indian Health Board

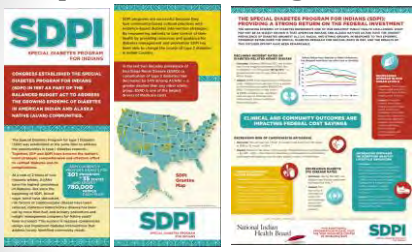
# Legislative Overview

1. Special Diabetes Program from Indians
2. Appropriations for Tribal Health
3. Indian Health Service Advance Appropriations
4. Medicaid Legislative Priorities
5. Public Health Legislation
6. Native Veterans' Care
7. Harm Reduction
8. Community Health Representatives/Community Health Aide Program



National Indian Health Board

# Special Diabetes Program for Indians




**More resources Available at www.nihb.org/sdpi**



National Indian Health Board

## §254c–3. Special diabetes programs for Indians

**(a) In general**

The Secretary shall make grants for providing services for the prevention and treatment of diabetes in accordance with subsection (b).

**(b) Services through Indian health facilities**

For purposes of subsection (a), services under such subsection are provided in accordance with this subsection if the services are provided through any of the following entities:

(1) The Indian Health Service.

(2) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act [25 U.S.C. 5321 et seq.)].

(3) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act [25 U.S.C. 1651 et seq.].

**(c) Funding**

**(1) Transferred funds**

Notwithstanding section 1397dd(a) of this title, from the amounts appropriated in such section for each of fiscal years 1998 through 2002, $30,000,000, to remain available until expended, is hereby transferred and made available in such fiscal year for grants under this section.

**(2) Appropriations**

For the purpose of making grants under this section, there is appropriated, out of any money in the Treasury not otherwise appropriated-

(A) $70,000,000 for each of fiscal years 2001 and 2002 (which shall be combined with amounts transferred under paragraph (1) for each such fiscal years);

(B) $100,000,000 for fiscal year 2003;

(C) $150,000,000 for each of fiscal years 2004 through 2017; and

(D) $150,000,000 for each of fiscal years 2018 and 2019, to remain available until expended.



National Indian Health Board

## Special Diabetes Program for Indians (SDPI)

- SDPI expires on September 30, 2019
- Senate Health Education Labor and Pensions (HELP) Committee leaders introduced a 5 year renewal for SDPI at the current $150 million/ year
  - Voted out of Committee on June 26
  - Included in Lower Health Care Costs Act of 2019
  - Awaiting Senate Floor Vote
  - Schedule uncertain





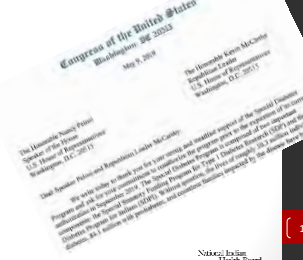
## Special Diabetes Program for Indians (SDPI)

- Rep. O'Halleran (D-AZ) introduced House bill
  - H.R. 2680: $200 million/year for 5 years!
  - Huge win for Indian Country!
  - BUT: on July 10 the House Energy and Commerce Health Subcommittee amended bill to $150 million for 4 years
  - NIHB working to secure funding increase
  - Full Committee markup expected today (7/17) or tomorrow (7/18)
  - Bill extends other public health programs, like Community Health Centers, so Committee needs to find a way to pay for all the expenditures
  - Very limited availability for extra funds for an increase to SDPI
- Working with partners at American Diabetes Association, Juvenile Diabetes Research Foundation and the Endocrine Society to ensure renewal





## SDPI Congressional Letters


Congress of the United States
Washington, DC 20515

- NIHB helped draft and circulate letters from House and Senate Diabetes Caucuses
  - Letters showed support for SDP and SDPI
  - Members could choose to sign on
- 379 House members (85%) signed the letter!!
- 68 Senators!!

## What's Next for SDPI?

- House of Representatives:
  - Week of July 15
    - Working on Amendments
    - Energy and Commerce Full Committee Mark Up
  - Week of July 22
    - Floor Vote Expected
- Senate:
  - Date of Vote on Senate Floor not yet set
  - Opportunity to amend legislation
- Conference Committee
  - Opportunity to amend legislation
- Signed into Law by the President




National Indian Health Board

## NIHB National Tribal Diabetes Summit Thursday, September 19th, 2019

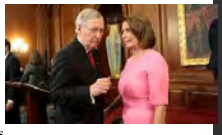
- Will be immediately following the close of the National Tribal Health Conference at Pechanga Resort and Casino
- To discuss making the Tribal Diabetes Program for Indians subject to self-governance contracts and compacts under the Indian Self Determination and Assistance Act
- Other Hot Topics in Diabetes in Indian Country



National Indian Health Board

## The Budget Deal Explained…or lack thereof

- Congress must pass a budget deal or sequestration takes effect
- Budget deal sets the total amount of discretionary funding Congress will spend for the upcoming fiscal year
- Then, Appropriations Subcommittees fight over their share of the funding
- Once each Appropriations Subcommittees have their allocation of funding, they craft draft appropriations bills
- The House drafted and passed their Appropriations bills even without a budget deal
- Senate is waiting for budget deal to pass
- Unclear if/when budget deal will happen





National Indian Health Board

## Indian Health Service (IHS) Appropriations

- House Bill
  - $6.3 Billion for IHS
    - $537 million above 2019 enacted level
    - Tribes recommended $7.1 billion
    - $25 million for HIV/AIDS and Hep C
    - $20 million for CHAP expansion
    - $25 million for EHR modernization
    - No cuts to CHRs, Health Ed, or Facilities
  - House Approved Bill on June 25

- NIHB Submitted Testimony to Senate Interior Appropriations in May
  - Andy Joseph Testified to Senate Committee on Indian Affairs

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National Indian Health Board

## Labor HHS Appropriations

- House approved bill on June 19
- Senate Labor HHS Bill expected once budget deal is reached
  - NIHB Submitted Testimony in June

- House Appropriations bill released in April
  - Total funding for HHS: $189.8 billion for FY 2020
  - Funds $50 million Tribal set aside in **opioid response grants** authorized in 2018.
  - Maintains $15 million set aside for placement of **National Health Service Corps** within IHS/Tribal/Urban Indian Health facilities.
  - Includes $14 million for the **Zero Suicide program**, an increase of $5 million over last year.
  - Maintains **Good Health and Wellness** at $21 million, and **Tribal Behavioral Health Grants** at $40 million

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National Indian Health Board

## IHS Advance Appropriations

- What is Advance Appropriations?
  - Funding that becomes available one year or more after the year of the appropriations act in which it is contained.
  - The appropriations law is passed, but funds cannot be used until the FY year for which they are allocated

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National Indian Health Board

## IHS Advance Appropriations

- What advance appropriations IS NOT:
  - "forward funding" allows funds to become available beginning late in the budget year and is carried into next year. Forward funding is counted against the same budget year. i.e. - it has a cost score!
  - "Mandatory appropriations" is automatic when Congress passes an authorization law. Medicare and Medicaid (entitlement programs) are funded through mandatory spending.

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National Indian Health Board

## IHS Advance Appropriations

- How to we get Advance Appropriations?
  - Budget Resolution – exemptions list
  - House Rules – Budget Committee Chairman must comply
  - Enacting law – S. 229/ H.R. 1128/ H.R. 1135
  - In the first year, there must be a double appropriation – one for FY 2020 and on for FY 2021


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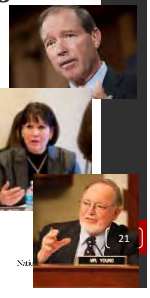
National Indian Health Board

## IHS Advance Appropriations

- Three bills on Advance Appropriations
  - S. 229 / H.R. 1128 – Indian Programs Advance Appropriations Act
    - Sponsors: Sen. Udall (D-NM)/ Rep. McCollum (D-MN)
    - IHS, Contract Support Costs, Bureau of Indian Affairs
  - H.R. 1135 – IHS Advance Appropriations Act
    - Rep. Don Young (R-AK)
    - All of IHS, not BIA
    - Senate bill coming soon



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# IHS Advance Appropriations

**Activities**:
- Letter to Appropriations Committee on Hearing
- Meeting with Chairman of the Budget Committee and Reps. Kennedy and Kildee
- Meeting with Senate Budget Committee Democratic Staff
- Sign on Letter to House Budget Committee
  - 60 Signatures

**Actions needed!**
- Legislation Co-sponsorship!
- IMPACT STORIES!!
- Every time you meet with your Representatives, talk about Advance Appropriations!

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National Indian Health Board

# Medicaid Legislative Initiative

- Medicaid is 68% of IHS's Third Party Revenue!
- Medicaid must be as strong as possible to fund the Indian Health system
- Wanted to have Centers for Medicare and Medicaid Services decision on Washington State Dental Therapy program before advocating for legislation
  - Still waiting for decision, and don't want to lose momentum
- Legislative Strategy:
  - Senator Udall (NM) and Rep. Lujan (NM) interested
  - Seeking Senate Republican Lead on Finance committee
- We need Resolution Support from Tribes and Areas:
  - Albuquerque Area Indian Health Board
  - California Rural Indian Health Board
  - Great Lakes Tribal Health Board
  - Great Plains Tribal Health Board
  - Inter-Tribal Council of Arizona
  - Navajo Nation
  - Rocky Mountain Tribal Leaders Council

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National Indian Health Board

# Medicaid Legislative Initiative

1. Allow states to extend Medicaid to all AI/ANs under 138% of the federal poverty level.
   - Implements Medicaid expansion for all eligible AI/ANs.
2. Authorize Indian health system to receive Medicaid reimbursement for services authorized under IHCIA.
   - Reinforces the direct relationship between Tribes and the federal government, rather than relying on state authority.
   - Currently, IHS & Tribes can only receive reimbursement for services authorized through the state Medicaid agency.
3. Extend 100% federal reimbursement to Medicaid services by Urban Indian providers to AI/ANs.
   - Currently, only services provided at IHS & Tribal facilities are reimbursed by the federal government at 100%.
4. Clarify in federal law and regulations that—
   - State Medicaid programs can't override Indian-specific provisions in federal Medicaid law.
   - AI/ANs cannot be negatively impacted by state requirements such as work requirements or adding co-pays and monthly premiums.
5. Allow billing for services provided outside a clinic facility's "four walls".
   - Under the current system, Tribes and IHS can only get reimbursed for services provided ***inside*** the facility.
   - This restricts reimbursements for home visits, or services referred outside the IHS or Tribal facility.

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National Indian Health Board

## Public Health Legislation

- Comprehensive Addiction Resources Emergency (CARE) Act
  - $800 million in direct funding to Indian Country for substance use prevention/treatment
  - Modeled off Ryan White/HIV Aids Legislation from 1990s
  - Senator Warren (D-MA) and Rep. Cummings (D-MD)

- Senate Committee on Indian Affairs Tribal Public Health Roundtable in May 2019
  - NIHB discussed the need to authorize public health emergency grants for Tribes and codify the Tribal Advisory Committee at CDC in statute
  - NIHB and Tribes want direct funding set-asides for public health programs within HHS

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National Indian Health Board

## Veteran's Affairs Tribal Advisory Committee Act

- S. 524 introduced in February
  - Tester (D-MT), Sullivan (R-AK), Udall (D-NM), Murkowski (R-AK)
  - House companion bill H.R. 2791

- Introduced last year in different form
- Current bill better reflects NIHB's asks
  - 15 members – one from each IHS area + 3 at large
  - ½ of members are veterans
  - Provides recommendations to VA on Native Veteran issues, including behavioral health challenges
  - Committee reports annually to Congress on activities
- Replicates the success STAC and other committees have created at HHS agencies

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National Indian Health Board

## Northwest Portland Area Indian Health Board and National Indian Health Board Harm Reduction Collaboration

- This represents a new area of work for NIHB
  - Interconnected to our opioid, HIV, and hepatitis work
- Hosted a panel on harm reduction during 2019 Tribal Public Health Summit Plenary Session
  - Leaders from Pascua Yaqui, White Earth, Eastern Band of Cherokee, and Lummi Nation
- Attended White Earth Harm Reduction Conference in May 2019
  - Delivered opening remarks to approximately 500 attendees
  - Co-facilitated a one-day strategic planning on a national Tribal opioid response for 70 people
  - Conducted a one-day training on strengthening advocacy for harm reduction efforts
- Applying for foundation funding to facilitate a national, Native harm reduction network
  - To provide Tribal capacity building, and national level advocacy

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National Indian Health Board

## Nursing Home Care for Native American Veterans Act

- Expected to be introduced by Sen. Sinema (D-AZ) and Rep. O'Halleran (D-AZ) in the near future
- Requires VA to reimburse Tribes for care provided in nursing home facilities
- NIHB requesting Tribal set asides for grant funding

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National Indian Health Board

## Community Health Representatives and Community Health Aide Program

**Community Health Representatives**

- Perform vital health screening services for Tribes nationwide
- Help patients handle logistics of health care access
- Can work in or out of facilities

**Community Health Aide Program**

- Operates in Alaska
  - IHS expanding CHAP currently
- Provides frontline medical, behavioral, and dental health services
- Often CHAP providers work in village clinic settings

- Administration wants to combine programs
- Each performs distinct roles in different settings
- Some Tribes prefer to keep CHRs, others want CHAP, others want to use both
- **Funding for CHAP expansion must not come from CHR program or any other IHS appropriation!**

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National Indian Health Board

## Questions?

Stacy A. Bohlen, Chief Executive Officer
sbohlen@nihb.org

National Indian Health Board

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National Indian Health Board

## Indian Health Service update

- Beverly Miller – Area Director
  - California Area
- Dean M. Seyler – Area Director
  - Portland Area
- Thunder Valley Casino Resort
  - Joint CRIB/NPAIHB Meeting
  - July 17, 2019



# IHS Strategic Plan FY 2019-2023

TBD

MONTH DAY, 2019

## What's New?

- Timeline
  - FY 2019-2023
- Additional Content related to:
  - Introduction / Background
  - Performance
  - Strategic Plan Development
- Minor language updates:
  - Goals
  - Objectives
  - Strategies
- Appendices
  - Crosswalks

## IHS Strategic Plan FY 2019-2023

- **Mission:** To raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.
- **Vision:** Healthy communities and quality health care systems through strong partnerships and culturally responsive practices.

**Access**

Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people.

**Quality**

Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization.

**Management and Operations**

Goal 3: To strengthen IHS program management and operations.



## Goal 1 - Access

- **To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people.**
- Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce.
  - 12 Strategies
- Objective 1.2: Build, strengthen, and sustain collaborative relationships.
  - 5 Strategies
- Objective 1.3: Increase access to quality health care services.
  - 14 Strategies



## Goal 2 - Quality

- **To promote excellence and quality through innovation of the Indian health system into an optimally performing organization.**
- Objective 2.1: Create quality improvement capability at all levels of the organization.
  - 8 Strategies
- Objective 2.2: Provide care to better meet the health care needs of American Indian and Alaska Native communities.
  - 6 Strategies

## Goal 3 – Management and Operations

- **To strengthen IHS program management and operations.**
- Objective 3.1: Improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public.
  - 6 Strategies
- Objective 3.2: Secure and effectively manage the assets and resources.
  - 10 Strategies
- Objective 3.3: Modernize information technology and information systems to support data driven decisions.
  - 9 Strategies



## Implementation of the Strategic Plan

- Road map that will guide IHS forward over the next five years.
- Implementation is no small task and requires input from across IHS.
- Everyone has a role and stake in its success.
- IHS employees are expected to identify how their work contributes to the IHS Strategic Plan.
- Anyone can provide feedback on the plan and ideas for implementation by emailing: IHSStrategicPlan@ihs.gov.



## Resources

- IHS Strategic Plan web site
  - Download a PDF version
  - DTLL/UIOLL link
  - Download Response to Comments
- Questions or comments?
  - E-mail: IHSStrategicPlan@ihs.gov

## Tribal Leader Letters

- June 21, 2019 – Consultation and Confer session on the Opioid Grant Program
- June 7, 2019 – Deadline extended on CHAP comment period
- May 24, 2019 – Update on IHS Sanitation Deficiency System
- May 15, 2019 – PRC Tribal Consultation results
- May 8, 2019 – Initiate Tribal Consultation on draft CHAP Policy
- April 23, 2019 – Accepting applications for the FY19 Small Ambulatory Program

- www.ihs.gov/newsroom/triballeaderletter/



## FY18 Catastrophic Health Emergency Fund

- **Status as of June 25, 2019 for the Portland Area**

  - 79 total cases
  - 53 amendments
  - $3,277,045.00 in reimbursements
  - $66,291.49 pending reimbursements
  - 98% Reimbursed
  - **FY18 CHEF Balance: $ 582,067.00**



## FY18 Catastrophic Health Emergency Fund

- **Status as of July 8, 2019 for the California Area**

  - 9 total cases
  - 5 amendments
  - $556,405 in reimbursements
  - $88.428 pending reimbursements
  - 84% Reimbursed

## FY19 Catastrophic Health Emergency Fund

- **Status as of July 8, 2019 for the California Area**
  - 1 case
  - 0 amendments
  - $0 in reimbursements
  - $53.876 pending reimbursements
  - 0% Reimbursed



## CHEF Online Tool

- Fully automated paperless process for identifying, documenting and submitting CHEF cases for reimbursement.
- Implemented for Federal PRC Programs on May 1, 2019
- Tribal programs have the option to opt-in/opt-out



## Indian Health Care Improvement Fund (IHCIF)

- FY 2018 Results Posted www.ihs.gov/IHCIF/
- FY 2019 Workgroup results to be presented to Principal Deputy Director on July 31st
- Phase II of the IHCIF workgroup is to make recommendations for potential revision to the formula, which would impact any future funding increases (if provided by Congress)

## Indian Health Care Improvement Fund Workgroup Members

- **Tribal Representatives for Portland**
  - Gail Hatcher
  - Steven Kutz (alternate)
  -
  -
- **Technical Support Team**
  - CAPT. Ann Arnett, Executive Officer
  - Nichole Swanberg (alternate)
  -



## Indian Health Care Improvement Fund Workgroup Members

- **Tribal Representatives for California**
  - Chris Devers, Tribal Representative, Pauma Band of Luiseno Indians
  - Mark LeBeau, Executive Director, California Rural Indian Health Board, Inc.
- **Technical Support Team**
  - Christine Brennan, CAIHS, Statistician



## Highlights of the FY 2020 President's Budget

$5.9 billion total discretionary budget authority

- **Current Services** $69 million (pay costs, inflation & pop growth)
- **Services** $4.3 billion
  - $2 million quality and oversight
  - $8 million recruitment and retention
  - $12 million Tribes that received federal recognition
  - $20 million expansion of the Community Health Aide Program (CHAP)
  - $25 million initial investment in modernizing the Electronic Health Record system
  - $25 million establishing the Eliminating Hepatitis C and HIV/AIDS in Indian Country Initiative
- **Facilities** $803 million
  - $166 million health care facilities construction
  - $193 million sanitation facilities construction
  - $444 million maintenance and improvement, medical equipment, and the Facilities and environmental Health Support program
- **Contract Supports Costs** $855 million (remains an indefinite discretionary appropriation for full funding)

## Indian Health Service Senior Leadership Team Announcements

- Mr. Christopher Mandregan, A Tribal member of the Aleut Community of St. Paul, Alaska, to serve as the new IHS Deputy Director for Field Operations
- Rear Admiral Chris Buchanan, current IHS Deputy Director, will also serve as Acting Deputy Director for Management Operations at IHS Headquarters until a permanent replacement is selected
- Mr. Mitchell Thornbrugh, an enrolled member of the Muscogee Creek Nation, as the permanent Chief Information Officer and the Director of the IHS Office of Information Technology



## Upcoming Events

- July 22-26: National Combined Councils Meeting – Scottsdale, AZ
- July 23-25: Tribal American Indian and Alaska Native Injury and Violence Prevention Conference – Denver, CO
- July 28: Work Hepatitis Day
- July 29: National 4th Quarter Direct Service Tribes Advisory Committee Meeting, Albuquerque, NM
- July 30-31: Direct Service Tribes National Meeting, Albuquerque, NM



## Upcoming Events Continued

- August 6-9: Diabetes in Indian Country Conference – Oklahoma City, OK
- August 24-30: National Clinical & Community-Based Services Conferences – Tigard, OR
- September 30: Federal Government Fiscal Year End 2019

# Thank You!

INDIAN HEALTH SERVICE


# California and Northwest Tribal Epidemiology Center Overview

Vanesscia Cresci, MSW, MPA
Acting Epidemiology Manager, California Tribal Epidemiology Center
Director, Research & Public Health Department
California Rural Indian Health Board, Inc.

