Health News & Notes

Northwest Portland Area Indian Health Board

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Behavioral Health

INSIGHTS AND LESSONS LEARNED FROM ZERO SUICIDE IMPLEMENTATION

By Colbie Caughlan
Suicide Prevention Project, THRIVE, Manager

The National Alliance for Suicide Prevention, describes the Zero Suicide Model as:

"a commitment to suicide prevention in health and behavioral health care systems and also a specific set of tools and strategies. It is both a concept and a practice... The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide in health care systems. It represents a commitment to patient safety--the most fundamental responsibility of health care--and also to the safety and support of clinical staff who do the demanding work of treating and supporting suicidal patients."

IN THIS ISSUE:

For three tribal clinics in the Pacific Northwest, Zero Suicide (ZS) has been a regular topic of conversation for the past two years. With funding from the NPAIHB's SAMHSA Garrett Lee Smith youth suicide prevention grant, these clinics are leading the way in applying the model in tribal healthcare settings. (They even began this journey before the Indian Health Service recommended it for its own Service Units!) Over the past couple of years, ZS activities have been moving forward with the help of amazing clinical and support staff at each site, with support from the THRIVE team at the NPAIHB and a stellar evaluation team at NPC.

If you visit the **www.zerosuicide.com** website, you will learn that the model is a system-wide change - more like a marathon than a sprint. The model lays out milestones across seven domains: **Lead, Train**, **Identify**, **Engage**, **Treat**, **Transition**, and **Improve**. As clinics move through the model, THRIVE staff provide ongoing technical assistance, facilitate monthly calls with site coordinators, organize one to two staff trainings for each site, and respond to additional inquiries as they arise.

As each site navigates through the seven elements of ZS, THRIVE staff have encountered several lessons that have helped them better understand the model and improve regional efforts to reach zero suicides. Two elements, **Lead** and **Train**, were both tackled quickly by the sites, as

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ISSUES IMPACTING TRIBAL HEALTH PROGRAMS

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

Following the general election outcome in November, 2016, questions have arisen about the future of several provisions in the Patient Protection and Affordable Care Act (PPACA) that are beneficial to the health of American Indians and Alaska Natives (AI/AN), including the Indian Health Care Improvement Act (IHCIA), which was enacted as Section 10221 of the PPACA. This article will briefly discuss some of critical issues that may arise during the transition and first 100 days of Congress. This article also provides updates on a number of other developments, including Indian Health Service appropriations for FY 2017; two bills in Congress for reforming the Indian Health Service; contract support costs; realignment of the Indian Health Service Headquarters; continuing consultation by the Veterans Administration on streamlining its reimbursements to tribal health programs; and the Department of Health and Human Services' proposed rule to impose new regulatory requirements on contractors and compactors under the Indian Self-Determination and Education Assistance Act.

The Upcoming Legislative Landscape and the New Administration

The President-elect and the Republicans who control the House and Senate have made it one of their top priorities to repeal and replace at least some portions of the PPACA. The House and Senate are reportedly already working on proposals that could be sent to the President-elect's desk early in 2017. A wholesale repeal of the law is unlikely, as it would require a supermajority in the Senate and the Senate Democrats could invoke cloture and filibuster any such proposal. Moreover, the President-elect has indicated that he would like to retain the requirement that insurance cover pre-existing conditions and for children to be able to stay on their parents' health insurance up to age 26.

On January 3, 2017, Senate Budget Committee Chairman Mike Enzi (R-WY) introduced a budget resolution, S.Con.Res. 3, which instructed four committees with authority over health care legislation to submit recommendations by January 27, 2017 for how to reduce the budget by at least $1 billion in fiscal years 2017 through 2026. The instructions to the committees open the door for dismantling budget-related pieces of the PPACA under the expedited procedures of the budget reconciliation process. Significantly, the IHCIA is not budget-related,

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and could not be repealed through this process. However, Indian-specific provisions of the PPACA could be repealed.

While it is not clear at this time what the repeal and replacement legislation might seek to do, it is likely the primary focus will be on Medicaid expansion; the individual mandate requiring individuals to have insurance coverage; the employer mandate for provision of insurance to employees; and the health insurance marketplaces, among others.

One issue that is critically important to Indian country is the retention of the IHCIA, as any wholesale repeal of PPACA would throw out the IHCIA along with the rest of the Act. Thankfully, congressional leaders have to date not identified this as a portion of the law to repeal, and on December 6, 2016, Representative Tom Cole (R-OK) sent a letter to House leadership asking that the IHCIA be retained in any proposed legislation repealing or replacing the PPACA. Representative Don Young (R-AK) is reportedly gathering signatures for a sign-on letter to the House asking for the same. Senator John Tester (D-MT) spoke during the National Indian Health Board's "Presidential Transition Summit" in Washington, D.C. on December 8, 2016, and said that he would fight any plan that would attempt to repeal the PPACA without protecting the IHCIA, Medicare, and coverage for pre-existing conditions. National tribal organizations have already been mobilizing to meet with allies in Congress to support retention of the IHCIA.

Also of significant concern is the status of Medicaid expansion. Several States in Indian country have opted to pursue Medicaid expansion, which provides federal funding to cover more low-income people. These states include Oregon and Washington, as well as a number of States with Republican governors, which could temper Republican support for fully repealing Medicaid expansion. Not only has Medicaid expansion resulted in coverage for an increased number of AI/AN individuals, but it creates an opportunity for IHS and tribal health programs to obtain increased Medicaid reimbursements for services provided to Medicaid eligible patients. The President-elect's transition website indicates that he intends to provide States with "maximum flexibility" to "experiment with innovative methods to deliver healthcare to our low-income citizens." Some of the current proposals being floated in Congress would sunset Medicaid expansion or cap Medicaid funding by moving to a block grant or a per capita allocation formula rather