Victoria Warren-Mears, PhD, RDN, FAND
Director, Northwest Tribal Epidemiology Center
Northwest Portland Area Indian Health Board

## Tribal Epidemiology Centers (TEC)

- Established via Indian Health Care improvement Act (IHCIA)
- Four TECs were started in 1996, now 12 TECs
- TECs function independently, but also as part of a national group called TEC-Consortium

## TECs as Public Health Authorities

- Established through permanent reauthorization of the Indian Health Care Improvement Act (IHCIA) as part of the Patient Protection and Affordable Care Act (2010)

  *The Secretary "shall grant to each epidemiology center… access to use of the data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary."*

  25 U.S.C.A. § 1621m(c)

- Health and Human Services (HHS) directive gives TECs access to HHS data systems and protected health information
- Centers for Disease Control and Prevention must provide TECs technical assistance
- Each Indian Health Service (IHS) Area must have TEC access

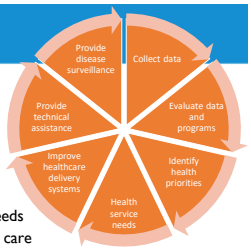
## California Tribal Epidemiology Center

- Formed in 2005
- Housed within the California Rural Indian Health Board's Research and Public Health Department
- Guided by an Advisory Council, but reports to CRIHB Board of Directors
- Staff by 6 Epidemiologists, 4 Program Evaluators, 2 Project Coordinators, 1 Research Associate, and 1 Outreach Coordinator

## Northwest Tribal Epidemiology Center

- Formed in1996
  - Tribal leaders had approved the concept and function of a tribal research and epidemiology center prior to this time.
- Housed within the Northwest Portland Area Indian Health Board
- Guided by the Public Health Committee of the NPAIHB, and report to the NPAIHB Board
- Functions as a departmental designation with oversight of over 30 employees

## 7 Core Functions




- Collect data
- Evaluate data and programs
- Identify health priorities with Tribes
- Make recommendations for health service needs
- Make recommendations for improving health care delivery systems
- Provide epidemiologic technical assistance to Tribes and Tribal organizations
- Provide disease surveillance to Tribes

## Mutual Areas of Focus

| Project Focus | California TEC | Northwest TEC |
|---|---|---|
| Technical Assistance | ★ | ★ |
| Workforce Development | ★ | ★ |
| Trainings | ★ | ★ |
| Data Access and Analysis | ★ | ★ |
| Grant Writing Training/Support | ★ | ★ |
| Publications | | ★ |
| Partnerships | ★ | ★ |
| Community Health Assessments | ★ | ★ |
| Communities of Practice | | ★ |
| Data Management Systems | | ★ |
| Subawardee Projects | ★ | ★ |
| Public Health Priority Settings | ★ | ★ |

## 1. Collect Data

- Tribal Behavioral Risk Factor Survey (adult and youth)
- Community Health Assessments
- California Health Interview Survey: AIAN oversample
- Health Priorities Survey
- Oral Health Needs Assessment
- California Tribal Opioid Strategic Plan

## Collect Data

- NWTEC does data linkage work with the Northwest Tribal Registry to correct misclassification of individuals in State and Regional data systems, who are not correctly identified as AI/AN.
- NWTEC collects original data from surveys and projects
- NWTEC collects both numeric and story based data

## 2. Evaluate Data and Programs

- Good Health and Wellness in Indian Country
- MSPI/DVPI Technical Assistance Provider
- California Tribal Comprehensive Cancer Control Program
- Tribal Personal Responsibility and Education Program
- Native Connections
- Building Public Health Infrastructure in Indian Community
- Tribal Public Health Capacity Building
- Project Pathway
- Tribal Opioid Response
- Dental Transformation Initiative
- Provide specialized evaluation to Tribal projects upon request

## Evaluate Data and Programs

- NWTEC evaluates behavioral health programs in our region
- NWTEC evaluates Good Health and Wellness activities
- Conduct internal evaluation on all of our programs
- Provide specialized evaluation to tribal projects upon request

## 3. Identify Health Priorities

- Health Priorities Survey: Statewide to community, 2017
- Annual Health Priorities Survey: THP/UIHP Directors
- Multi-site THP priorities reports


## Identify Health Priorities with Tribes

- NWTEC conducts an annual health priorities survey with regional tribal leadership and health directors
- NWTEC staff scan the environment for emerging public health topics.
- NWTEC collaborates with the Portland Area Office of Indian Health Service to identify priority health concerns.

## 4. Make Recommendations for Health Service Needs

- Provide feedback and data for Tribal consultations
- Serve as a resource for federal agency Tribal Advisory Committees' California delegates
- Develop and publish data reports


## Make Recommendations for Health Service Needs

- NWTEC publishes data to inform the decision making processes around health service needs.
- NWTEC provides data to support regional consultation and budget development for HHS programs.
- Provide technical assistance for advocacy.

## 5. Improving Healthcare Delivery Systems

- Collaborate with Medical Director/Medical Epidemiologist and Public Health Nurse on projects
- Summer Research Assistant Program
- Annual Data, Evaluation, and Grant Writing training
- Tribal Adverse Childhood Experiences pilot project

## Improving Health Care Delivery Systems

- NWTEC staff has created communities of practice for Hepatitis C, Opioid treatment and Diabetes.
  - More communities of practice are on the horizon to assist communities with treatment of complex disease cases.
  - Have provided opportunities for other health boards to develop these services.
- Conduct data analysis for SDPI programs within our area
- Conduct various trainings regionally and nationally to improve care

## 6. Provide Technical Assistance

- Access to data
- Data collection
- Data interpretation and dissemination
- Program evaluation
- Survey development
- Evaluation plan development
- Focus groups
- Key Informant Interviews
- Community health assessments
- Community Readiness Model
- Outbreak response
- Surveillance
- Data management and use

## Provide Epidemiologic TA

- NWTEC offers training in a variety of topics, including health data literacy to assist tribes in understanding and using data.
- Provide access to linkage corrected data to both States and Tribes.
- Provide technical assistance across all of our program areas for health promotion and disease prevention.
- Staff include a Centers for Disease Control and Prevention Epidemic Intelligence Service Officer (EISO) and Public Health Associate Program Staff.
- House the Portland Area Office IHS medical epidemiologist to ensure close collaboration to benefit Area tribes.

## 7. Provide Disease Surveillance and Promotion of Public Health

- Development of a Disease Outbreak Response Protocol
- Development of a Disease Surveillance Protocol
- Monitor infectious diseases
  - Disseminated information regarding Zika and Measles outbreak
- Emergency Preparedness staff capacity development

## 7. Provide Disease Surveillance and Promotion of Public Health: Opioid Surveillance

- Implement a Tribal Opioid Surveillance Assessment
  - Assess Tribal-specific capacity and gaps
- Partner with Tribes and Stakeholders to improve opioid surveillance
  - Partner with California Department of Public Health to improve AIAN reporting via California Opioid Surveillance Dashboard
- Address and improve data issues related to racial classification across data systems
  - Partner with 2 Tribal Health Programs to link AIAN data with death vital statistics to assess racial misclassification
- Improve non-fatal overdose data collection
  - Work with 2 Tribal Health Programs and hospitals to assess data issues and improve data sharing
  - Partner with a Tribe to pilot ODMAP use
- Improve fatal overdose data collection
  - Develop partnerships with medical examiners, coroners, funeral directors

## Provide Disease Surveillance and Promotion of Public Health

- NWTEC has provided a Public Health Emergency Preparedness conference, annually over the last 13 years to enhance jurisdictional collaboration during an emergency.
- NWTEC provides assistance with tasks related to Public Health Accreditation preparation.
  - Assists with MOU development for medical countermeasures and disease investigation
- Staff assisted States of Washington and Oregon with recent measles outbreak

## Questions

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Director, Research & Public Health Department
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## Questions

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http://www.npaihb.org/epicenter/

# CRIHB Telehealth & Workforce Development Initiatives

Health Systems Development Department

CRIHB
The California Rural Indian Health Board, Inc.

## Unique Advantages of Indian Health Boards



Telehealth Services

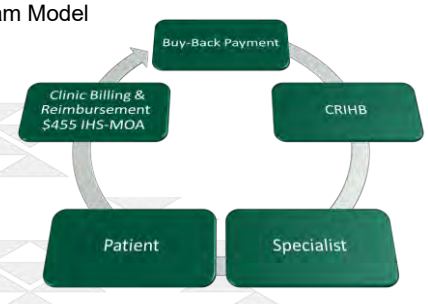
## Health Care Workforce Development Initiatives

## The Telehealth Paradox

## CRIHB Telehealth Program
*Identifying our Assets*

- Recruitment of independent specialists
- Bundling clinic demand for price negotiation
- CRIHB administrative support, training, TA
- Streamlined payment mechanism through buy-back
- IHS-MOA Medi-Cal rate = $455 per visit

## Program Model



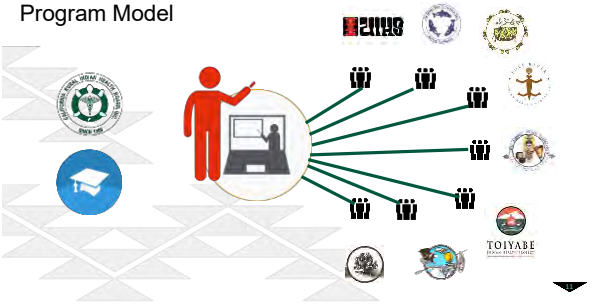
## Results Over Two Years

- Multiple specialties
  - Adult Psychiatry
  - Pediatric Psychiatry
  - Endocrinology
  - Pain Medicine
  - Behavioral Health Counseling (LCSW)
  - Primary Care
- **993** contracted service hours of **$224,620** value
- Full financial analysis pending


## Workforce Development
*Discovering our Assets*

- Motivated clinic staff and community members
- Demonstrated commitment to the community
- Academic partnerships
- Private foundation funding
- Aligned with Tribal sovereignty & self-determination

## Workforce Development
Program Model




## Results

- Medical Assistant Training Program (2 yrs)
  - San Francisco State University
  - 29 graduates
  - 100% pass rate for national certification exam
  - 72% working in Tribal Clinics
- Community Health Representative Training (2 yrs)
  - Washington State Department of Health
  - 39 participants
  - 12 Tribal Health Programs + Tribal Head Start
  - 25% clinics using *PRAPARE Social Determinants of Health Survey*
- Medical Scribe Certification Program (starting Aug 2019)
  - Shasta Community College

## Lessons Learned

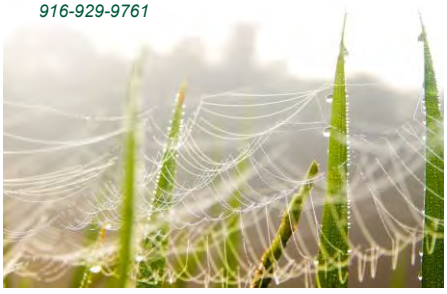
- Importance of community outreach to increase telehealth demand and acceptance
- Need for continual support and training of Telehealth Coordinators
- Role of eConsult services to preserve PRC funds and improve care

## Lessons Learned

- Creating entry point and pipeline for health care career
- Importance of soft skills training for professional success
- Importance of providing training in social determinants health and team-based care
- Need for Health Information Management (CAC) and Practice Management training leading to certification

*Indian Health Boards are uniquely positioned to create high impact programs*

CRIHB Health Systems Development
*916-929-9761*



## VA Office of Tribal Government Relations


## VA Communications with Tribes

### Mission Act

- Sep 2018 Office of Academic Affiliation (OAA) held Q&A NIHB Oklahoma City, OK
- Oct 2018 OAA presented to the Tribal Self-Governance Advisory Committee in DC
- Mar 2019 Office of Community Care (OCC) invited Alaska Tribal Leaders to participate in Tribal Self-Governance Conference in Traverse, MI
- Apr 2019 OCC presented to National Tribal Self-Governance Conference, Traverse City, MI
- Apr & May 2019 DTLL Office Enterprise Integration, VA compiling feedback w/anticipation of release to tribes
- Jun 2019 DTLL OTGR sent key information on implementation of Mission Act
- Jun 2019 SECVA taping with national syndicated radio show "Native American Calling" to discuss Mission Act

## VA Communications with Tribes

### Reimbursement Agreements

- Mar 2019 Office of Community Care (OCC) met with Alaska Native Tribal Health Consortium
- TBD DTLL seeking nominees for the Care Coordination Workgroup

## VA Communications with Tribes

### On the Horizon - FYI

- Jun 2019 DTLL from HUD regarding expanding Tribal HUD-VASH responses due by July 3, 2019
- 2019 Senators Tester (D-MT), Sullivan (R-AK), Udall (D-NM) and Murkowski (R-AK) introduced legislation for a VA Tribal Advisory Act of 2019 - to establish a VA Advisory Committee on Tribal and Indian Affairs

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## Regional Update

### Highlights

- Tribal Veteran Representative Training – 3 events, 1 OR, 2 CA anticipate 1 CA and 1 WA – these training are in collaboration with State Departments of Veterans Affairs and hosted by tribes
- Claims Events – 3 so far and 2 more scheduled – connecting Veterans to benefits and services in Indian Country
- Working with Urban Indian Health Programs to connect with VA programs
- Working with Senior Tribal Programs to connect with VA programs
- Working on National "I am Not Invisible Campaign" featuring Native Women Veterans who have served in the military
- VA will be releasing 2018 Executive Summary Report on VA Claims Events in Indian Country – Guide for Best Practice
- VA released its 2018-2024 Strategic Plan updated May 2019 – see link: https://www.va.gov/performance/

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## VA ~ Office of Tribal Government Relations

### Contact Info

Stephanie Birdwell - Director
VA Office of Tribal Government Relations:
StephanieElaine.Birdwell@va.gov
(202) 461-4851

Terry Bentley- Pacific District Regional Specialist
VA Office of Tribal Government Relations:
Terry.Bentley@va.gov (541) 440-1271 direct

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# VA Indian Health Service (IHS) / Tribal Health Program (THP) Reimbursement Agreement Program

6/1/2019

**Kara Hawthorne,**
Program Manager

VA | U.S. Department of Veterans Affairs

## Background

- The VA- IHS/THP Reimbursement Agreements Program provides a means for IHS and THP health facilities to receive reimbursement from the VA for direct care services provided to eligible American Indian/Alaska Native (AI/AN) Veterans.
- This program is part of a larger effort set forth in the VA and IHS Memorandum of Understanding signed in October 2010 to improve access to care and care coordination for our nation's Native Veterans.
- The National VA-IHS Reimbursement Agreement signed in December 2015, and we began executing individual THP Agreements at that time.
- The National Agreement and THP Reimbursement Agreements with individual THPs and Alaska THPs extended to June 30, 2022.





## IHS/THP Milestones

- October 1, 2010: the VA Under Secretary for Health and the IHS Director signed a Memorandum of Understanding (MOU).
- March-May 2012: VA, IHS, and THPs initiated tribal consultation on a draft national agreement.
- June 2012: Confirmed the approach of one National Agreement with IHS and individual sharing agreements under 38 USC 8153 for THPs due to their sovereign nature.
- August 24, 2012: VA Under Secretary for Health signed and distributed the Dear Tribal Leader Letter with program guidance.
- December 5, 2012: VA-IHS National Agreement signed.
- June 28, 2018: VA-IHS National Agreement was extended through June 30, 2022.
- June 2018 - present: Most THPs Agreements were extended through June 30th, 2022.
- Present: Ongoing coordination and onboarding of THPs.

## Benefits

- **Collaboration** - Promotes quality health care through collaborative relationships both intergovernmental by sharing resources and with the community
- **Choice of Provider and Access -** Eligible AI/AN Veterans can choose to receive their health care from the IHS/THP facility and/or VA facility closer to their homes in a culturally sensitive environment.
- **Pharmacy** – facilities will be reimbursed for outpatient medications dispensed by the facility that are on the VA's formulary. This is not limited to emergent prescriptions
- **No Copayment** – Pursuant to section 405(c) of the Indian Health Care Improvement Act (IHCIA), VA copayments do not apply to direct care services delivered by the IHS or THP healthcare facility to eligible AI/AN Veterans under agreements with VA.



## Benefits Continued

- **No Outstanding Balances**
  - For United States lower 48 states, IHS and THP medical facilities bill third parties prior to billing VA. This means VA is only responsible for the balance remaining after third party reimbursements.
  - For Alaska Tribal Facilities, VA reimbursement payment under this agreement is considered as payment in full. Alaska THPs or other organizations cannot be reimbursed for such care from entities or individuals other than the VA.



## Direct Care Services

- Reimbursement is for Direct Care Services
- Direct Care Services are defined as any health service that is provided directly by IHS/THP. This does not include Contract Health Services, unless those services are provided within the walls of the IHS or THP facility.
- VA will not reimburse for any services that are excluded from the Medical Benefits package or for which the eligible AI/AN Veteran does not meet qualifying criteria.

## Payment Methodologies and Fees

- **Inpatient** hospital services are based on Medicare Inpatient Prospective Patient System (IPPS) for Lower 48 and All Inclusive Per diem Rate for Alaska.
- **Outpatient** services are based on the IHS All Inclusive Rate published in the Federal Register.
- **Critical Access Hospitals** are reimbursed at the established rate as determined by Medicare.
- **Ambulatory Surgical Services** are reimbursed at Medicare rates.
- **Administrative fees** applied to the following claims:
  - Except for Pharmacy, paper claims will incur a $15 fee for the duration of agreements



## Eligibility and Enrollment

- VA, IHS and THP are responsible for determining eligibility for health care services within their respective programs.
- The eligible Veteran must also meet IHS eligibility requirements and be eligible for services in accordance with 42 C.F.R. Part 136.
- Veterans must be enrolled in the VA system before a claim can be processed and reimbursed.



## Status

- To date, VA has reimbursed over $96 million for direct care services provided by IHS & THPs covering over 10,100 eligible AI/AN Veterans.
- IHS:77 Implementation plans signed.
- THP: Currently 114 signed agreements, with ~40 tribes in progress.

## Basics for Establishing Agreements


- Using the agreement template, the VAMC, THP, and Contracting Officer work together to complete the draft reimbursement agreement.
- The national template shall always be used.
- Concurrently, the THP works to satisfy local implementation criteria.
- Once the draft is complete, it will be reviewed by Office of Community Care, Network Contracting Office and Regional Counsel, respectively.
- After final signatures, reimbursement for direct care can commence.



## IHS/THP Agreements Versus Other MOUs

Reimbursement agreements:

- Apply only to AI/AN Veterans receiving direct care services, except in Alaska.
- Do not relate to existing Memorandum of Understandings (MOUs) or sharing agreements.
- Program guidance and authorities for these agreements do not apply to other agreements or MOUs that maybe in progress and/or in place.
- While some VA Medical Centers' (VAMCs) staff involved with Reimbursement Agreements might also be the points of contact for other MOU development efforts, the efforts should be considered separate and distinct.



## IHS/THP Resources and Contact Information

Information on how to establish agreements, templates, forms and guides about the program are housed at Veterans Health Administration (VHA), Office of Community Care

https://www.va.gov/COMMUNITYCARE/programs/veterans/ihs/index.asp

https://www.va.gov/COMMUNITYCARE/providers/info_IHS-THP.asp.

For more information on getting started with Tribal Health Program agreements, please contact us via email at; tribal.agreements@va.gov



## VA MISSION Act: An Overview Of Key Elements

### What is the MISSION Act?

The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 will fundamentally transform VA's health care system. It will fulfill the president's commitment to provide Veterans with more choice in their health care providers. The Act includes four main pillars:

1. Consolidating VA's community care programs.
2. Expansion of Caregivers Program
3. Flexibility to align its asset and infrastructure
4. Strengthening VA's ability to recruit and retain health care professionals.

### What is it NOT?

The MISSION Act is not a step toward privatization. It's about significantly improving Veterans' experience and enhancing their access to care.

### Key Elements

**Community Care** - Consolidates VA's multiple community care programs into one that is easier to navigate for Veterans and their families, community providers and VA employees.

**Caregivers Program** - The Act expands eligibility for VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC) by including eligible Veterans from all eras of service.

**Asset and Infrastructure** - The Asset and Infrastructure Review (AIR) process in the Act will provide VA the necessary flexibility to align its infrastructure footprint with the needs of the nation's Veterans.

**Recruit and Retain** - The Act will allow for additional, improved recruitment efforts, including a new scholarship program, greater access to VA's education debt-reduction program and improved flexibility for providing bonuses for recruitment, relocation and retention.

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## Veteran Community Care: Key Changes

### New for Veterans

Veterans receive new benefits under the Veteran Community Care Program. These benefits include:

- Access to urgent care
- Expanded eligibility for community care
- Scheduling by the Veteran and VHA
- Technology that streamlines communication

### New for Community Care Providers

Establishment of the Community Care Network and Veteran Care Agreements. Community providers must now:

- Undergo an industry standard credentialing process
- Be subject to an exclusionary process
- Complete mandatory training
- Technology that streamlines bidirectional communication

### New for VA Staff

Introduction of new and modernized IT systems and business processes that will result in:

- Fewer manual process / increased automation
- Increased availability of performance metrics
- Broader options for care coordination
- Faster, easier, auditable information sharing

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Only direct impact to the IHS/THP reimbursement program is section 101, which allows for the continuation of the program

## Community Care Network (CCN)

The **Community Care Network (CCN)** is a new set of **region-based** contracts to provide health care services in the community through a contractor who **builds** and **credentials** the associated network and **processes claims**.

**Benefits of the CCN:**

- Gives VA control of Veteran care and experience
  - VA is taking back **scheduling**, **care coordination**, and **customer service** functions
- Gives VA convenient access to a network of qualified, **credentialed providers**
  - by having a provider network **accredited** by a nationally recognized accrediting body
  - by increasing local collaboration on **network development**
  - by having visibility into the **provider network** via the Provider Profile Management System (PPMS)
- Gives VA a streamlined community care processes
  - by including **more services** under CCN
  - by **no longer** adjudicating claims



VA U.S. Department of Veterans Affairs

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## Community Provider Resources

**VA Community Provider Website**

- Update with latest Community Care Network, MISSION Act, etc. fact sheets,
- Post any Community Care programs and policy changes,
- Provide links to external websites of interest/use for providers
- https://www.va.gov/COMMUNITYCARE/providers/index.asp

**VHA Provider Updates Newsletter**

- A monthly e-publication for community providers that delivers scheduled updates about programs, policies and changes.
- Subscribe at: https://public.govdelivery.com/accounts/USVHA/subscriber/new?topic_id=USVHA_1240

**VA Community Provider Webinar Series**

- Office of Community Care Overview Series: An overview of Community Care Programs.
- Accredited Topics Series: Accredited webinars with VA experts presenting on health care-related topics.
- Register at: https://www.train.org/vha/welcome

Click here for detailed information on community care and urgent care.

VA U.S. Department of Veterans Affairs

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## Community Resources

- VA Mission Act and New Veterans Community Care Program Fact Sheet https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/FactSheet_20-13.pdf
- Video – Community Care Network https://youtu.be/T4t4M1cVybE
- Community Providers Webpage https://www.va.gov/COMMUNITYCARE/providers/index.asp
- CCN fact sheet

  CCN Fact Sheet
- Community Care Network (CCN) Fact Sheet Library https://www.va.gov/COMMUNITYCARE/pubs/factsheets.asp

VA U.S. Department of Veterans Affairs

# Tribal Community Health Provider and Community Health Aide Program Projects

CRIHB/NPAIHB Quarterly Board Meeting
July 17, 2019
Christina Peters, TCHPP Director
Sue Steward, CHAPP Director

Northwest Portland Area Indian Health Board
*Indian Leadership for Indian Health*

## Goals for Today

- Provide a brief history of CHAP in Alaska
- Discuss the Draft Interim Policy, CHAP TAG and the President's proposed budget
- Review CHAP and CHR programs, how they complement each other
- Inform about the Portland Area CHAP Board Advisory Workgroup
- Familiarize about the Dental Health Aide Therapist (DHA/T);
- Behavioral Health Aide Practitioner BHA/P; and
- Community Health Aide Practitioner CHA/P
- Conclude with Why CHAP Matters!

## What is CHAP?

The Community Health Aide Program (CHAP) is a multidisciplinary system of mid-level behavioral, community, and dental health professionals working alongside licensed providers to offer patients increased access to quality care in tribal communities.

- Community Health Aide/Practitioners are primary care, mid level providers who provide full spectrum, wrap around care for oral, behavioral and medical health in the clinic or in the home. This can include patient history, vitals, diagnostics, assessments, dispensing of medications and follow up care.

## What is CHAP?

**Inception**

- Remote Alaska access by air or water
- IHS physician visits
- Traditional healers
- Physician extenders
  - CHA/P, BHA/P and DHAT
- TB epidemic
- High rate of infant mortality
- High rate of unintentional injury

**Providers**

- Typically Tribal or Village Member
- Often Generational
- Role model for the village
- Understands and may also speak the language
- Understands and participates in ceremonies
- Is familiar with and open to Tribal based or best practices understanding that evidence based is not always preferred

## National Policy on CHAP (May 2019)

- *As a result of Tribal Consultation in 2016, where Tribes overwhelmingly supported CHAP expansion outside of Alaska, IHS began putting in motion the necessary step to implement CHAP.*
- *The Indian Health Service, as a result of the 2016 consultation formed the CHAP Tribal Advisory Workgroup (TAG) IHS Circular 18-01*
- *The CHAP TAG in partnership with IHS released a draft interim National Policy on CHAP for Tribal Consultation*
- *This policy development included Tribal and IHS representation*
- *The CHAP TAG does not support eliminating or defunding the CHR program*



## National Policy on CHAP

- The Purpose of this Interim National Policy on CHAP
  - *To permit those Areas, that do have Resources and Infrastructures to Implement CHAP, to move forward with CHAP expansion at their own expense*
  - *This Policy does not require Tribes or Areas to implement CHAP or hire CHAP providers*
  - *This policy does not affect CHR program or its funding*
  - *Congress has not yet provided funding for this policy implementation*
  - *There has been NO consultation on the elimination of the CHR program which is separate from the current tribal consultation on CHAP policy.*

## CHR and CHAP

•**Legislative Authority**- CHAP is authorized under 25 USC § 1616 a-d while the CHR Program is authorized under IHCIA PL. 100-713.

•**Funding Sources**- The Alaska CHAP is funded through the hospital and health clinics (H&HC) line item in the IHS budget and CHRs are funded through a specific CHR line item.

•**Scopes of Work**- While the "community health" portion of the names are similar, the scope of work for a Community Health Aide and Community Health Representative are vastly different. CHAs are mid-level primary medical providers who can provide basic medical attention and can connect a patient to clinical care. CHRs provide health promotion, prevention, and outreach to community members.



## Complementary Programs

### CHR

- CHRs fill critically important roles to the health of their communities
- Longstanding presence in some communities
- Trained from the community
- May include indigenous knowledge informed systems of care
- Experience navigating patients to care and services in that specific community
- Deep understanding of culture, community, and existing health care infrastructure

### CHAP

- Broad scope of practice, provides routine, preventative, and emergent care
- Respects the knowledge and resources in the tribal community and grows providers from that source.
- Trains AI/AN community members who speak the native languages and provide culturally appropriate care
- Breaks down barriers to care and barriers to training;
- Training minimizes time away from communities and families.
- Brings care to communities;
- Fosters a team approach to delivering health care services.



## Complementary Programs

- CHR is a great place to recruit for CHAP providers
- Thriving CHR program supports the entire health delivery system
- CHR and CHAP providers work together with the rest of the medical/dental team to improve the health of the community

## President's FY 2020 proposed budget (March 2019)

The President's FY 2020 proposed budget includes a cut of $39 million from the CHR program and at the same time creates a new $20 million line item for CHAP nationalization.

- *The Administration has indicated their intent to transition CHRs into the CHAP*
- *Congress has not yet funded this proposal*
- *Tribes oppose CHAP expansion at the expense of reducing or eliminating the CHR Program*
- *Tribes would like to preserve and strengthen the CHR program*
- *For those Tribes that CHOOSE to implement a transition from CHR to CHAP, then resources and technical assistance must be provided by IHS*



## CHAP Board Advisory Workgroup

**Priorities**

IHS Interim Policy for CHAP;
Portland Area CHAP Certification Board (PACCB);
PACCB Membership Recommendations;
Portland Area Standards and Procedures for DHAT, BHA/P and CHA/P; and
Dental Health Academic Review Committee (DHARC), Behavioral Health Academic Review Committee (BHARC) and Community Health Academic Review Committee (CHARC)

- Andrew Shogren, Chair – Suquamish
- Libby Cope, Co-Chair - Makah
- Kay Culbertson, Secretary - Cowlitz

- CHAP Board Advisory established 7/18/18
- 36 member workgroup
- Meets monthly via zoom and in person at QBMs

## Progress toward PACCB

## DHAT Education

- DHAT Curriculum
  - Year 1: basic health sciences, basic dental concepts, professional role development, introduction to clinic, patient and facilities management.
  - Year 2: clinical year, expansion of concepts learned in first year, extractions, community project, village dental rotations.



## DHAT Scope of Practice

- **Primary DHA (CDHC)**
  - Oral Health Educators
- **Expanded Function DHA**
  - Restorations, cleanings, temporary fillings
- **DHA Hygienist**
  - Local anesthesia
- **DHA Therapist (DHAT)**
  - Prevention, operative, urgent

**Supervised providers**
**Teams led by Licensed Dentists**



## BHA Education & Training

### BHA-I
- Screening
- Initial intake process
- Case management
- Community education, prevention, early intervention

### BHA-II
- Substance abuse assessment and treatment

### BHA-III
- Rehabilitative services for clients with co-occurring disorders
- Quality assurance case reviews

### BHP
- Team leadership
- Mentor/support BHA-I, II, and III

## Behavioral Health Aides / Practitioners

- Village-based counselors to provide culturally-informed, community-based, clinical services
- Provide behavioral health prevention, intervention, aftercare, and postvention
- Training and practicum requirements
- On-the-job training
- Four levels of certification



## CHA Education & Training

- Hired, usually by village council
- ▪**Pre-session:** Intro to CHAM/CHA role/ETT or EMT
- ▪**Session I:** 4 weeks →60 hours in village clinic
- ▪**Session II:** 4 weeks →200 hours in village clinic
- ▪**Session III:** 3 weeks →200 hours in village clinic
- ▪**Session IV:** 4 weeks →200 hours in village clinic
- ▪**Session IV Blended:** 18 weeks (16 weeks in village via Distance Learning Network, 2 weeks at Training Center )→200 hours in village clinic, Blended Session I/II in progress
- ▪**Preceptorship:** 1 week-skills & patient encounters; exam



## Community Health Aides and Community Health Practitioners

**CHA/Ps**

- **Local people**
- **Initially described as "the eyes, ears and hands of the physician"**
- **300,000 encounters per year**
- **Includes emergency, acute, chronic, and preventive health components**
- **Does not include differential diagnosis but does provide an assessment**
- **Under medical supervision of a licensed physician**

**Alaska Education Includes**

- CPR / AED
- Emergency Trauma Technician or Emergency Medical Technician Certification
- Remote clinics operate as 24 hour access to emergency care

### Why CHAP Matters

Proven history of safe, quality care in Alaska for over 50 years

Uniquely developed for Alaskans by Alaskan and the same is true for Lower 48 Tribes

Tribes can tailor their programs to their needs

Decreases travel for routine or non emergency care

Increases AI/AN local workforce

- Home grown, culturally knowledgeable and respected providers
- Competency based, skilled providers who increase access to care
- Extend the reach of services into hard to access areas
- Creates wrap around care and referral services for Tribes
- Increases the number of AI/AN providers
- Creates a career path for AI/AN providers



## Questions?

# *Listening Session on Tribal Public Health Accreditation*

**California Rural Indian Health Board (CRIHB) & Northwest Portland Area Indian Health Board (NPAIHB)**
**Joint 15th Biennial Board of Directors Meeting**

PHAB

*Advancing public health performance*

Kaye Bender, PHAB President/CEO
Thunder Valley Resort, Lincoln, CA
July 17, 2019

# PHAB Board of Directors 2019

Thank you!!!!

# Public Health Accreditation Board

- The Public Health Accreditation Board (PHAB) is the national, non-profit organization that administers accreditation for state, local, tribal, and territorial health departments.
- Located in Alexandria, VA
- Incorporated in 2009; issued first accreditations in 2013.
- Our development was funded by the CDC and the RWJF. Accreditation fees are now almost half of our budget.

# Public Health Accreditation Board Update

- Initial Accreditation

| | Accredited | In process | Total |
|---|---|---|---|
| **State** | 36 | 4 | 40 |
| **Local** | 229 | 151 | 380 |
| **Tribal** | 3 | 3 | 6 |
| **Territorial** | . | 1 | 1 |
| **Integrated*** | 1/67 | . | 1/67 |
| **Multijurisdictional** | . | 8 | 8 |
| **Army** | . | 2 | 2 |
| **Total** | 268 + 1 system | 169 | 504 |

** Of the 504, 60 that are accredited and 72 that are in process serve 50,000 or fewer.

- Reaccreditation

| | Reaccred In Process | Reaccred completed | Total |
|---|---|---|---|
| **State** | 5 | 1 | 6 |
| **Local** | 37 | 9 | 46 |
| **Total** | 42 | 10 | 52 |

# Public Health Accreditation Board Update

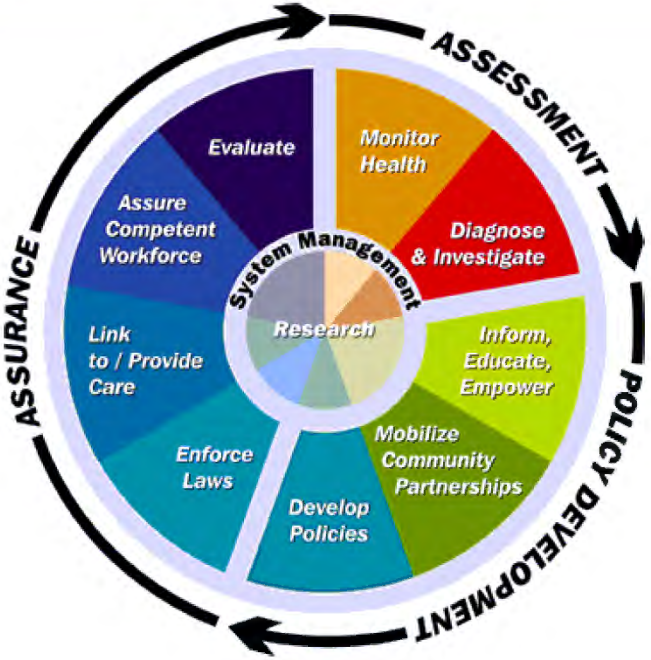
- Vital Records/Health Statistics at the State Level (Launched February 2019)

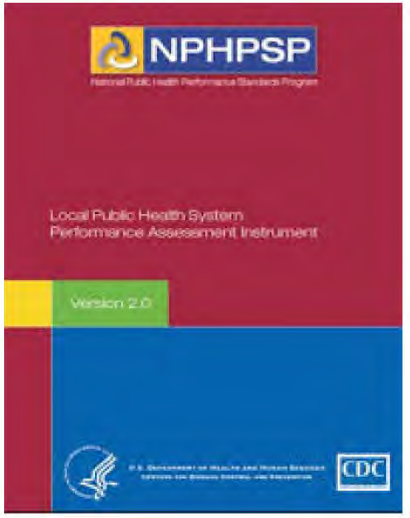
| | In process |
|---|---|
| VRHS | 12 |

**Initial Accreditation Population Summary (as of 6/18/2019)**

| | |
|---|---|
| All HDs in the system (437 + system) | **401,545,870** |
| All HDs in the system (unduplicated) | **277,264,005** |
| Accredited HDs | **343,413,019** |
| Accredited HDs (unduplicated) | **245,334,057** |
| Smallest Population of Applicant | **725** |
| Largest Population of Applicant | **37,691,912** |

- International Accreditation



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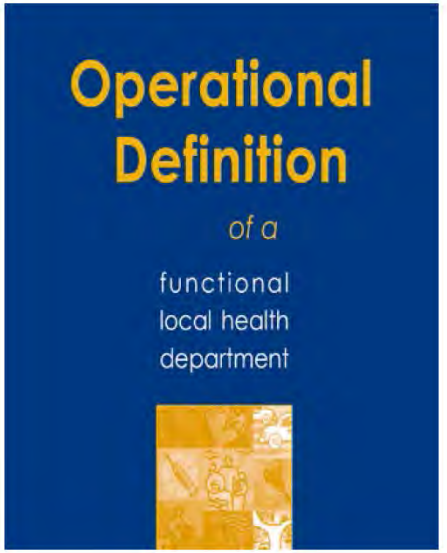


# Benefits One Year after Accreditation

**% Strongly Agree or Agree**

| | |
|---|---|
| **91%*** | • Accreditation has stimulated greater collaboration across HD departments/units |
| **88%** | • Accreditation has improved the management processes used by the leadership team |
| **86%*** | • Accreditation has improved the credibility of the HD within the community and/or state |
| **83%** | • Accreditation has improved the HD's accountability to external stakeholders |

*Post-Accreditation Survey, N=118*
**N=35*

# Financial Effects

**% Strongly Agree or Agree**

| | |
|---|---|
| **56%** | • Accreditation has improved the utilization of resources within the health department |
| **42%** | • Accreditation has improved the health department's competitiveness for funding |

*Post-Accreditation Survey, N=118 and 72, respectively*

**Respondent Quote**

*Accreditation "created some **efficiencies**, especially with QI projects. As we try to diffuse that culture of QI throughout the agency, we get lots of suggestions for QI projects that **save staff time and resources**."*

# Integration of Public Health and Healthcare in Tribal Health Systems

## *National Indian Health Board*

National Indian Health Board

***"Strong linkages across healthcare and public health are vital to addressing national health priorities at a systemic level." -CDC***

## History of Tribal Public Health

Despite the colonial period devastation on Native populations and cultures, many elements and values of traditional systems of health and wellness practiced prior to Western contact continue to this day. These systems tend to focus on holistic health, including spiritual, mental, emotional, and physical. Culture, history, and ultimately a focus on Tribal Sovereignty established community health as a foundational element of Tribal health systems.

The first public health services offered by the federal government came in response to infectious diseases, such as in the early 1800's through the US Army in the establishment of smallpox immunization campaigns. Health services provisions soon became a quintessential clause in Tribal treaties. Today, the federal trust responsibility is the legal obligation of the federal government to carry out certain provisions and protections, including health services, to Tribal Nations, and applies to all federal agencies.


**Integration of Primary Care and Public Health***

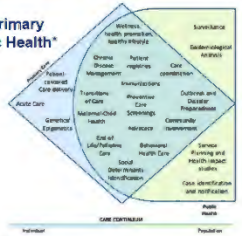



FIGURE 1-2 Degrees of integration.**

## What is System Integration?

System Integration has become a buzz word in public health. Recent research has illuminated the benefits of strong linkages between public health and healthcare. Integration in Tribal health systems often go beyond partnerships to "a merger", with public health and healthcare as part of the same organizational structure. While other health systems may actively seek higher levels of coordination between public health and healthcare, Tribal systems are often already set up this way.

### *Benefits of Integration*

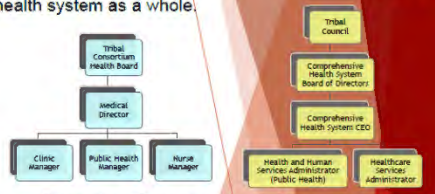
- Centralized source of health information
- Dissemination of health promotion materials through primary care
- Greater prevention focused-practice for healthcare professionals
- Healthcare support for population-based strategies (i.e. collecting individual-level data for surveillance and Tribal Health Assessments

### *Integration Challenges*

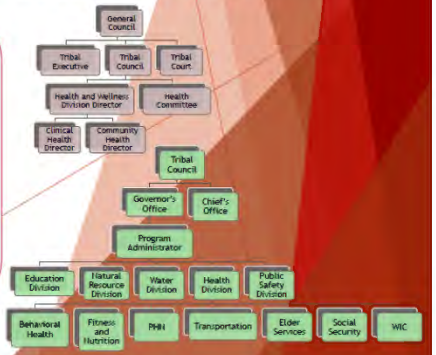
- Healthcare focus over public health
- Community confusion regarding the difference between public health and healthcare
- Lack of a common agenda or vision
- Limited funds go to the most urgent issues
- Limited research on impact of integration

## Tribal Self-Governance

- 1954: The Transfer Act (42 U.S.C §§ 2001-2005f) created the Indian Health Service as the primary responsible party for Tribal health services.
- 1975: The Indian Self-Determination and Education Assistance Act Title I (P.L.93-638) was passed directing the federal government to enter into self-determination contracts with Tribes, including IHS.
- 1988: The Title III amendment (P.L. 100-472, 25 U.S.C Sec. 450f.) gave Tribes the opportunity to contract the health system as a whole.




**Examples Organizational Charts for Integrated Tribal Health Systems**




**Author:**
Sarah Price, Public Health Project Coordinator | National Indian Health Board | Sprice@nihb.org

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# Public Health Accreditation Board

## Supplemental Process and Documentation Guidance for Tribal Public Health Department Accreditation

Approved February 2018

PHAB

# How Was The Document Developed?

- The document was developed in partnership with the Tribal Public Health Accreditation Advisory Board, part of the National Indian Health Board.
- It was reviewed by the PHAB Board of Directors.
- It was placed for public comment on PHAB's website for approximately three months.

# Purpose and Use of the Document

- The document was developed to be used with the *PHAB Standards and Measures, Version 1.5* in order to provide some Tribal specific guidance related to the documentation and process requirements.
- PHAB recommends that the user of this document put it side-by-side with the standards and measures so as to appropriately apply the supplemental guidance.
- This webinar does not attempt to re-state the language in the document. It is a guide to use the document. Tribal health departments should refer to the specific language in the document and not these slides when working on their documentation.

# Version 2.0 Timeline

Psychometrics
Evidence Base
Content Analysis

Commissioned Papers
Expert Panels
Think Tanks

Develop Drafts
Accreditation Improvement Committee

**Vetting Draft Standards & Measures Version 2.0**

*2017 & 2018*

*2018-2020*

*Mid-2020*

*End of 2020*



# Tribal Public Health and Accreditation

https://www.nihb.org/tribalasi/tribal_asi_tools.php



# Questions


# Public Health Accreditation Board

## www.phaboard.org

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***SIGN UP TO RECEIVE THE PHAB NEWSLETTER***

HOBBS STRAUS DEAN & WALKER

# California Rural Indian Health Board & Northwest Portland Area Indian Health Board

## 15th Biennial Board of Directors Joint Board of Directors Meeting July 15-18 2019



## Discussion Topics

- **IHS Advance Appropriations Initiative**
- **SDPI Reauthorization and Funding**
- **Section 105(*l*) Leasing**
- **Contract Support Cost and IHS Policy**
- ***Texas v. United States* – ACA Litigation**
- **Opioid Litigation**



## Advance Appropriations

- For many years tribes have sought advance appropriations for IHS funding to address negative impacts of CRs and government shutdowns
- Advance appropriations is **not** the same as forward funding
- Advance appropriations has applied to VA medical accounts for many years
- Legislation was previously introduced in House that would implement this initiative and House directed GAO to conduct a study on feasibility
- GAO issued study last year making it clear concepts can work for IHS
- Recent 35-day government shutdown increased interest in advance appropriations and led to introduction of new legislation

## Advance Appropriations (cont.)

- There are 3 pending bills
  - HR 1135 by Rep. Don Young (R-AK). It would authorize advance appropriations for IHS Services and Facilities Accounts. There are 23 co-sponsors from both parties. Referred to the following committees: Natural Resources, Energy and Commerce, and Budget.
  - HR 1128 by Rep. Betty McCollum (D-MN) who is Chair of the House Appropriations Subcommittee on Interior. It would authorize advance appropriations for IHS Services and Contract Support and some BIA/BIE programs. There are 32 co-sponsors from both parties. Referred to the following committees: Natural Resources, Energy and Commerce, and Budget.
  - S. 229 by Sen. Tom Udall (D-NM) who is Ranking Member on the Senate Interior Appropriations Subcommittee. There are 9 co-sponsors, all Democrats. It is the same as HR 1128 and it was referred to the Senate Budget Committee.



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## Advance Appropriations (cont.)

- "Advance Appropriations.—In 2018, the Government Accounting Office (GAO) identified considerations for Congress when considering whether to advance appropriate funds to IHS, including whether IHS has the processes in place to develop and manage an advance appropriation. The Committee directs IHS to examine its existing processes and determine what changes are needed to develop and manage an advance appropriation and report to the Committee within 180 days of enactment of this Act on the processes needed and whether additional Congressional authority is required in order to develop the processes." (House Appropriations Committee FY 2020 Interior, Environment, and Related Agencies bill Committee report (House Report 116-100))



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## Advance Appropriations (cont.)

- House Interior Appropriations Chair McCollum noted at the May 22, 2019 markup that the Committee is asking both the IHS and Indian Affairs for additional information as part of the effort to move forward on providing both agencies advance appropriations, although Committee Report mentions only the IHS.

## Advance Appropriations (Cont.)

- Numerous national and regional tribal organizations, as well as many tribes support this initiative
- The ABA is about to enact resolution in support of advance appropriations
- Not clear when hearings will happen or when bills will move
- Including ask for extension of advance appropriations to BIA in addition to IHS complicates the landscape



## SDPI Reauthorization and Funding

- Authorization for SDPI expires on 9/30/2019
- SDPI has been level funded at $150 million per year since fiscal year 2004
- NCAI and NIHB are advocating that Congress increase the annual appropriation for SDPI to $200 million for fiscal year 2020 to begin to address this unmet need



## SDPI Reauthorization and Funding (Cont.)

- H.R. 2680, the SDPI Reauthorization Act of 2019.
- On May 10, 2019, bipartisan legislation was introduced in the House of Representatives to extend both SDPI and the Type 1 Diabetes Research Program for five years at $200 million per year (a $50 million annual increase).
- Referred to Committee on Energy and Commerce.
- 379 House Members and 67 Senators signed letters of support urging the extension of these important programs dedicated to preventing and treating diabetes.

## SDPI Reauthorization and Funding (Cont.)

- S. 1895.
- This broad healthcare package legislation would extend SDPI authorization through 2024.
- It does not include an increase in appropriations for the program.
- There is concern that other healthcare extenders in the package are too expensive, which may create challenges in securing wide bipartisan support for the bill.



## SDPI Reauthorization and Funding (Cont.)

- On June 4, 2019, the House Committee on Energy and Commerce Subcommittee on Health held a hearing which included legislation to extend SDPI and the Type I Special Diabetes Program.
- A total of 12 health care bills, set to expire September 30, 2019, were the subject of the hearing.
- Even though there is bipartisan and bicameral support for extension of these health programs Republican Subcommittee members object because there is no funding offset for the funding increases.



## SDPI Reauthorization and Funding (Cont.)

- A National Tribal Summit on SDPI will take place on September 17, 2019, in conjunction with the NIHB 36th Annual National Tribal Health Conference in Temecula, California.
- The Summit is intended to foster a collaborative discussion on extending 638 authorities to SDPI.
- Additional details will be posted on the NIHB website closer to the conference.

## Section 105(*l*) Leasing

- All tribes use tribal facilities to provide services under ISDEAA agreements
- Appropriated funds for both BIA and IHS have historically been inadequate to fully fund these facility costs
- Section 105(*l*)of ISDEAA:
  - Tribally owned/leased
  - Used for the purpose of providing PFSAs in FA
  - Mandatory: *Maniilaq I* and *II*



## Section 105(*l*) (Cont.)

- 105(*l*) leasing has spread throughout Indian Country – approx. 125 leases/lease proposals so far.
- Virtually all of the leases negotiated to date have been with IHS. But the provision applies to BIA and BIE as well.
- Supplemental tribal clinics appropriation: Congress has appropriated additional funds for VBC program and 105(*l*) lease compensation since 2016.
- Not enough has been appropriated to fully fund and IHS has had to use other discretionary funds.
- The ideal solution: a separate, indefinite appropriation for 105(*l*) like that for contract support costs.



## Section 105(*l*) (Cont.)

- The FY 2019 appropriations act included a $36 million supplemental tribal clinics appropriation for IHS—an increase of $25 million to match the amount IHS had to reprogram in FY 2018.
- In 2018 IHS reprogramed mandatory inflation cost funds to pay the total amount.
- With 105(*l*) leasing expected to continue growing in FY 2019, $36 million will almost certainly not be enough to cover all of the 105(*l*) lease obligations.
- Where will IHS find funds to pay any amount over $36 million?

## Section 105(*l*) (Cont.)

- The House Appropriations Committee's Interior, Environment, and Related Agencies Subcommittee has marked up its FY 2020 Appropriations bill. The recommendation for clinic leases (both VBC and 105(*l*)) is $53 million, which is $42 million over the Administration's request.
- The Senate Interior Appropriations Subcommittee has not yet marked up its FY 2020 appropriations bill.
- The House and Senate have not agreed to a funding cap number for domestic discretionary spending.
  - The House has proceeded to mark up its funding bills anyway with about a 10% increase over FY 2019 enacted levels.
  - The House- recommended funding amounts are generally seen as a starting point for negotiations with the Senate.



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## Section 105(*l*) (Cont.)

- At the TSGAC meeting on July 16-17, 2019, IHS reported that they are struggling with how to estimate costs going forward:
  - Current estimate of need is $54-56 million (per IHS)
  - Recognition of need to convene a dedicated technical workgroup
  - Adding 105(*l*) leases as a funding needs to the FAAB facilities construction report
  - National Tribal Budget Formulation Workgroup seen as natural entity to host further discussion with tribal leaders
- IHS also wants to conduct a survey on tribally-owned and leased facilities being used under ISDEAA and invite feedback on the level of information that would be appropriate to request from tribes



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## Contract Support Cost

- IHS CSC policy has been partially suspended for a number of months: disagreement with tribes over duplication issues and 97/3 default formula for new program funds.
  - At TSGAC meeting earlier this week, RADM Weahkee reported that the CSC Policy is almost ready for the CSC Workgroup's review, but he did not specify exactly when that would be.
- Recent court ruling that may impact future CSC payments: *Navajo Health Foundation – Sage Memorial Hospital v. Burwell*
  - Ruling in one Federal District Court that IHS owed CSC on health care programs and services funded by third-party revenues such as Medicare, Medicaid, and private insurance.
  - IHS dropped the appeal in 10th Circuit so decision has limited applicability.
  - Same issues are currently being litigated by the Swinomish Tribe in Federal Court in the District of Columbia, a court that all tribes have access to.
- Status of other litigation:
  - *Cook Inlet Tribal Council v. Mandregan*.
  - *Seminole Tribe of Florida v. Azar*.
  - *Norton Sound v. Azar.*

## Legal Challenges to the Affordable Care Act: *Texas v. United States*

- District Court Decision. In December 2018, a federal district court in Texas held that, following passage of the Tax Cuts and Jobs Act of 2017, the "individual mandate" provision of the Affordable Care Act (ACA) can no longer be considered a valid exercise of Congress's power to tax and is therefore unconstitutional.
- The district court also held that the individual mandate is not severable from the remainder of the Act (meaning it cannot be separated out without affecting the operation of the rest of the law) and went on to declare the Act invalid in its entirety.
- Appeal. The district court's decision was appealed to the Fifth Circuit Court of Appeal, where the case is now pending.



## *Texas v. United States* (cont.)

- Tribal Health Impact. The district court's ruling extends to Section 10221 of the ACA, which amended and permanently authorized the Indian Health Care Improvement Act (IHCIA), and to other Indian-specific health care provisions incorporated into the Act, even though they are not dependent on the ACA's individual mandate.
- If the district court's decision is upheld in full, the IHCIA and other Indian-specific provisions in the ACA would therefore be struck down.



## *Texas v. United States* (cont.)

- Tribal Amicus. On April 1, 2019, an amicus brief was submitted in the appeal on behalf of a national coalition of Tribes and tribal organizations, arguing:
  - That the district court did not correctly apply long-established severability rules when it invalidated the ACA in its entirety. These rules state that a court should preserve as much of a statute as possible when one provision is found unconstitutional.
  - The IHCIA and certain other Indian-specific provisions in particular should be preserved, because: (1) they can operate as intended by Congress without the individual mandate in place; (2) the IHCIA's legislative history shows that it originated as a freestanding bill in 1976, separate from the rest of the ACA, underscoring that it operates independently of the remainder of the ACA; and (3) there is no evidence whatsoever that Congress would have wanted the IHCIA and other Indian provisions to fail if the individual mandate were deemed unconstitutional.

## *Texas v. United States* (cont.)

- United States' Litigation Position. In the district court, the United States agreed that the individual mandate is now unconstitutional, but argued that most of the rest of the ACA should be preserved.
- The United States changed its position in the court of appeals, supporting the district court's decision holding that the entire law is invalid.
- The United States brief, filed on May 1, argues that "minor" provisions included in ACA should not be severed.
  - Essentially argues that the IHCIA and Indian provisions are invalid.



## *Texas v. United States* (cont.)

- Jurisdictional Questions on Appeal. Shortly before argument was scheduled, the 5th Circuit asked the parties to file supplemental briefs addressing three questions relating to the court's jurisdiction to hear the appeal:

(1) Do the state intervenors and the U.S. House of Representatives—the parties defending the ACA in the litigation—have standing to intervene in the appeal, and were their interventions were timely;

(2) if not, is there still any live case or controversy between the plaintiff states and the federal defendants, given the federal government's new legal position on appeal; and

(3) what is the appropriate conclusion if there is no live controversy between the plaintiff states and the federal defendants and no other party has standing to appeal?



## *Texas v. United States* (cont.)

- This raised the question of whether the Fifth Circuit would even consider the merits of the appeal, and if not, whether it would leave the district court's decision in place or order the district court to vacate its ruling.
- However, in their briefs all parties agreed that there is still a live controversy between the plaintiff states and the federal government and that the Fifth Circuit can and should hear the appeal.
- The parties said the federal government is still enforcing the ACA for now, and the Department of Justice is arguing on appeal that the district court's relief was too broad.

## *Texas v. United States* (cont.)

- Oral Argument. A three-judge panel heard the case on July 9, 2019.
- Panel made up of judges appointed by Carterm Bush and Trump.
- None of the Judges, and none of the parties' attorneys, specifically raised or addressed the Indian Health Care Improvement Act or other Indian-specific provisions of the ACA.
- One Judge noted that some provisions of the ACA, like a provision requiring certain restaurant menus to include calorie counts, are not related to the law's health insurance reforms.



## *Texas v. United States* (cont.)

- Attorneys for the intervenor states and the House argued that Congress clearly intended for the rest of the law to survive when it eliminated the mandate penalty.
- They also pointed out that several Republican lawmakers represented to the American public that they were not touching protections for preexisting conditions or other popular provisions of the law by zeroing out the tax penalty.



## *Texas v. United States* (cont.)

- The judges were confused by the Trump Administration's legal position.
  - After defending the ACA in the district court, the DOJ now supports the lower court's *legal* conclusion that the entire ACA is invalid.
  - At the same time, however, the DOJ argued that the district court's *judgment* striking down the whole law is overbroad, and that some unspecified provisions of the law should not be included in the judgment because they don't affect the plaintiffs in the case.

## *Texas v. United States* (cont.)

- Possible Outcomes:
  - Back the lower court decision invalidating the ACA, or overturn it entirely.
  - Determine that the elimination of the individual mandate penalty only renders certain parts of the ACA unconstitutional.
  - Dismiss the entire lawsuit if they determine that no party has standing to pursue the appeal, in which case they would either leave the lower court judgment in place or require that it be vacated.



## Opioid Litigation

- Disproportionately impacting Indian Country
  - Health services have been overwhelmed
  - Education and addiction therapy costs have substantially increased
  - Evictions from housing for drug-related criminal activity
  - Almost every tribal member has been affected



## Opioid Litigation (cont.)

- Well over 2,000 suits have been filed in the last few years by states and their political subdivisions, insurance carriers, hospitals, individuals, and Indian tribes and tribal organizations.
- There are 3 classes of defendants who bear significant liability for the crisis – and who benefitted from it:
  - Manufacturers
  - Distributors
  - Retail Pharmacies in some cases

## Opioid Litigation (cont.)

- All federal court cases have been combined as "Multidistrict Litigation" (MDL) under the leadership of Cleveland Federal Judge Dan A. Polster.
- MDL is a unique federal court process different than a class action.
- Judge Polster has stated he would prefer to see the parties reach a "global settlement" of opioid claims, although litigation is proceeding in the meantime on a number of tracks.
- Various "bellwether" (test) cases have been selected for pre-trial briefing and, if necessary, trial.
- First bellwether trial in MDL scheduled this October, involving local government plaintiffs.



## Opioid Litigation (cont.)

- There are over 100 tribal cases on behalf of over 340 tribes pending in the MDL litigation.
- Two "tribal track" bellwether cases have been established: Muscogee (Creek) Nation and Blackfeet Tribe.
- In October an amicus brief was filed on behalf of 448 Tribes in both cases.
- Earlier this year the Defendants filed Motions to Dismiss in both cases, asking the court to make a threshold ruling that the Tribes' complaints were not sufficient to state any legal claims for relief.
- On June 13, 2019 the Judge issued an Opinion and Order ruling that rejected most of the Defendants' dismissal arguments.
- Both tribal bellwether cases now proceed to discovery and trial phases. No trial dates scheduled yet.



## Opioid Litigation (cont.)

- A Tribal Leadership Committee (TLC) has been appointed by the Court to advise the Plaintiff's MDL Leadership Committee on litigation and settlement strategy for the tribal cases.
- The TLC has had several meetings with State Attorney Generals who have committed to support a key principal: Tribes will be treated independently (and as sovereigns) in any settlement.
- Methodology that is used to calculate the overall set aside for tribal claimants in any global settlement might be different than the methodology that will be used to reallocate settlement amount among tribes.
- Settlement discussions are still very preliminary. Plaintiffs have claims for past damages, but settlement focus has so far been mainly on prospective remedies to help fix the problem.

## Opioid Litigation (cont.)

- Other plaintiffs in the MDL continue to pursue a settlement as well.
- In one approach, on June 14, 2019 cities and counties across the country filed a Motion to establish a "Negotiation Class."
- If approved, the class would be solely for the purpose of negotiating a comprehensive settlement with regard to such entities—it would not create a class action for purposes of litigation.
- Momentum on all settlement discussions is directly linked to aggressive litigation: more pressure on the defendants is brought through trial dates and removal of cases to State courts for more trials.



## Questions?

For more information, please contact:

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Swinomish

# didgʷálič

Wellness Center

John Stephens
EXECUTIVE DIRECTOR

## DIDGʷÁLIČ BACKGROUND

In 2016, the Swinomish Senate ambitiously decided to use their own funds and resources to combat the opioid crisis.

The community understands that this is a local and national issue affecting Native and non-Native populations.

## SERVING THE NEED

The didgʷálič Wellness Center remains the only facility in Skagit County that provides full-service medication assisted treatment ("MAT") and is the only MAT facility to provide fully-integrated primary care, mental health services, and counseling.

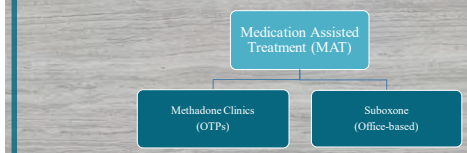
this *affects* us all

## Critical Treatment Gaps in Opioid Epidemic

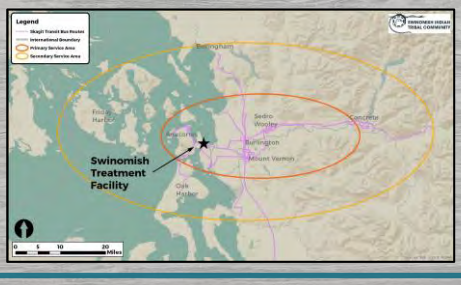
1. **MAT is not available for most patients**. Only 23% of publicly funded treatment programs and fewer than 50% of private programs offer MAT. *American Journal of Public Health*
2. **Most MAT patients don't have adequate access to counseling.** "[B]y itself, medically supervised withdrawal is usually not sufficient to produce long-term recovery, and it may increase the risk of overdose[.]" *New England Journal of Medicine*
3. **Referrals to primary care are ineffective.** Research demonstrates referrals result in only 35% of patients actually receiving primary care. *American Journal of Public Health*

## Two Types Of Medication Assisted Treatment (MAT)

- Methadone and Suboxone are delivered in two "siloed" environments.
- Methadone is highly regulated and can only be provided through licensed Opioid Treatment Programs (OTPs).
- Under the Drug Addiction Treatment Act of 2000, Suboxone is prescribed by physicians.




## Service Area




didg$^{w}$álič provides patients with

## *all the tools necessary for success*

- Outpatient Treatment Services
- Primary Medical Care
- Mental Health Counseling
- Medication-assisted Therapies
- Shuttle Transportation
- Case management & referrals
- Social Work Services
- Group & Family Therapy
- On-Site Public Benefits Enrollment
- On-Site Childcare
- On-Site Security
- Dental Care

## The didg$^{w}$álič Model

- Holistic – treats the medical and psychological collateral damage caused by opioid use disorder
- Blends best practice, evidence-based treatment with culturally appropriate care
- Eliminates unreliable and non-compliant patient referrals
- Keeps families together – avoids need to send patients far away for treatment
- Continuity of care within the wellness eco-system
- Nationally award-winning program – National Leadership Award from Indian Health Services

# PHASE II EXPANSION

- Square footage:
  - Current size: 10,000 square feet
  - Expansion size: 20,000 square feet
- 3 story addition to north side of current facility
- Double patient capacity from 250 to 500 patients

# PERSONNEL

| | Current | Expanded |
|---|---|---|
| **Executive Staff** CEO, COO, CMO, CIO | 3 | **4** |
| **Medical Staff** DR, LPNs, RNs, ARNPs, CNAs | 7 | **12-14** |
| **Chemical Dependency Professionals** Clinical Supervisor, CDP, CDPT | 7 | **14** |
| **Licensed Mental Health Counselors** Clinical Supervisor, LMHC, LMHCA | 3 | **6-8** |
| **Social Worker(s)** | 1 | **2** |

| | Current | Expanded |
|---|---|---|
| **Administration** Office Manager, Admin Ass't, Child Watch Attendants, Data Entry/UA Tech | 8 | **16-18** |
| **Billing** Manager, Specialist, Billing Ass't | 4 | **6** |
| **Security/Transportation/Other** Manager, Security Guards, Transporters | 9 | **18** |
| **Dental** Dentist, Clinical Supervisor, Hygienist, Dental Assistants, Office Support | 0 | **7** |

# PERSONNEL

- Providing high quality, well-paying jobs for local residents

Medication assisted treatment - when delivered in conjunction with appropriate supportive counseling and behavioral therapies - has long been recognized as the best and most highly effective, evidence-based treatment for opioid addiction.

Karen Caspar, Ph.D. *Models of Integrated Patient Care Through OTPs and DATA 2000 Practices*. Published by American Association for the Treatment of Opioid Dependence, Commissioned by Substance Abuse and Mental Health Services Administration, February 2016.

# DIDGʷÁLIČ "INTEGRATED CARE" MODEL


*Unique model, gaining national attention*

- Brings all necessary treatment components under one roof
- Integrated care vs. coordinated care
- Not a "triage" model
- Patient-centered – care determined by patient need
- Fully integrated Methadone/Suboxone/Vivitrol options
- Integrated primary care and behavioral health
- Removes barriers that otherwise prevent care
- Adaptive to rural or urban environments
- Adaptive to Vermont or Johns Hopkins eco-system
- Accredited as OTP
- Goal is to remove barriers to care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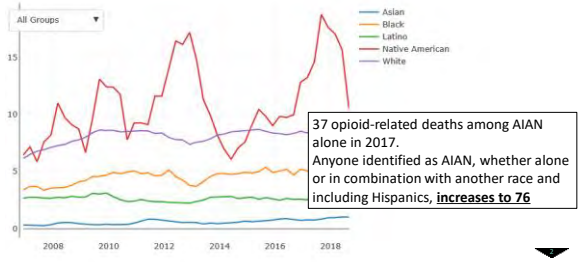
# *Tackling the Opioid Epidemic in California Indian Country*

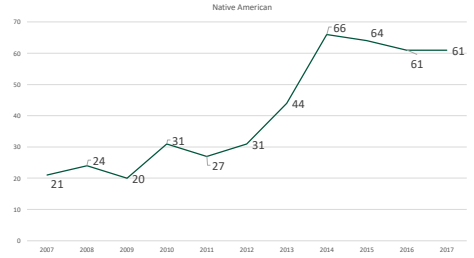
Vanesscia Cresci, MSW, MPA
Acting Epidemiology Manager, California Tribal Epidemiology Center
Director, Research and Public Health Department

## What is happening in California? Opioid-related deaths

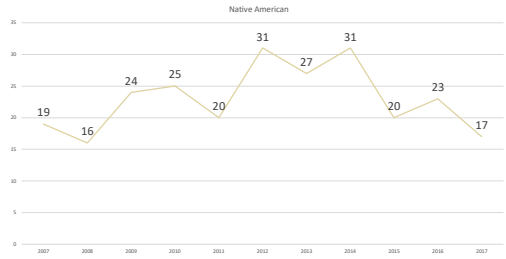



37 opioid-related deaths among AIAN alone in 2017.
Anyone identified as AIAN, whether alone or in combination with another race and including Hispanics, **increases to 76**

## California emergency room visits are on the rise for opioid-related non-fatal overdoses



## Hospitalizations for opioid-related non-fatal overdoses

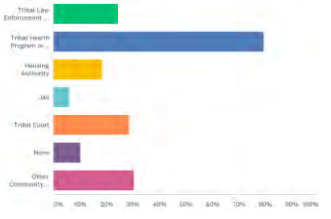



## Tribal Opioid Capacity Assessment preliminary results

- Has your Tribal Council passed any policies, laws, or ordinances to address the opioid crisis in your Tribal community?
  - No: 84% (32)
  - Yes: 16% (6)
    - Tribal ordinances, housing policies, pre-employment testing

## Tribal Opioid Capacity Assessment preliminary results

- Which of the following Tribal organizations in your community have been involved in addressing the opioid crisis?

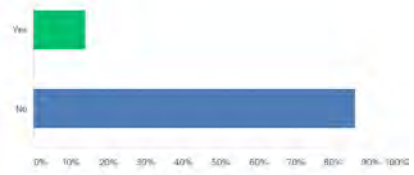


## Tribal Opioid Capacity Assessment preliminary results

| Which of the follow statements best describes the Tribe's access to opioid-related health data to monitor trends and patterns pertaining to your Tribal community? | % | # |
|---|---|---|
| The Tribe manages their own database to monitor opioid-related health trends and patterns. | 13.33% | 6 |
| The Tribe has an agreement/collaborates with outside agencies who share data with the Tribe about opioid-related health trends and patterns. | 8.89% | 4 |
| The Tribe does not have their own database to monitor opioid-related health trends and patterns. | 11.11% | 5 |
| The Tribe does not have access to opioid-related health data about our Tribal community. | 11.11% | 5 |
| The Tribe does not currently manage their own database, but has an interest in managing their own database to monitor opioid-related health trends and patterns. | 13.33% | 6 |
| ***The Tribe does not currently manage their own database, but has an interest in collaborating with an outside agency to receive data to monitor opioid-related health trends and patterns about our Tribal community.*** | ***26.67%*** | ***12*** |
| Other (please specify) | 15.56% | 7 |

## Tribal Opioid Capacity Assessment preliminary results

- Does your Tribe have any system to detect early signs of potential opioid overdoses in your Tribal community?




## California Tribal Opioid Summit

*What does an opioid-free Tribal community look like?*

**North**

- Limit prescription of pain medication and use **alternative treatments**
- Overall recovery and healing is inclusive of all community members and everyone has a role in a strong, resilient, and thriving community
- **Active lifestyles and healthy eating**
- Increase in behavioral health staff
- Communities working together

**Central**

- Redesign services to reach clients at critical points: jail, prisons, hospitals, wellness courts, treatment centers
- Transformational housing with mentoring and psychological services
- Community has **healthy parents, elders, and children**
- Limit pain medication prescriptions and use **alternative treatments**
- Telemedicine in remote areas to provide services
- Cultural and traditional, sober living, and treatment services
- Integrate services at the Tribal Health Program

**South**

- Increased access to **physical and spiritual activities**
- Drug and alcohol free community events and gatherings
- Phase out western approaches to wellness and strengthen **traditional medicine**

# How is CRIHB responding?

CRIHB
OPIOID RESPONSE PROJECTS

- SAMHSA funded Tribal Opioid Response (TOR)
  - Working with 6 Tribal Health Programs, serving 25 Tribes
- CDC funded California Tribal Opioid Strategic Plan
  - Collecting data across the State
- CDPH funded Tribal Medication Assistant Treatment (MAT)
  - Working with 14 Tribal Local Opioid Coalitions
  - Providing training across the State

## Tribal Opioid Response Activities

| Culturally based Community Education | Enhance Community Support Services | Culturally appropriate, trauma-informed, harm reduction PSEs in Tribal Health Programs and Tribes | Tribal and Tribal Health Program Leader Engagement | Other Supportive Activities |
|---|---|---|---|---|
| • Elder workshops<br>• Community workshops<br>• Opioids 101<br>• Medication safety<br>• Importance of using medications as prescribed<br>• Proper medication disposal<br>• Elder abuse prevention<br>• Pain management alternatives<br>• Historical trauma<br>• Building recovery ecosystems<br>• MAT self-assessment | • White Bison programming<br>• Prayer ties<br>• Purification ceremonies<br>• Pain management alternative treatment<br>• Recovering honoring ceremonies<br>• Talking circles | • Needle exchange<br>• Naloxone education and distribution<br>• Safe injection sites<br>• Safe prescribing guidelines<br>• Safe disposal sites<br>• Tribal Health Program-wide harm reduction approach<br>• Chronic pain management using alternative approaches | • Tribal Health Program partnership with Tribe<br>• Community stakeholder engagement<br>• Community meetings<br>• Partner with spiritual leaders | • Increasing the number of x-waivered providers<br>• Regional opioid summit<br>• MAT program<br>• Partnering with California Hub and Spoke Systems to become a spoke<br>• Provide treatment, transitional housing, and sober living services |

## California Tribal Opioid Strategic Plan

- Create an Tribal Opioid Strategic Plan
  - 6 Youth Focus Groups
  - 5 Elder Focus Groups
  - 15 Key Informant Interviews with adults and elders
  - Tribal Opioid Summit feedback
- Form a Tribal Opioid Advisory Committee
  - Provide guidance to all CRIHB opioid projects
  - Guide the development of the Tribal Opioid Strategic Plan
- Implement a Tribal Opioid Capacity Assessment
  - Assess Tribal-specific capacity and gaps
- Tribal Head Start pilot project
  - Focus on developing resiliency-focused, culturally-based interventions

## Tribal Medication Assisted Treatment (MAT)

**Three MAT Champions**

| | | | |
|---|---|---|---|
| Statewide Opioid Summit and Regional Opioid Trainings | Distribution and training of Naloxone | Community opioid education campaign | Funding 14 Tribal Local Opioid Coalitions |
| Telehealth infrastructure support | Alternative Treatment Options: acupuncture, yoga, reiki, traditional healers, herbalists | Provider, CHR & MA Training | Partner with Project ECHO and TeleWell to implement MAT |

## Tribal Local Opioid Coalition Framework

**Phase 1: Setting Up for Success**

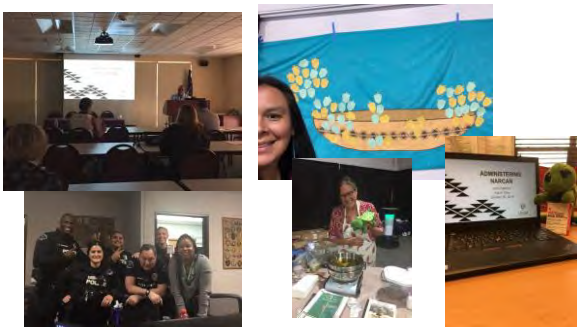
- Community Readiness Assessment
- Tribal Action Plan
- Identify and develop community partnerships
- Develop coalition work plans
- Tribal MAT Champions provide coaching

**Phase 2: Getting the Work Done**

- Increase access to MAT
- Implement Safer Prescribing Practices and Guidelines
- Stigma reduction strategies
- Support recovery and peer support services
- Youth prevention activities
- Community-based, culturally appropriate prevention strategies
- Expand access to non-opioid pain treatment
- Link coalitions to Subject Matter Experts
- Tribal MAT Champions provide coaching

**Phase 3: Growing & Sustaining**

- Continue to implement and expand 7 strategies
- Develop sustainability plan
- Develop Tribal Subject Matter Experts
- Tribal MAT Champions provide coaching




# Thank You!

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# NPAIHB Tribal Opioid Response Update

Colbie Caughlan
TOR Project Director
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503-416-3284

## Overview

Tribal Opioid Response

What have our communities started?

What comes next?

## NPAIHB Opioid Projects

- Tribal Opioid Response (TOR) – SAMHSA
  - Consortium of 22 Tribes (35 Total)
  - *Capacity Building*
- Strategic Planning (CDC)
  - Regional and National Work
  - Comprehensive
- Opioid Overdose Data and Surveillance (CDC)
  - Improve accuracy and access to data on drug and opioid overdoses for Northwest Tribes
- Indian Country Substance Use Disorder ECHO clinic (SAMHSA + OMH)
  - Integrating Medications for Addictions Treatment in Primary Care
  - *Clinical Focus*

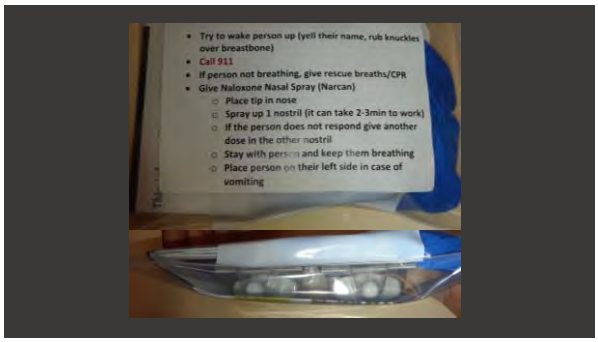
## NPAIHB Tribal Opioid Response Consortium

The overarching goal of the NPAIHB TOR Consortium is to develop a comprehensive and strategic approach to assist Tribes in developing capacity to address the complex factors associated with a comprehensive opioid response. This includes:

- Developing a framework for a NW Opioid Response strategic plan,
- Increasing awareness of opioid use disorder,
- Preventing opioid use disorder,
- Increasing access to treatment and recovery services and overdose reversal capacity
- Reducing the health consequences of opioid use disorder in tribal communities.

## Current Activities

- Since January 3 Tribes and the NPAIHB have purchased Naloxone (Narcan nasal spray) and started to distribute them.
- At least 3 Tribes have started to develop or have implemented policies related to Naloxone use.

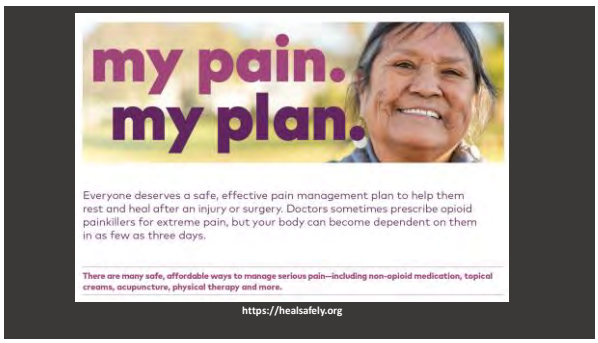




## Current Activities

- 4 Public awareness campaigns have already been implemented and at least a handful more are in the process of developing their campaigns
- At least 5 Clinics who chose to, are beginning to develop, adapt, or have adopted safer opioid prescribing practices and/or policies in the past four months.
- At least 8 Tribes have started providing MAT services by linking to other external clinics or to an IHS clinic.

## Recovery Services

- Implemented culturally-based recovery services and at least 30 clients have started receiving these services
- Implemented a recovery coaching program with at least 8 people already served
- Implemented housing recovery services with at least 6 people having been served



## Prevention & Wraparound Services

- Implemented prevention programs and have served over 300 community members including at least 130 youth
- Wraparound services provided:
  - community outreach
  - Transportation
  - Benefits
  - legal issues
  - family services
  - general case management
  - assistance/referral for help with housing
  - education regarding OUD and mental health issues


## Challenges

- Stakeholder buy-in
- Setting up account to purchase Naloxone
- Hiring staff for short term grant
- Prevention activities vs. providing MAT because. . . .
- **Potential Reporting Requirement: GPRA data**

# Best Practice – Indian Country ECHO

Project ECHO
Northwest Portland Area Indian Health Board (NPAIHB)
Indian Leadership for Indian Health

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DATA 2000 Waiver Training + ECHO Onboarding

**Upcoming Trainings:**

Rocky Boy, MT – July 30
Quinault, WA – August 29
Tahlequah, OK– September 12-13
Oklahoma City, OK – September 18

**Want to be the next location?**

Contact Eric Vinson at evinson@npaihb.org

# Northwest Portland Area Indian Health Board

Jessica Leston - Tsimshian
Northwest Portland Area Indian Health Board

## Indian Leadership for Indian Health

## Background – HCV in Indian Country

American Indians/Alaska Natives (AI/AN) have more than double the national rate of HCV -related mortality, and the highest rate of acute HCV infection.[1]

The most current national study estimates 40,000 persons served by Indian Health Service (IHS) have chronic HCV.[2]

## Background – SUD in Indian Country

More AI/AN have died of a drug overdose than members of any other racial or ethnic group in the US.[3]

AI/AN had the largest percentage increase in the number of deaths over time.[3]

## Background – Diabetes in Indian Country

AI/AN have a greater chance of having diabetes than any other US racial group.[4]

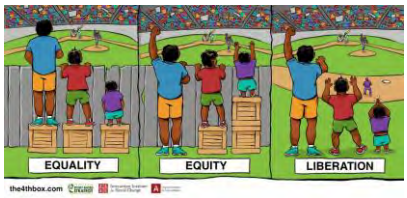
Kidney failure from diabetes among AI/AN was the highest of any race.[4]

### Disparities

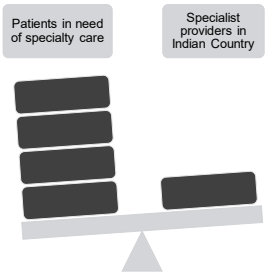
(% greater than US all races) [5]

| |
|---|
| Alcohol related (520%) |
| TB (450%) |
| Chronic liver disease (368%) |
| Motor vehicle crashes (207%) |
| Diabetes (177%) |
| Unintentional injuries (141%) |
| Poisonings (118%) |
| Homicide (86%) |
| Suicide (60%) |

## The Big Problem




**A 'Small' Problem –** Lack of specialist availability limits access to medical treatment



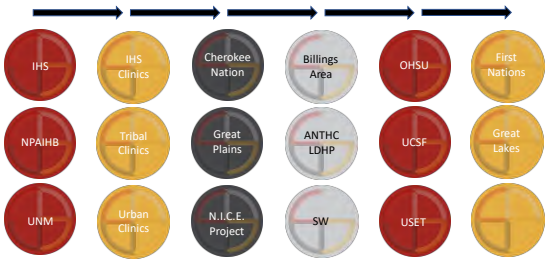

## A Solution

"We choose to go to the Moon! We choose to go to the Moon in this decade and do the other things, not because they are easy, but because they are hard; **because that goal will serve to organize and measure the best of our energies and skills**, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one we intend to win, and the others, too." – John F. Kennedy



INDIAN COUNTRY ECHO

## Building Relations and Partnerships



## Accomplishments so far…

- HCV ECHO 2 1/2 years old at the end of January
- Trained over 350 medical professionals on HCV
- 557 patient recommendations for HCV treatment
- SUD clinic started in January, trained over 136 people in MAT and OUD
- Engaged over 100 I/T/U clinics
- Partnerships across Indian Country




## **NEW** Diabetes ECHO

- Successful pilot in 2018
- Led to Diabetes ECHO implementation
- Presenting at Annual Diabetes Conference – ECHO Style
- *"Extremely helpful when discussing specific cases"*

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## Extra-ECHO Accomplishments

- Working to change Medicaid policy in "Grade F" states
  - Oregon, South Dakota
- Working with IHS to advocate for resources for HCV treatment
  - 25 million dollars for Ending the HIV Epidemic in Indian Country – ALSO addressing HCV
- Working with IHS to systematically increase DATA Waived providers to increase access to MAT
  - Partnership with HOPE Committee
  - MAT training at NCC


## IndianCountryECHO.org

| |
|---|
| Hepatitis C – *Text HCV to 97779* |
| SUD/OUD – *Text Opioid to 97779* |
| Diabetes – *Text Endo to 97779* |
| Youth Leadership |
| First People' ECHO Collaborative |
| Harm Reduction – *Text Harm Reduction to 97779* |
| Pallative Care (ANTHC) |
| HIV (UNM) |
| PrEP and HIV Prevention – *Text PrEP – coming soon* |
| LGBTQ 2-Spirit Health – *Text LGBTQ2 – coming soon* |

## Lessons Learned

- **Tribes and tribal organizations can and should be the hub of delivering ECHO clinics to Indian Country**
- Tribes and tribal organizations are well suited to bring together front line clinicians, tribal partners and medical experts from a variety of fields in a culturally appropriate way
- We work with anyone who has the passion to drive the work – advancing the top of licensure
- We raise up champions to continue to expand
- The key to scaling up has been relationships, often fostered in-person at regional trainings, and site visits

*"Power is the ability to achieve a purpose. Whether or not it is good or bad depends on the purpose."*

– Dr. Martin Luther King Jr.


Image Credits – Creator: ROBYN BECK Credit: AFP/Getty Images

## Equity in Healthcare


## References

1. Centers for Disease Control and Prevention. (2015). Division of viral hepatitis, surveillance for viral hepatitis, United States, Retrieved Aug 28, 2017, from https://www.cdc.gov/hepatitis/statistics/2015surveillance/index.htm
2. Haverkate R, Reilley B. Hepatitis C Virus in Indian Country. Retrieved March 10, 2017 from https://www.ihs.gov/newsroom/ihs-blog/may2017/hepatitis-c-virus-in-indian-country/
3. Joshi S, Weiser T, Warren-Mears V. Drug, Opioid-Involved, and Heroin-Involved Overdose Deaths Among American Indians and Alaska Natives — Washington, 1999–2015. MMWR Morb Mortal Wkly Rep 2018;67:1384–1387.
4. Centers for Disease Control and Prevention. (2017). Native Americans with Diabetes, Retrieved July 11, 2019, from https://www.cdc.gov/vitalsigns/aian-diabetes/index.html
5. Trends in Indian Health 2014 Edition, US DHHS, Indian Health Service

# What Tribal Leaders Need to Know

In 2020, the U.S. Census will define who we are as a nation. It is vital that the census also have an accurate portrait of our tribal nations.

## Your Participation in the 2020 Census Matters

Every year, more than $675 billion federal funds is awarded to tribes and states and communities based on census data. The decennial census also helps determine the number of state representatives and boundaries for voting and school districts.

Census population counts guide local decision makers in important community and tribal planning efforts, including where to build child care and community centers.

Tribal governments and planners rely on census data to determine where the most need exists for additional social services and who gets needed funding, such as tribal development programs, education, and health care services.

### Why should tribal members participate in the 2020 Census?

The 2020 Census will shape the future of your tribal community, define your voice in Congress and impact economic development and other opportunities for your tribal citizens.

- Federal and state agencies depend on census data to determine funding allocations for tribal programs.
- Census data can assist tribal leaders in their decision making for economic development projects and community service programs.
- Many researchers, the media and others use census data. Full tribal participation ensures that these data more closely represents the American Indian and Alaska Native population.
- Census data are the official data used for U.S. population counts. Congress and other federal decision makers refer to census data when making political and economic decisions.

### Why is working in partnership with tribal governments so important to the 2020 Census?

The U.S. Census Bureau acknowledges its government-to-government relationship with the 573 federally recognized tribal governments. Our commitment to work in partnership with American Indian and Alaska Native (AIANs) populations includes working with state-recognized tribes and AIAN people and organizations in metropolitan and rural locations.

In the past there have been challenges in obtaining a full accounting of the AIAN population on tribal lands and in urban and rural areas. The U.S. Census Bureau's mandate is to provide a full accounting of all Americans and this must include a complete count of American Indian and Alaska Native people wherever they live.

## The Census: A Snapshot

The U.S. Constitution requires a national census once every 10 years. The census is a count of everyone residing in the United States: on tribal lands, the 50 states, Washington, D.C., Puerto Rico, U.S. Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa. This includes people of all ages, tribes, races, ethnic groups, both citizens and noncitizens.

# What Tribal Leaders Need to Know

## Completing the 2020 Census Questionnaire: Simple and Secure

The 2020 Census questionnaire asks only a few simple questions of each person and will be a simple short questionnaire that will take just a few minutes to complete.

People can respond using the online, telephone or paper response options. The 2020 Census will offer internet self-response (ISR) where people can respond online, Census Questionnaire Assistance (CQA) which will allow respondents to complete the census questionnaire over the telephone and the paper questionnaire will still be available which can be returned by mail.

The U.S. Census Bureau does not release or share information that identifies individual respondents or their household for 72 years. By law, the U.S. Census Bureau cannot share an individual's answers with anyone, *including immigration enforcement agencies, like ICE; law enforcement agencies, like the FBI or police; or allow it to be used to determine their eligibility for government benefits. The results from any census or survey are reported in statistical format only.*

All census workers, including tribal members working for the U.S Census Bureau, take an oath for life to protect the confidentiality of census responses. Violation would result in a jail term of up to five years, and/or a fine of up to $250,000. By law, the U.S. Census Bureau cannot share an individual's answers with anyone, including the tribal government, tribal programs, or any other tribal, federal or state entity.

In addition, all systems used in the 2020 Census adhere to laws, policies, and regulations that ensure appropriate systems and data security, and protects respondent and employee privacy and confidentiality. The Census Bureau is monitored by the Einstein 3A system which is run by the Department of Homeland Security (DHS), to ensure Web traffic to and from government Web sites are safe. DHS analysts monitor traffic for cyberattacks, not to get information on individuals. The law prohibits DHS from using any information they might see for anything other than cybersecurity protection.

## 2020 Census Time Line: Key Dates

| | |
|---|---|
| Fall 2018 | Recruitment begins for early census operations. |
| Fall 2019 | Recruitment begins for peak operations in 2020. |
| August-October 2019 | In-field address canvassing where needed. |
| March – July 2020 | Internet Self-Response. |
| March – September 2020 | Census Questionnaire Assistance. |
| April 1, 2020 | Census Day – Respondents will be able to respond via internet, telephone or paper questionnaire. |
| December 2020 | U.S. Census Bureau delivers population counts to President for apportionment. |
| March 2021 | U.S. Census Bureau delivers redistricting data to states. |

**RESOLUTION # 19-04-02**
**NORTHWEST PORTLAND AREA**
**INDIAN HEALTH BOARD**

**RESOLUTION # 334-08-19**
**CALIFORNIA RURAL INDIAN**
**HEALTH BOARD**

## JOINT RESOLUTION

## A CALL TO CONGRESS TO SUPPORT ADVANCE APPROPRIATIONS FOR THE INDIAN HEALTH SERVICE

**WHEREAS,** the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

**WHEREAS,** the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

**WHEREAS,** the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

**WHEREAS,** the primary goal of the NPAIHB and CRIHB is to improve the health and quality of life of its member Tribes; **AND**

**WHEREAS,** the United States has a unique and special relationship with AI/ANs to provide health care as established through the U.S. Constitution, treaties, U.S. Supreme Court decisions and federal legislation; **AND**

**WHEREAS,** although the trust relationship requires the federal government to provide for the health and welfare of Tribal nations, the Indian Health Service (IHS) remains chronically underfunded and AI/ANs suffer from among the lowest health status nationally; **AND**

**WHEREAS,** IHS, an agency within the Department of Health and Human Services, administers health care to 2.6 million AI/ANs residing in Tribal communities in 35 states, directly, or through contracts or compacts with Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act; **AND**

**WHEREAS,** in recent years, federal appropriation bills have not been enacted in a timely manner, thus hampering Tribal and IHS health care providers' budgeting, recruitment, retention, provision of services, facility maintenance, and construction efforts; **AND**

**WHEREAS,** since Fiscal Year 1998, there has only been one year (FY2006) in which the Interior, Environment and Related Agencies Appropriations bill has been enacted before the beginning of the new fiscal year; **AND**

**WHEREAS,** the budgetary solution to this failure to uphold the federal trust responsibility, and the one which does not require the Congressional appropriations committees to count Advance Appropriations against their spending cap is Advance Appropriations; **AND**

**WHEREAS,** the NPAIHB and CRIHB believe that moving to the Advance Appropriations process protects Tribes and Tribal organizations and the IHS direct service units from cash flow problems that regularly occur at the start of the federal fiscal year due to delays in enactment of annual appropriations legislation; **AND**

**WHEREAS,** Congress has recognized the difficulties inherent in the provision of direct health care that relies on the appropriations process and traditional funding cycle through enactment of the Veterans Health Care Budget Reform and Transparency Act of 2009 (PL 111-81), which authorized Advance Appropriations for Veterans Administration (VA) medical care programs; **AND**

**WHEREAS,** the IHS should be afforded the same budgetary certainty and protections extended to the VA, which is also a federally-funded provider of direct health care.

**THEREFORE BE IT RESOLVED** that the NPAIHB and CRIHB request that Congress amend the Indian Health Care Improvement Act to authorize Advance Appropriations for the IHS; **AND**

**BE IT FURTHER RESOLVED,** that the NPAIHB and CRIHB request that Congress include our recommendation for Advance Appropriations for IHS in the Budget Resolution; **AND**

**BE IT FURTHER RESOLVED,** that the NPAIHB and CRIHB request that Congress include in the enacted appropriations bill Advance Appropriations for IHS.

**CERTIFICATION**

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

**NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD**
2121 SW Broadway, Suite 300
Portland, OR 97201
(503) 228-4185

Chairperson of the Board

Attest

**CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.**
1020 Sundown Way
Roseville, CA 95661
(916) 929-9761

Chairperson of the Board

Attest

**RESOLUTION # 19-04-03**
**NORTHWEST PORTLAND AREA**
**INDIAN HEALTH BOARD**

**RESOLUTION # 335-08-19**
**CALIFORNIA RURAL INDIAN**
**HEALTH BOARD**

## JOINT RESOLUTION

## FULL FUNDING FOR THE INDIAN HEALTH SERVICE

**WHEREAS,** the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

**WHEREAS,** the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

**WHEREAS,** the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

**WHEREAS,** the primary goal of the NPAIHB and CRIHB is to improve the health and quality of life of its member Tribes; **AND**

**WHEREAS,** Indian Nations and the United States (US) government have a sovereign-to-sovereign relationship established by treaties, agreements, acts of Congress, and court decisions; **AND**

**WHEREAS,** this relationship has resulted in the federal trust responsibility to Indian Nations and it is a legally enforceable fiduciary obligation on the part of the US to protect Tribal treaty rights, lands, assets, and resources, as well as a duty to carry out the mandates of federal law with respect to AI/AN Tribes and villages; **AND**

**WHEREAS,** in several cases discussing the trust responsibility, the US Supreme Court has used language detailing the legal duties, moral obligations, and fulfillment of understandings and expectations that have been established by law between the US and the Indian Nations; **AND**

**WHEREAS,** the US Court of Appeals for the Ninth Circuit declared that the system used by the Indian Health Service (IHS) for the allocation of its funds violated the California Indians' constitutional right to equal protection. Furthermore, in a subsequent clarification of that judgment, the district court declared that, "(i)n accordance with this conclusion, defendants are obligated to adopt a program for providing health services to Indians in California which is comparable to those offered [to] Indians elsewhere in the United States"; **AND**

**WHEREAS,** as stated in treaties and other federal issuances with Indian Nations, health care is guaranteed to AI/ANs in perpetuity in exchange for the millions of acres of Indian lands that now make up the US; **AND**

**WHEREAS,** IHS, an agency within the Department of Health and Human Services, administers health care to 2.6 million AI/ANs residing in Tribal communities across the US, directly, or through contracts or compacts with Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act; **AND**

**WHEREAS,** Tribal leaders representing the 12 IHS Areas sit on the National Tribal Budget Formulation Workgroup and make recommendations to the administration annually on IHS funding; **AND**

**WHEREAS,** the National Tribal Budget Formulation Workgroup recommended that the amount necessary to fully fund IHS was $32 billion in Fiscal Year 2019, and the IHS only received a $5.8 billion appropriation in Fiscal Year 2019; **AND**

**WHEREAS,** in Fiscal Year 2017, the IHS per capita expenditures for patient health services were just $3,332[1], compared to $9,207 per person for health care spending nationally[2], and $12,744 for Medicare spending per capita[3]; **AND**

**WHEREAS,** for Fiscal Year 2021, the National Tribal Budget Formulation Workgroup, in an updated recommendation, suggests that IHS be fully funded at $37.61 billion; **AND**

**WHEREAS,** AI/ANs continue to suffer some of the worst health disparities of all Americans, and according to the Center for Disease Control and Prevention, include, but are not limited to:

- An overall life expectancy that is 5.5 years less than the national average;
- The second highest age-adjusted mortality rate of any demographic nationwide at 800.3 deaths per 100,000 people;
- The highest Hepatitis C mortality rates nationwide (10.8 per 100,000) and higher rates of chronic liver disease and cirrhosis deaths (2.3 times that of Whites);
- A suicide rate that is more than 3.5 times higher than other racial/ethnic groups;

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[1] The figure on congressional appropriations for IHS includes funding for health care delivery as well as sanitation, facilities and environmental health. Per capita IHS appropriation was calculated from $4,957,856,000 in total appropriations divided by 1,638,687 Active Users. Source: *2017 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita*," February 26, 2018, available at: https://www.ihs.gov/ihcif/includes/themes/responsive2017/display_objects/documents/2018/2017_IHS_Expenditures.pdf, last accessed 10/15/2018.

[2] NHE Projections 2016-2025 –Tables, Table 5 Personal Health Care Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2016-2025; Per Capita Amount; Projected; available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

[3] Honoring The Federal Trust Responsibility: A New Partnership to Provide Quality Healthcare to America's First Citizens: The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2019 Budget, March 2017, p. 14, https://www.nihb.org/docs/04032017/TBFWG%20Testimony%20FY%202019%20FINAL.pdf

- A significant increase in cancer rates, while overall cancer rates for Whites declined from 1990 to 2009;
- A lower prevalence of having a personal doctor or health care provider (63.1%) compared to Whites (72.8%); **AND**

**WHEREAS,** all of these determinants of health and poor health status could be dramatically improved with adequate investment into the health, public health, and health delivery systems in Indian Country**.**

**NOW THEREFORE BE IT RESOLVED,** that the CRIHB and NPAIHB recommend Congress fully fund the IHS at $37.61 billion pursuant to the recommendation of the National Tribal Budget Formulation Workgroup for Fiscal Year 2021 and ensure the Portland and California Areas receive their fair share of the resources.

**CERTIFICATION**

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

**NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD**
2121 SW Broadway, Suite 300
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(503) 228-4185

Chairperson of the Board

Attest

**CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.**
1020 Sundown Way
Roseville, CA 95661
(916) 929-9761

Chairperson of the Board

Attest

**RESOLUTION # 19-04-04**
**NORTHWEST PORTLAND AREA**
**INDIAN HEALTH BOARD**

**RESOLUTION # 336-08-19**
**CALIFORNIA RURAL INDIAN**
**HEALTH BOARD**

## JOINT RESOLUTION

### A CALL TO CONGRESS TO SUPPORT MANDATORY APPROPRIATIONS FOR THE INDIAN HEALTH SERVICE

**WHEREAS,** the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

**WHEREAS,** the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

**WHEREAS,** the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

**WHEREAS,** the primary goal of the NPAIHB and CRIHB is to improve the health and quality of life of its member Tribes; **AND**

**WHEREAS,** Indian Nations and the United States (US) government have a sovereign-to-sovereign relationship established by treaties, agreements, acts of Congress, and court decisions; **AND**

**WHEREAS,** this relationship has resulted in the federal trust responsibility to Indian Nations and it is a legally enforceable fiduciary obligation on the part of the US to protect Tribal treaty rights, lands, assets, and resources, as well as a duty to carry out the mandates of federal law with respect to AI/AN Tribes and villages; **AND**

**WHEREAS,** in several cases discussing the trust responsibility, the Supreme Court has used language detailing the legal duties, moral obligations, and fulfillment of understandings and expectations that have been established by law between the US and the Indian Nations; **AND**

**WHEREAS,** as stated in treaties and other federal issuances with Indian Nations, health care is guaranteed to AI/ANs in perpetuity in exchange for the millions of acres of Indian lands that now make up the US; **AND**

**WHEREAS,** in 2010, the US Congress declared, “It is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians… to ensure the highest possible health status for Indians and to provide all resources necessary to effect that policy”; **AND**

**WHEREAS,** the Indian Health Service (IHS), an agency within the Department of Health and Human Services, administers health care to 2.6 million AI/ANs residing in Tribal communities across the US, directly, or through contracts or compacts with Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act; **AND**

**WHEREAS,** the IHS received a $5.8 billion appropriation in Fiscal Year (FY) 2019, yet the National Tribal Budget Formulation Workgroup recommends that the amount necessary to fully fund IHS is $37.61 billion pursuant to their FY 2021 recommendation; **AND**

**WHEREAS,** in FY 2017, the IHS per capita expenditures for patient health services were just $3,332, compared to $9,207 per person for health care spending nationally; **AND**

**WHEREAS,** Tribes and Tribal Health Programs cannot properly establish proper planning procedures due to current fluctuation of funding each FY in conjunction with congressionally approved budgets and recent government shutdowns; **AND**

**WHEREAS,** Tribes and Tribal Health Programs cannot recruit, maintain, and sustain staff for their clinics due to funding uncertainties; **AND**

**WHEREAS,** AI/ANs continue to suffer some of the worst health disparities of all Americans and according to IHS data, they die at higher rates than other Americans from alcoholism (552% higher), diabetes (182% higher), unintentional injuries (138% higher), homicide (83% higher), and suicide (74% higher); **AND**

**WHEREAS,** AI/ANs suffer from higher mortality rates from cervical cancer (1.2 times higher), pneumonia/influenza (1.4 times higher), and maternal deaths (1.4 times higher) compared to the larger US population; **AND**

**WHEREAS,** the instability of the current discretionary funding process for IHS continues to put the lives of AI/ANs at risk; **AND**

**WHEREAS,** moving IHS to the mandatory side of the federal budget would stabilize the IHS budget and ensure that the care that AI/ANs need is always guaranteed; **AND**

**WHEREAS,** making spending for IHS mandatory would exempt IHS form broad-based cuts in discretionary spending, and budget rescissions **AND**

**WHEREAS,** other direct health programs like the Veterans Health Administration have a mandatory spending designation; **AND**

**WHEREAS,** IHS should be treated like the obligation it is, and the Congress should move IHS funding to the mandatory side of the federal budget; **AND**

**NOW THEREFORE BE IT RESOLVED,** that the CRIHB and NPAIHB urge Congress to enact mandatory appropriations for the IHS, in order to provide the highest level of health care service for all AI/ANs, as is the government’s duty to fulfill this obligation under the federal trust responsibility.

## CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

**NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD**
2121 SW Broadway, Suite 300
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Chairperson of the Board

Attest

**CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.**
1020 Sundown Way
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(916) 929-9761

Chairperson of the Board

Attest

**RESOLUTION # 19-04-05**
**NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD**

**RESOLUTION # 337-08-19**
**CALIFORNIA RURAL INDIAN HEALTH BOARD**

## JOINT RESOLUTION

## A CALL TO CONGRESS TO FULLY FUND SECTION 105(l) INDIAN SELF-DETERIMINATION AND EDUCATION ASSISTANCE ACT (ISDEAA) LEASE OBLIGATIONS TO TRIBES AND TRIBAL ORGANIZATIONS

**WHEREAS,** the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

**WHEREAS,** the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

**WHEREAS,** the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

**WHEREAS,** the primary goal of the NPAIHB and CRIHB is to improve the health and quality of life of its member Tribes; **AND**

**WHEREAS,** the United States (U.S.) has a unique and special relationship with AI/ANs to provide health care as established through the U.S. Constitution, treaties, U.S. Supreme Court decisions and federal legislation; **AND**

**WHEREAS,** Section 105(l) of ISDEAA requires IHS, upon Tribal request, to enter into a lease for a facility owned or leased by the Tribe or Tribal organization and used to carry out its ISDEAA agreement; **AND**

**WHEREAS,** as established in *Maniilaq*, IHS must compensate the Tribe or Tribal organization fully for its reasonable facility expenses under Section 105(l); **AND**

**WHEREAS,** on July 10, 2018, IHS sent a Dear Tribal Leader Letter (DTLL) proposing to fund a $13 million Fiscal Year (FY) 2018 shortfall of Section 105(l) ISDEAA lease costs by reprogramming funding from IHS unallocated inflation increases; **AND**

**WHEREAS,** on July 25, 2018, NPAIHB sent a letter to IHS asking it to seek and obtain a supplemental appropriation of $13 million from Congress; and

**WHEREAS,** on September 14, 2018, IHS sent a follow-up DTLL informing Tribes that it had decided that in order to meet FY 2018 105(l) lease funding requirements it had reprogrammed $25 million from the $70.4 million increase identified for inflation; **AND**

**WHEREAS,** on March 2, 2019, IHS issued an additional DTLL that stated:

- IHS has received 100 105(l) lease proposals from Tribes and Tribal organizations, totaling approximately $39 million, for FY 2019; and
- In addition to an initial $5 million that the IHS identified in the base services appropriation, Congress provided IHS an increase of $25 million for Tribal clinic operational costs in FY 2019; and
- Base IHS appropriation increases IHS's capacity to address the anticipated FY 2019 funding need, but full FY 2019 need remains unknown; and
- FY 2018 reprogramming was done on a one-time basis in the hopes that other options might become available in FY 2019; and
- Due to the continued need for resources beyond those identified for Tribal clinic operational costs in FY 2019, IHS is legally required to use a portion of the funds included in the IHS appropriation to fund 105(l) leases; **AND**

**WHEREAS,** it is anticipated that 105(l) lease costs will far exceed appropriations for FY2020; **AND**

**WHEREAS,** Tribes and Tribal organizations rely on program increases to keep pace with the cost of living; **AND**

**WHEREAS,** unless additional funding is provided for IHS appropriations, the additional funds required for 105(l) leases will come at the expense of the overall health program and result in cuts in services for both direct service and self-governance tribes as 105(l) lease costs increase; **AND**

**WHEREAS,** the National Tribal Budget Formulation Workgroup's recommendations for FY 2021 requested that IHS take adequate steps to fully address 105(l) leasing obligations and work proactively with Congress to ensure its full payment as an indefinite appropriation.

**THEREFORE BE IT RESOLVED** that the NPAIHB and CRIHB call on Congress to fully fund Section 105(l) ISDEAA lease obligations to Tribes and Tribal organizations as an indefinite discretionary appropriation for such sums as are necessary.

## CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

**NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD**
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Chairperson of the Board

Attest

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(916) 929-9761

Chairperson of the Board

Attest

**RESOLUTION # 19-04-06**
**NORTHWEST PORTLAND AREA**
**INDIAN HEALTH BOARD**

**RESOLUTION # 338-08-19**
**CALIFORNIA RURAL INDIAN**
**HEALTH BOARD**

## JOINT RESOLUTION

### A CALL TO CONGRESS TO ENACT MANDATORY APPROPRIATIONS IN SUPPORT OF THE NATIONAL CHILD TRAUMATIC STRESS INITIATIVE

**WHEREAS,** the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest**; AND**

**WHEREAS,** the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California**; AND**

**WHEREAS,** the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people**; AND**

**WHEREAS,** the National Center for Child Traumatic Stress (NCCTS), is part of the National Child Traumatic Stress Initiative (NCTSI), under the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency within the Department of Health and Human Services (HHS)**; AND**

**WHEREAS,** the purpose of NCTSI is to improve the quality of trauma treatment and services in communities for children, adolescents, and their families who experience or witness traumatic events, and to increase access to effective trauma-focused treatment and services for children and adolescents throughout the nation**; AND**

**WHEREAS,** the initiative is designed to address child trauma issues by creating a national network of grantees—the National Child Traumatic Stress Network that works collaboratively to develop and promote effective trauma treatment and services for children, adolescents, and their families exposed to a wide array of traumatic events**; AND**

**WHEREAS,** NCCTS awards grants and block grants to federally-recognized AI/AN Tribes and Tribal organizations through an extremely detailed application process with unrealistic time frames, submission of two separate budget proposals with budget justifications and extensive supporting documents**; AND**

**WHEREAS,** Tribes and Tribal health clinics, especially small Tribes, face barriers such as limited access to broadband wireless, computers, and unfamiliarity with the grant application process, putting them at a disadvantage to be awarded grants through NCCTS**; AND**

**WHEREAS,** grants, if awarded, may not exceed $6 million per year**; AND**

**WHEREAS,** in November 2014, according to the Attorney General's Advisory Committee on AI/AN Children Exposed to Violence: Ending Violence so Children Can Thrive [the Committee] found,

- AI/AN children suffer exposure to violence at rates higher than any other in the United States**;** and
- Immediate and long-term effects of this exposure to violence includes increased rates of altered neurological development, poor physical and mental health, poor school performance, substance abuse, and overrepresentation in the juvenile justice system**;** and
- Chronic exposure to violence often leads to toxic stress reactions and severe trauma, which is compounded by historical trauma**;** and
- AI/AN children experience post-traumatic stress disorder at the same rate as veterans returning from Iraq and Afghanistan and triple the rate of the general population**;** and
- With the convergence of exceptionally high crime rates, jurisdictional limitations, vastly under-resourced programs, and poverty, it is likely that *all* AI/AN children have been exposed to violence**; AND**

**WHEREAS,** according to SAMHSA's 2012 National Survey on Drug Use and Health (NSDUH),

- 5.2% of AI/AN youth had a major depressive episode (MDE) and 2.6% had an MDE with severe impairment**;** and
- 11% of AI/AN youth had specialty mental health services during the past year with services provided in a range of settings from education and juvenile justice settings to general and specialty health settings**; AND**

**WHEREAS,** according to the SAMHSA and the Center for Disease Control and Prevention, AI/AN youth are disproportionally impacted by suicide**; AND**

**WHEREAS,** according to the Committee, critical Tribal funding has been cut for housing, law enforcement, child welfare, juvenile justice, health care and education, negatively impacting the children in Tribal communities**; AND**

**WHEREAS,** according to the Committee, a routine lack of funding, in violation of the trust obligations to AI/ANs and their children, negatively impacts AI/AN children in Tribal communities**; AND**

**NOW THEREFORE BE IT RESOLVED,** the CRIHB and NPAIHB urge Congress to enact mandatory appropriations for programs that provide critical services and care to AI/AN children and youth.

**BE IT FURTHER RESOLVED**, the CRIHB and NPAIHB also urge Congress and the Executive Branch to uphold treaties and existing law and trust responsibilities by directing sufficient funds to AI/AN Nations to bring funding into parity with the rest of the United States in order to effectively address violence in their communities, prevent children from being exposed to violence, and respond to those children who need to heal.

**CERTIFICATION**

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

**NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD**
2121 SW Broadway, Suite 300
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Chairperson of the Board

Attest

**CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.**
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(916) 929-9761

Chairperson of the Board

Attest

**RESOLUTION # 19-04-07**
**NORTHWEST PORTLAND AREA**
**INDIAN HEALTH BOARD**

**RESOLUTION # 339-08-19**
**CALIFORNIA RURAL INDIAN**
**HEALTH BOARD**

## JOINT RESOLUTION

## SUPPORT OF ENACTING LEGISLATION TO ENSURE MEDICAID FULFILLS FEDERAL TRUST RESPONSIBILITY TO AMERICAN INDIANS/ALASKA NATIVES

**WHEREAS,** the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

**WHEREAS,** the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

**WHEREAS,** the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

**WHEREAS,** the primary goal of the NPAIHB and CRIHB is to improve the health and quality of life of its member tribes; **AND**

**WHEREAS,** Tribes have a unique government-to-government relationship with the federal government, and it is required that the federal government consult with Tribes on any policy or action that will significantly impact Tribal governments; **AND**

**WHEREAS,** Tribal Nations are political, sovereign entities whose status stems from the inherent sovereignty they possess as self-governing people predating the founding of the United States (U.S.), and since its founding, the U.S. has recognized Tribal Nations as such and have entered into treaties with them on that basis; **AND**

**WHEREAS,** Executive Order 13175 sets forth clear definitions and frameworks for consultation, policymaking, and accountability to ensure that consultation with Indian Tribes is regular, meaningful, and collaborative; **AND**

**WHEREAS,** in 24 U.S.C. § 1602(a)(1) Congress declared that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians…to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy"; **AND**

**WHEREAS,** in 1955, Congress created the Indian Health Service (IHS) in order to help fulfill its trust responsibility for health care to Tribes; **AND**

**WHEREAS,** the unmet health needs of AI/ANs are severe and the health status of AI/ANs is far below that of the general population of the U.S., resulting in an average life expectancy for AI/ANs to be 4.5 years less than that for the U.S. population; **AND**

**WHEREAS**, in 1976, Congress noted that Medicaid payments were a "needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian" (H.R. Rep. No. 94-1026-Part III); **AND**

**WHEREAS,** in 1976, Congress established the authority for the IHS, Tribal Nations, and Tribal health organizations, to seek reimbursement under the federal Medicaid program in order to help fulfill its trust responsibility for health care to the Tribes; **AND**

**WHEREAS**, in Fiscal Year 2017, the congressional appropriations for IHS was only $3,332 per person,[4] as compared to average per capita spending nationally for personal health care services of $9,207[5] and $12,744 for Medicare spending per capita[6]; **AND**

**WHEREAS,** the IHS continues to be significantly underfunded by Congress—even when considering government health insurance resources—leading to rationed care and worse health outcomes for AI/ANs;[7] **AND**

**WHEREAS,** the federal Medicaid program generates significant resources that are critical to the ability of Tribal Nations to meet the health care needs of Tribal citizens, but there are significant gaps in access to quality health care services under the federal Medicaid program for low and moderate-income AI/ANs, depending upon state of residence; **AND**

**WHEREAS,** AI/ANs across the U.S. have substantially different eligibility and access to services under the federal Medicaid program based on their state of residence; **AND**

**WHEREAS**, state governments are not reimbursed for the costs of care provided by urban Indian health care providers to AI/ANs to the same degree that state governments are reimbursed for care to AI/ANs provided by IHS and Tribal health care providers; **AND**

**WHEREAS,** Tribal Nations have developed a legislative proposal to address these gaps in access to quality health care services which will create authority for states to extend Medicaid eligibility to all AI/ANs with household income up to 138% of the federal poverty level;

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[4] The figure on congressional appropriations for IHS includes funding for health care delivery as well as sanitation, facilities and environmental health. Per capita IHS appropriation was calculated from $4,957,856,000 in total appropriations divided by 1,638,687 Active Users. Source: *2017 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita*," February 26, 2018, available at: https://www.ihs.gov/ihcif/includes/themes/responsive2017/display_objects/documents/2018/2017_IHS_Expenditures.pdf, last accessed 10/15/2018.

[5] NHE Projections 2016-2025 –Tables, Table 5 Personal Health Care Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2016-2025; Per Capita Amount; Projected; available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

[6] Honoring The Federal Trust Responsibility: A New Partnership to Provide Quality Healthcare to America's First Citizens: The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2019 Budget, March 2017, p. 14, https://www.nihb.org/docs/04032017/TBFWG%20Testimony%20FY%202019%20FINAL.pdf

[7] "FY2017 Indian Health Service Level of Need Funded (LNF) Calculation" (shown at https://www.ihs.gov/ihcif/includes/themes/responsive2017/display_objects/documents/2018/FY_2017_LevelofNeedFunded_(LNF)_Table.pdf) indicates an LNF funding percentage of 46.6%. A preliminary LNF figure for FY 2018 of 48.6% was calculated by IHS, which includes consideration of third-party coverage made available through the Affordable Care Act.

authorize Indian Health Care Providers in all states to receive Medicaid reimbursement for mandatory and optional health care services authorized under federal Medicaid law, as well as select services authorized under the Indian Health Care Improvement Act when delivered to Medicaid-eligible AI/ANs; extend full federal funding (through 100% FMAP) to states for Medicaid services furnished by urban Indian providers to AI/ANs, in addition to services furnished by IHS/Tribal providers to AI/ANs; clarify that state Medicaid programs are not permitted to override Indian-specific Medicaid provisions in federal law through state waivers; and removes the limitation on billing by Indian health care providers for services provided outside the four walls of a clinic facility; **AND**

**WHEREAS,** these provisions, if enacted, will improve access to quality health care services for AI/ANs across all states, and thereby advance the Federal government's trust responsibility to AI/ANs and Tribal governments.

**THEREFORE BE IT RESOLVED**, that the NPAIHB and CRIHB support the enactment of legislation to ensure Medicaid advances the federal government's trust responsibility to AI/AN Tribal governments, including:

- Creates authority for states to extend Medicaid eligibility to all AI/ANs with household income up to 138% of the federal poverty level;
- Authorizes Indian Health Care Providers in all states to receive Medicaid reimbursement for mandatory and optional health care services authorized under federal Medicaid law, as well as select services authorized under the Indian Health Care Improvement Act when delivered to Medicaid-eligible AI/ANs;
- Extends full federal funding (through 100% FMAP) to states for Medicaid services furnished by urban Indian providers to AI/ANs, in addition to services furnished by IHS/Tribal providers to AI/ANs;
- Clarifies that state Medicaid programs are not permitted to override Indian-specific Medicaid provisions in federal law through state waivers;
- Removes the limitation on billing by Indian health care providers for services provided outside the four walls of a clinic facility.

## CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

**NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD**
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Chairperson of the Board

Attest

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Chairperson of the Board

Attest

**RESOLUTION # 19-04-08**
**NORTHWEST PORTLAND AREA**
**INDIAN HEALTH BOARD**

**RESOLUTION # 340-08-19**
**CALIFORNIA RURAL INDIAN**
**HEALTH BOARD**

## JOINT RESOLUTION

## DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF MINORITY HEALTH AMERICAN INDIAN/ALASKA NATIVE HEALTH RESEARCH ADVISORY COMMITTEE

**WHEREAS,** the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

**WHEREAS,** the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

**WHEREAS,** the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

**WHEREAS,** the primary goal of the NPAIHB and CRIHB is to improve the health and quality of life of its member tribes; **AND**

**WHEREAS,** the Department of Health and Human Resources (HHS) Office of Minority Health established the AI/AN Health Research Advisory Council (HRAC) in 2006 to serve as an advisory body to HHS; **AND**

**WHEREAS,** the purpose of the HRAC was to help ensure that federally recognized Tribes and AI/AN people have meaningful and timely input in the development of relevant HHS policies, programs, and priorities specific to AI/AN research; **AND**

**WHEREAS,** for more than a decade, the HRAC was instrumental in developing research priorities that served as a foundation for several public health initiatives to improve the health status of AI/AN communities; **AND**

**WHEREAS,** on or about December 24, 2018, the Acting Director, Division of Policy and Data, Office of Minority Health, sent a memorandum to the Acting Director, Office of Minority Health, recommending that HRAC be decommissioned and cease to convene as an HHS FACA exempt advisory committee effective December 31, 2018; **AND**

**WHEREAS,** the memorandum stated that "[Office of Minority Health] identified many overlapping priorities between HRAC and NIH TAC [National Institutes of Health Tribal Advisory Committee]," and that "NIH TAC is poised to assume the leadership role in guiding research for Tribal Nations;" **AND**

**WHEREAS,** NIH TAC sent a strong letter of opposition to the decommissioning of HRAC and proposal for NIH TAC to take over HRAC responsibilities, **AND**

**WHEREAS,** the duties of the HRAC and NIH TAC are separate and distinct; **AND**

**WHEREAS,** pursuant to Presidential Executive Order No.13175, November 6, 2000, executive departments and agencies are charged with engaging in regular and meaningful consultation; **AND**

**WHEREAS,** HHS has adopted a Tribal Consultation Policy that applies to all HHS Operating and Staff Divisions, including Office of Minority Health; **AND**

**WHEREAS,** Tribal consultation under the HHS Tribal Consultation Policy is required when there is a critical event affecting one or more Indian Tribe(s); **AND**

**WHEREAS,** decommissioning the HRAC without notice is such a critical event and Tribal consultation was required; **AND**

**WHEREAS,** no Tribal consultation was conducted prior to the decommissioning of the HRAC.

**THEREFORE BE IT RESOLVED** that NPAIHB and CRIHB request Tribal consultation on whether the HRAC should continue under the HHS Office of Minority Health or whether its focus can be accomplished by other HHS tribal advisory committees.

**CERTIFICATION**

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

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**RESOLUTION # 19-04-09**
**NORTHWEST PORTLAND AREA**
**INDIAN HEALTH BOARD**

**RESOLUTION # 341-08-19**
**CALIFORNIA RURAL INDIAN**
**HEALTH BOARD**

## JOINT RESOLUTION

### SUPPORT FOR INCREASED FUNDING FOR THE SPECIAL BEHAVIORAL HEALTH PILOT PROGRAM AND OPTION FOR FUNDING THROUGH TITLE I AND TITLE V FUNDING AGREEMENTS

**WHEREAS,** the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

**WHEREAS,** the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

**WHEREAS,** the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

**WHEREAS,** the primary goal of the NPAIHB and CRIHB is to improve the health and quality of life of its member Tribes; **AND**

**WHEREAS,** as stated in treaties and other federal issuances with Indian Nations, health care is guaranteed to AI/ANs in perpetuity in exchange for the millions of acres of Indian lands that now make up the United States; **AND**

**WHEREAS,** the Indian Health Service (IHS), an agency within the Department of Health and Human Services, administers health care to 2.6 million AI/ANs residing in Tribal communities across the United States, directly, or through the Indian Self-Determination and Education Assistance Act (ISDEAA), Title I and Title V contracts, or compacts with Tribes and Tribal organizations; **AND**

**WHEREAS,** since 1997, Northwest AI/AN people have had consistently higher drug and opioid overdose mortality rates compared to non-Hispanic Whites (NHW) in the Northwest region; **AND**

**WHEREAS,** from 2006-2012, AI/AN age-adjusted death rates for drug and prescription opioid overdoses were nearly twice the rate for NHW in the region; **AND**

**WHEREAS,** the Center for Disease Control (CDC) National Center for Health Statistics (NCHS), reported in 2016 that California had the second highest number of total deaths due to overdose and age-adjusted death rate for drug overdose in the United States with 4,654 total deaths; **AND**

**WHEREAS,** AI/ANs continue to suffer some of the worst health disparities of all Americans and according to the CDC include, but are not limited to:

- Nationally, the AI/AN population has experienced the largest increases in drug and opioid-involved overdose mortality rates compared with any other racial/ethnic groups;
- Misclassification of AI/AN race is known to underestimate AI/AN mortality rates;
- Mortality rates among AI/ANs were 2.7 and 4.1 times higher than rates among NHW for total drug and opioid-related overdoses and heroin-related overdoses, respectively;
- AI/AN communities experience high rates of physical, emotional, and historical trauma and significant socioeconomic disparities, all of which may contribute to higher rates of drug use in these communities; and
- AI/AN face barriers to receiving quality medical and behavioral health care, resulting in part from longstanding underfunding of the IHS, Tribal, and urban Indian clinics, as well as stigma associated with accessing behavioral health care in some communities; **AND**

**WHEREAS,** according to the SAMHSA 2012 National Survey on Drug Use and Health (NSDUH),

- The rate of substance dependence or abuse among people aged 12 and up was higher among the AI/AN population (21.8%) than among other groups; and
- AI/AN individuals have the highest rate of binge alcohol use (30.2%) compared with other groups; **AND**

**WHEREAS,** the Consolidated Appropriations Act, 2019 (Public Law 116-6), provided a $10 million increase to the IHS in the Alcohol and Substance Abuse Program budget line to better combat the opioid epidemic by creating the Special Behavioral Health Pilot Program (SBHPP), modeled after the Special Diabetes Program for Indians; **AND**

**WHEREAS,** $10 million is not enough for Tribes to establish pilot programs, however the fully funded amount of $150 million annually with medical inflation increases after year one is enough to establish pilot programs; **AND**

**WHEREAS,** while California Area Tribes and Portland Area Tribes have had successful SDPI programs, it is critical that SBHPP funding provide the option for Tribes to receive funding through ISDEAA Title I and Title V funding agreements.

**THEREFORE BE IT RESOLVED** that the NPAIHB and CRIHB request that Congress fund the IHS SBHPP at $150 million in FY 2021 with medical inflation rate increases annually thereafter; **AND**

**BE IT FURTHER RESOLVED** that NPAIHB and CRIHB request that Tribes have the option to receive IHS SBHPP funding through ISDEAA Title I and Title V funding agreements.

**CERTIFICATION**

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0

*Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

**NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD**
2121 SW Broadway, Suite 300
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Chairperson of the Board

Attest

**CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.**
1020 Sundown Way
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(916) 929-9761

Chairperson of the Board

Attest

**RESOLUTION # 19-04-10**
**NORTHWEST PORTLAND AREA**
**INDIAN HEALTH BOARD**

**RESOLUTION # 342-08-19**
**CALIFORNIA RURAL INDIAN**
**HEALTH BOARD**

## JOINT RESOLUTION

### A CALL TO INDIAN HEALTH SERVICE TO MOVE THE PURCHASED/REFERRED CARE (PRC) DEPENDENT FACTOR IN THE PRC FUNDING FORMULA TO THE ANNUAL ADJUSTMENT CATEGORY

**WHEREAS,** the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

**WHEREAS,** the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

**WHEREAS,** the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

**WHEREAS,** the primary goal of the NPAIHB and CRIHB is to improve the health and quality of life of its member Tribes; **AND**

**WHEREAS,** the Indian Health Service (IHS), an agency within the Department of Health and Human Services, administers health care to 2.6 million AI/ANs residing in Tribal communities across the United States, directly or through contracts or compacts with Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act; **AND**

**WHEREAS,** the IHS received a $5.8 billion appropriation in Fiscal Year (FY) 2019, yet the National Tribal Budget Formulation Workgroup recommends that the amount necessary to fully fund IHS is $37.61 billion pursuant to their FY 2021 recommendation; **AND**

**WHEREAS,** of the 12 IHS Areas, four are formally designated PRC Dependent (California, Portland, Bemidji, and Nashville) because they have limited or no access to IHS/Tribal hospitals; **AND**

**WHEREAS,** the Tribal health clinics in PRC Dependent Areas must use their extremely limited PRC funding to cover the costs of placing patients in non-IHS/Tribal hospitals and/or buying other specialty care services; **AND**

**WHEREAS,** the extremely limited PRC funding is often depleted before the end of each fiscal year, leading to the denial or rationing of inpatient and other specialty care; **AND**

**WHEREAS,** the remaining eight IHS areas have IHS/Tribal hospitals funded through the IHS and also receive PRC funding which further assists these areas in strengthening the system of care they provide; **AND**

**WHEREAS,** the June 2012 Government Accountability Office Report entitled, *Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program* (PRC), notes that the distribution of PRC funding varies widely across IHS Areas and recommends IHS "improve the equity of how it allocates program increase funds to Areas through improvements in its implementation of the PRC Allocation Formula [by refining, among other factors,]…the access to care factor to account for differences in available health care services at IHS and Tribally operated facilities"; **AND**

**WHEREAS,** a critically important need exists to move the PRC Dependent/Access to Care Factor from the Program Increases category to the Annual Adjustment category in the PRC Funding Distribution Formula to assist in eliminating inequities in funding for PRC programs; **AND**

**WHEREAS,** 40 House lawmakers issued a letter to IHS on June 17, 2019, outlining this issue for the agency and inquiring if IHS will implement this change; **AND**

**NOW THEREFORE BE IT RESOLVED,** that the CRIHB and NPAIHB urge IHS to move the PRC Dependent/Access to Care Factor in the PRC Funding Distribution Formula to the Annual Adjustment category in FY 2020.

**CERTIFICATION**

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

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Chairperson of the Board

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Chairperson of the Board

Attest

**RESOLUTION # 19-04-11**
**NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD**

**RESOLUTION # 343-08-19**
**CALIFORNIA RURAL INDIAN HEALTH BOARD**

## JOINT RESOLUTION

## SUPPORT FOR LEGISLATION THAT ESTABLISHES A DEPARTMENT OF VETERANS AFFAIRS' (VA) TRIBAL ADVISORY COMMITTEE (TAC)

**WHEREAS,** the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

**WHEREAS,** the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

**WHEREAS,** the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

**WHEREAS,** the primary goal of the NPAIHB and CRIHB is to improve the health and quality of life of its member Tribes; **AND**

**WHEREAS,** the United States (U.S.) has a unique and special relationship with AI/ANs to provide health care as established through the U.S. Constitution, treaties, U.S. Supreme Court decisions and federal legislation; **AND**

**WHEREAS,** AI/AN Veterans have played a vital role in the U.S. military for over two hundred years in all of the U.S.' wars since the Revolutionary War and have served in several wars before they were even recognized as American citizens; **AND**

**WHEREAS,** AI/AN Veterans have distinctive cultural values that drive them to serve their country; **AND**

**WHEREAS,** AI/ANs serve in the U.S. Armed Forces at higher rates per capita, are younger as a cohort and have a higher concentration of female Service members compared to all other Service members, yet they are underrepresented among Veterans who access the services and benefits they have earned; **AND**

**WHEREAS,** in Fiscal Year (FY) 2016, the National Center for Veterans Analysis and Statistics estimated 1,766 AI/AN Veterans in Idaho, 2,979 in Oregon, and 6,315 in Washington; **AND**

**WHEREAS,** in FY 2016, the National Center for Veterans Analysis and Statistics estimated 13,518 AI/AN Veterans in California; **AND**

**WHEREAS,** the VA must take into consideration that AI/AN Veterans are more likely to lack health insurance and to have a disability, service-connected or otherwise, than Veterans of other races; **AND**

**WHEREAS,** in FY 2016, the National Center for Veterans Analysis and Statistics highlighted about 19 percent of AI/AN Veterans had a service-connected disability rating in 2010; **AND**

**WHEREAS,** the National Center for Veterans Analysis and Statistics also reported that AI/AN Veterans have lower incomes, lower educational attainment, and higher unemployment than Veterans of other races; **AND**

**WHEREAS,** for the VA to better serve AI/AN Veterans after their service to this country, the VA must create a Tribal Advisory Committee (TAC) to address inequities of AI/AN Veterans and to fulfill the federal trust responsibility; **AND**

**WHEREAS,** the creation of a VA TAC is critical to ensuring that the VA, in partnership with Tribes, provides improved comprehensive, culturally responsive care and benefits to better serve our AI/AN Veterans; **AND**

**WHEREAS,** a VA TAC would supplement meaningful Tribal consultation and provide deliberation on issues and proposals that pertain to the need of AI/AN Veterans and the complex and varying infrastructure of IHS and Tribal health care facilities for the 573 federally-recognized Tribes in the U.S.; **AND**

**WHEREAS,** a VA TAC is needed to ensure that pertinent issues are brought to the attention of Tribes in a timely manner for Tribal feedback to be obtained; **AND**

**WHEREAS,** a VA TAC is needed to develop effective collaboration and informed decision-making with Tribes prior to, during, and after the development of VA policy decisions and opportunities for our AI/AN Veterans; **AND**

**WHEREAS,** a VA TAC should be comprised of designated Tribal representatives from the IHS Areas to ensure ongoing communications with the leadership of the VA regarding policy decisions that significantly impact the health care and well-being of AI/AN Veterans.

**THEREFORE BE IT RESOLVED** that the NPAIHB and CRIHB supports legislation that establishes a VA TAC with these provisions:

- Tribes must be able to select their own representatives to participate on the VA TAC, and such representatives may or may not be elected Tribal leaders;
- Be comprised of 17 voting members;
- Include 12 representatives from the Indian Health Service (IHS) Areas;
- Incorporate five “National At Large Member (NALM)” positions and two “Alternate NALM” positions;
- Include Alternate Representatives and two Technical Advisors for each Area;

- No term limits on TAC membership except that a TAC member may be replaced if the TAC member is unable to attend two of four meetings per year;
- Membership must include non-voting representatives from the VA Office of Tribal Government Relations and IHS; and
- Quarterly meetings must be held, along with monthly calls, as necessary; and
- Submission of an annual report and recommendations to Tribes.

**CERTIFICATION**

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

**NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD**
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Chairperson of the Board

Attest

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Chairperson of the Board

Attest

**RESOLUTION # 19-04-12**
**NORTHWEST PORTLAND AREA**
**INDIAN HEALTH BOARD**

**RESOLUTION # 344-08-19**
**CALIFORNIA RURAL INDIAN**
**HEALTH BOARD**

## JOINT RESOLUTION

## SUPPORT FOR PERMANENT REAUTHORIZATION OF THE SPECIAL DIABETES PROGRAM FOR INDIANS AND CHANGE TO INDIAN SELF-DETERMINATION EDUCATION ASSISTANCE ACT (ISDEAA) TO SUPPORT SDPI FUNDING THROUGH TITLE I AND TITLE V FUNDING AGREEMENTS

**WHEREAS,** the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

**WHEREAS,** the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

**WHEREAS,** the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

**WHEREAS,** the primary goal of the NPAIHB and CRIHB is to improve the health and quality of life of its member Tribes; **AND**

**WHEREAS,** the United States (U.S.) has a unique and special relationship with AI/ANs to provide health care as established through the U.S. Constitution, treaties, U.S. Supreme Court decisions, and federal legislation; **AND**

**WHEREAS,** AI/AN adults are 2.3 times more likely to have diagnosed diabetes compared with non-Hispanic whites; **AND**

**WHEREAS,** the death rate due to diabetes for AI/ANs is 1.8 times higher than the general U.S. population; **AND**

**WHEREAS,** the Balanced Budget Act of 1997 established the Special Diabetes Program for Indians (SDPI) for “the prevention and treatment of diabetes in American Indians and Alaska Natives (AI/AN) for five years; **AND**

**WHEREAS,** Congress reauthorized SDPI for one to three year periods from 2002 to 2019; **AND**

**WHEREAS,** the current renewal of SDPI expires in September, 2019; **AND**

**WHEREAS,** SDPI provides grants for diabetes treatment and prevention services to 301 IHS, Tribal, and Urban Indian health programs in 35 states and funds Community Directed Grant Programs; **AND**

**WHEREAS,** SDPI has had positive clinical and community outcomes, including the incident rate of end-stage renal disease (ESRD) due to diabetes in AI/AN people fell by 54% between 1999 and 2003 - a greater decline than for any other racial or ethnic group; the average blood sugar level (A1c) decreased from 9.0% in 1996 to 8.1% in 2014; and the average LDL ("bad" cholesterol) declined from 118 mg/dL in 1998 to 92 mg/dL in 2014; **AND**

**WHEREAS,** California Area Tribes and Portland Area Tribes have successful SDPI programs, 39 in California Area and 40 in the Portland Area, with consistent positive clinical and community outcomes; **AND**

**WHEREAS,** SDPI funding has been at $150 million since 2004 and does not include medical inflation; **AND**

**WHEREAS,** SDPI grant application and reporting requirements are burdensome and California Area Tribes and Portland Area Tribes have successful ISDEAA Title I or Title V funding agreements and could manage SDPI funds through such funding agreements.

**THEREFORE BE IT RESOLVED** that the NPAIHB and CRIHB support permanent reauthorization of SDPI at $200 million per year with medical inflation rate increases annually; **AND**

**BE IT FURTHER RESOLVED**, that the NPAIHB and CRIHB request an amendment to Section 505(b) of the ISDEAA (25 U.S.C. 458aaa-4(b)) to add the following new subparagraph (3):

(3) At the option of an Indian Tribe grant for special diabetes programs for Indians awarded to Indian tribes under Section 330C(b)(2) of the Public Health Service Act (42 U.S.C. 254c-3(b)(2)) shall, after award, be added to the Title I or Title V funding agreements of any Indian Tribe under this Act, and shall be administered and implemented in accordance with the provisions of this Act rather than the Secretary's grant regulations (including the regulation).

**CERTIFICATION**

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

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Chairperson of the Board

Attest

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Chairperson of the Board

Attest

**RESOLUTION # 19-04-13**
**NORTHWEST PORTLAND AREA**
**INDIAN HEALTH BOARD**

**RESOLUTION # 345-08-19**
**CALIFORNIA RURAL INDIAN**
**HEALTH BOARD**

## JOINT RESOLUTION

## URGING THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICE ADMINISTRATION (SAMHSA)TO REMOVE UNNECESSARY GOVERNMENT PERFORMANCE AND RESULTS MODERNIZATION ACT REPORTING REQUIREMENTS FOR OPIOID TREATMENT SERVICES PROVIDED BY TRIBES AND URGING CONGRESS TO INCREASE FUNDING FOR THESE SERVICES

**WHEREAS,** the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

**WHEREAS,** the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest**; AND**

**WHEREAS,** the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people**; AND**

**WHEREAS,** the primary goal of the NPAIHB and CRIHB is to improve the health and quality of life of its member Tribes**; AND**

**WHEREAS,** Indian Nations and the United States (US) government have a sovereign-to-sovereign relationship established by treaties, agreements, Acts of Congress, and court decisions**; AND**

**WHEREAS,** this relationship has resulted in the federal trust responsibility to Indian Nations and it is a legally enforceable fiduciary obligation on the part of the US to protect Tribal treaty rights, lands, assets, and resources, as well as a duty to carry out the mandates of federal law with respect to AI/AN Tribes and villages**; AND**

**WHEREAS,** in several cases discussing the trust responsibility, the Supreme Court has used language detailing the legal duties, moral obligations, and fulfillment of understandings and expectations that have been established by law between the US and the Indian Nations**; AND**

**WHEREAS,** as stated in treaties and other federal issuances with Indian Nations, health care is guaranteed to AI/ANs in perpetuity in exchange for the millions of acres of Indian lands that now make up the US**; AND**

**WHEREAS,** AI/ANs continue to suffer some of the worst health disparities of all Americans and according to the Center for Disease Control and Prevention (CDC) include, but are not limited to, the largest increases in drug and opioid-involved overdose mortality rates compared with any other racial/ethnic group and mortality rates 2.7 - 4.1 times higher than rates among whites for total drug and opioid-related overdoses and heroin-related overdoses**; AND**

**WHEREAS,** vital statistics and surveillance systems contain racial misclassification and according to multiple reports, including *Accuracy of Race Coding On American Indian Death Certificates* and *Self-Reported vs. Administrative Race/Ethnicity Data And Study Results,* AI/ANs are identified as another racial population, causing underestimated morbidity and mortality measures; **AND**

**WHEREAS,** the Tribal Epidemiology Centers have devoted extensive work to accurately identify effects of opioid abuse in AI/AN communities and have issued *The Opioid Crisis Impact on Native American Communities* report showing the opioid overdose death rate among AI/AN males significantly exceeds the rate among AI/AN females (10.0 per 100,000 vs. 7.0 per 100,000, respectively), and more than 1 in 10 AI/AN high school students in a state (11%) used a prescription pain medication without a doctor's order in the past 30 days, and 22 % of AI/AN high school students who used a prescription pain medication also used heroin in the past 30 days**; AND**

**WHEREAS,** Tribes have consistently advocated Congress and the federal administration provide additional funding to prevent and treat opioid abuse and addiction among AI/ANs, **AND**

**WHEREAS,** the 115th US Congress passed the Department of Defense, Labor, Health and Human Services (HHS) and Education Appropriations Act of 2019, and Continuing Appropriations Act of 2019 in Fiscal Year (FY) 2019, which became law**; AND**

**WHEREAS,** through the HHS, $50 million of $1.5 billion was allocated to Indian Tribes or Tribal organizations for the purpose of combating opioid abuse, with 15% of the remaining amount for the states with the highest mortality rate related to opioid use disorders**; AND**

**WHEREAS,** the amounts provided for State Opioid Response (SOR) Grants in California is $36 million, in Idaho is $2.1 million, in Oregon is $4.1 million, and in Washington is $11.2 million, and not all Tribes have access to these funds due to distribution by the state**; AND**

**WHEREAS,** the CDC National Center for Health Statistics (NCHS), reported in 2016 that California had the second highest number of total deaths due to overdose and age-adjusted death rate for drug overdose, in the US with 4,654 total deaths**; AND**

**WHEREAS,** the SAMHSA allocated a total of $89 million for the Medication-Assistance Treatment for Prescription Drug and Opioid Addiction (MAT-PDOA) program, of which only 11% ($10 million dollars) was allotted for Tribes, Tribal organizations, or consortia**; AND**

**WHEREAS,** SAMHSA anticipated total available funding for Tribal Opioid Response (TOR) grants decreased from $50 million in FY 2018 to $35 million in FY 2019; **AND**

**WHEREAS,** AI/ANs continue to suffer some of the worst health disparities of all Americans and according to the CDC include, but are not limited to:

- Nationally, the AI/AN population has experienced the largest increases in drug and opioid-involved overdose mortality rates compared with any other racial/ethnic groups;
- Misclassification of AI/AN race is known to underestimate AI/AN mortality rates;
- Mortality rates among AI/AN were 2.7 and 4.1 times higher than rates among whites for total drug and opioid-related overdoses and heroin-related overdoses, respectively;
- AI/AN communities experience high rates of physical, emotional, and historical trauma and significant socioeconomic disparities, which might contribute to higher rates of drug use in these communities;
- AI/AN face barriers to receiving quality medical and behavioral health care, resulting in part from longstanding underfunding of the Indian Health Service (IHS), Tribal, and urban Indian clinics, as well as stigma associated with accessing behavioral health care in some communities; **AND**

**WHEREAS,** according to the SAMHSA 2012 National Survey on Drug Use and Health (NSDUH),

- The rate of substance dependence or abuse among people aged 12 and up was higher among the AI/AN population (21.8 percent) than among other groups;
- AI/AN individuals have the highest rate of binge alcohol use (30.2%) compared with other groups**; AND**

**WHEREAS,** the Government Performance and Results Modernization Act of 2010 (GPRA) places a burden on understaffed Tribes and Tribal Health Programs by requiring reporting measures at zero, three, six, and twelve months as part of the process for the TOR, MAT-PDOA, and SOR grant programs. This reporting can take up to three hours to complete thereby inhibiting effective implementation of education, prevention and treatment of individuals suffering from substance abuse; **AND**

**WHEREAS,** the opioid crisis in Indian Country could be dramatically improved with adequate investment into the health, public health and health delivery systems in Indian Country**; AND**

**NOW THEREFORE BE IT RESOLVED,** that the CRIHB and NPAIHB recommend the SAMHSA remove the Government Performance and Results Modernization Act of 2010 reporting requirements of Tribal Opioid Response, Medication-Assistance Treatment for Prescription Drug and Opioid Addiction, and State Opioid Response as it places further strain on understaffed Tribal Health Programs.

**BE IT FURTHER RESOLVED,** that the CRIHB and NPAIHB urge Congress to increase funding to $75 million for Tribal Opioid Response grants, $15 million for Medication-Assistance Treatment for Prescription Drug and Opioid Addiction, and $10 million to administer evaluation, data collection, training and technical assistance for Tribal Epidemiological Centers in order to combat the opioid crisis in Tribal Communities, which would provide much needed support for education, prevention, and substance abuse treatment programs, thereby reducing the number of opioid-related deaths in Indian Country.

**BE IT FURTHER RESOLVED,** that the CRIHB and NPAIHB urge states to ensure State Opioid Response funding is distributed to Tribes.

## CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0

*Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

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Chairperson of the Board

Attest

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Chairperson of the Board

Attest

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Colville Tribe
Coos, Suislaw & Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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# RESOLUTION # 19-04-01

## OREGON HEALTH AUTHORITY AND OREGON HEALTH SCIENCES UNIVERSITY --HEALTHY OREGON WORKFORCE TRAINING OPPORTUNITY (HOWTO) GRANT

**WHEREAS**, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

**WHEREAS**, the NPAIHB is a non-governmental "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) (ISDEAA) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

**WHEREAS**, in accordance with the definitions of the ISDEAA at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

**WHEREAS**, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

**WHEREAS**, American Indians and Alaska Natives (AI/AN) have very limited access to health care services and are disproportionately affected by behavioral health disparities and these disparities are directly attributed to the lack of health professionals in AI/AN communities, which has caused a serious access issue and backlog of health services for AI/AN people; and

**WHEREAS,** many of our Oregon Tribes have great difficulty and face significant challenges in recruiting health professionals to serve their communities that results in further challenges in ensuring continuity and comprehensive healthcare for AI/AN people; and

**WHEREAS**, this specific funding opportunity supports developing the behavioral health workforce for AI/AN people in Oregon to deliver sustainable, culturally relevant behavioral health services in AI/AN communities; and

**WHEREAS**, the Alaska Community Health Aide Program (CHAP) has been in existence since 1964 as a program of the Indian Health Service (IHS) and includes Community Health Aides, Behavioral Health Aides (BHA) and Dental Health Aide Therapists; and

**WHEREAS**, CHAP grows providers from within tribal communities who provide patient-centered quality care that comes from providers that understand the history, culture, and language of their patients, and

**WHEREAS**, CHAP workforce is contingent upon the development of CHAP education programs and training centers; and

**WHEREAS**, NPAIHB has a longstanding relationship with Northwest Indian College, Northwest Native American Center of Excellence, and Alaska Native Tribal Health Consortium to expand CHAP for Northwest Tribes;

**WHEREAS**, AI/ANs in Oregon are faced with significant behavioral health issues, including:

- Higher rates of poor mental health and depression than non-Hispanic white (NHW) in the state; and
- Despite reporting relatively high levels of poor mental health, AI/AN men were less likely than NHW men to receive treatment for these conditions; and
- Females were more likely than males to be hospitalized for suicide, while males had higher mortality rates from suicide; and
- Suicide is the eighth leading cause of death for AI/AN in Oregon; and

**WHEREAS**, Oregon Tribes and AI/ANs would benefit from a BHA training center in Oregon; and

**WHEREAS**, one goal in NPAIHB's strategic plan states that NPAIHB will be a national leader in healthcare delivery, and will support health infrastructure development for our member tribes; and another goal is that NPAIHB will support health promotion and disease prevention activities occurring among Northwest Tribes; and

**WHEREAS**, Oregon Health Authority (OHA) and Oregon Health Sciences University (OHSU) – Healthy Oregon Workforce Training Opportunity (HOWTO) have announced a funding opportunity that would support an Oregon CHAP BHA training center; and

**WHEREAS**, a successful proposal for this funding initiative to OHA and OHSU would provide an opportunity for Oregon Tribes to expand their behavioral health workforce by growing their own providers and increasing behavioral health services to AI/AN in Oregon.

**THEREFORE, BE IT RESOLVED** that the Northwest Portland Area Indian Health Board endorses and supports efforts by staff of the *Tribal Community Health Provider Project,* under the guidance of the Executive Director, to pursue funding through the ***Oregon Health Authority and Oregon Health Sciences University – Healthy Oregon Workforce Training Opportunity (HOWTO) funding to support an Oregon CHAP BHA training center.***

**CERTIFICATION**

**NO: 19-04-01**

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 4 for, 0 against, abstain on May 15th, 2019.

Andrew C. Joseph Jr.

**Chairman**

Greg J. Abrahamson

**Secretary**

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Colville Tribe
Coos, Suislaw & Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Klallam Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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Portland, OR 97201
(503) 228-4185
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## RESOLUTION # 19-04-14

## SUPPORT FUNDING FROM NORTH SOUND ACCOUNTABLE COMMUNITIES OF HEALTH FOR DHAT EDUCATION AND TRAINING CURRICULA

**WHEREAS**, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

**WHEREAS**, the Northwest Portland Area Indian Health Board is a "Tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized Tribes in the states of Idaho, Oregon, and Washington ("member tribes" or "Portland Area Tribes"); and

**WHEREAS**, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a Tribal organization is recognized as a governing body of any Indian Tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

**WHEREAS**, the Northwest Portland Area Indian Health Board is dedicated to assisting and promoting the health needs and concerns of Indian people and its member Tribes; and

**WHEREAS**, American Indians and Alaska Natives (AI/AN) have very limited access to health care services and are disproportionately affected by oral health disease and these disparities are directly attributed to the lack of dental health professionals in Indian communities, which has caused a serious access issue and backlog of dental treatment among AI/AN people; and

**WHEREAS**, many of our member Tribes have great difficulty and face significant challenges in recruiting oral health professionals to work in their communities that results in further challenges in ensuring comprehensive dental health care for Tribal members; and

**WHEREAS**, the Alaska Community Health Aide Program (CHAP) has been in existence since 1964 as a program of the Indian Health Service (IHS); and

**WHEREAS,** Dental Health Aide Therapists (DHATs) are one discipline of CHAP which are currently working within the Portland Area Tribes and Urban Tribal Health Facility, Native American Rehabilitation Association; and

**WHEREAS,** seven (7) Portland Area DHATs graduated from the Alaska DHAT Education and Training program on June 14, 2019; and

**WHEREAS**, DHATs have proven to be an effective method for diminishing the health disparities of Alaska Natives by promoting access to oral health services for Alaska Natives residing in rural and remote communities; and

**WHEREAS**, DHATs are midlevel providers grown from within Tribal communities who provide patient-centered, culturally relevant, quality care that comes from providers that understand the history, culture and language of their patients; and

**WHEREAS**, DHATs provide patient-centered primary care and delivers more care in the community rather than an acute care setting; and

**WHEREAS**, DHATs provide routine, preventative and emergent health care; and

**WHEREAS**, DHAT providers provide continuity of care in communities that face recruitment and retention challenges; and

**WHEREAS**, Skagit Valley Community College in partnership with Swinomish Health Services have built a DHAT education and training program; and

**WHEREAS**, the North Sound Accountable Communities of Health has offered up funding to assist with the purchase of the Alaska Dental Health Aide Curricula to educate and train DHATs within the Education and Training facility as built and staffed by Skagit Valley Community College and Swinomish Health Services; and

**WHEREAS**, the North Sound Accountable Communities of Health has offered to assist the Northwest Portland Area Indian Health Board staff to identify and obtain the remaining funding for the purchase of the Alaska Dental Health Aide Curricula to educate and train DHATs.

**NOW THEREFORE BE IT RESOLVED** that the Northwest Portland Area Indian Health Board supports the education of DHATs within the Portland Area to reduce health disparities for our Tribes; and

**BE IT FURTHER RESOLVED** that the Northwest Portland Area Indian Health Board supports the receipt of grant funding from North Sound Accountable Communities of Health in the amount of up to $500,000.00 for the sole purpose of purchasing the Alaska DHAT Education and

Training Curricula, which will become the property of the Northwest Portland Area Indian Health Board, for the education of DHATs in the Northwest.

## CERTIFICATION

**NO: 19-04-14**

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 23 for, 0 against, abstain on July 16, 2019.

**Chairman**

July 16, 2019
**DATE**

**Secretary**

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Colville Tribe
Coos, Suislaw & Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Klallam Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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# RESOLUTION # 19-04-15

## NORTHWEST TRADITIONAL FOODS POLICY PROJECT

**WHEREAS**, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

**WHEREAS,** the NPAIHB is a non-governmental "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

**WHEREAS**, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

**WHEREAS**, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

**WHEREAS,** diabetes is the fourth leading cause of death among Washington AI/ANs, and the fifth leading cause of death among AI/ANs in Oregon and Idaho; and

**WHEREAS**, heart disease is the leading cause of death among AI/ANs in Idaho and Washington, and the second leading cause after cancer for Oregon AI/ANs; and

**WHEREAS,** stroke is the seventh leading cause of death among Oregon AI/ANs, and the eighth leading cause of death among AI/ANs in Washington and Idaho; and

**WHEREAS**, the NPAIHB's Northwest Tribal Epidemiology Center (NW Tribal EpiCenter) has worked with tribes and tribal clinics throughout the Northwest for over 5 years on upstream approaches to chronic disease prevention in the areas of nutrition and traditional foods, and is authorized to carry out the goals and objectives of the Robert Wood Johnson (RWJ) Foundation: Healthy Eating Research Addressing: Nutritional Disparities, Improving Nutrition, and Increasing Food Security – Integral Components to Building A Culture of Health in America – Round 12; and

**WHEREAS,** the proposed Community Based Participatory Research Funding would be a 2-year research project addressing priorities identified by NPAIHB member tribes including chronic disease prevention, obesity, diabetes and the need to create public health strategies that integrate and reflect tribal culture and values; and

**WHEREAS,** the project would examine the implementation of a traditional foods educational curriculum within a tribe's early childhood care and education setting including partnering on nutrition policy development and training for childcare center caregivers; and

**WHEREAS**, the results will be disseminated with all Northwest Tribes to strengthen the regional approaches to improve tribal youth's ability to learn about and access to healthy, traditional foods; and

**WHEREAS**, this specific funding opportunity supports developing the capacity of states, territorial, and local education agencies to deliver sustainable, culturally relevant initiatives for AI/AN children ages 0-8 and their families; and

**WHEREAS**, the goals of this initiative are consistent with the goals and objectives of both the NPAIHB and the NW Tribal EpiCenter.

**THEREFORE, BE IT RESOLVED** that the NPAIHB endorses and supports efforts by staff of the NW Tribal EpiCenter, under the guidance of the Executive Director, to pursue funding through the Robert Wood Johnson (RWJ) Foundation: Healthy Eating Research Addressing: Nutritional Disparities, Improving Nutrition, and Increasing Food Security – Integral Components to Building a Culture of Health in America – Round 12 funding opportunity.

## CERTIFICATION

## RESOLUTION # 19-04-15

**The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 23 for, 0 against, 0 abstain on July 16, 2019.**

Chairman

July 16, 2019
**DATE**

**Secretary**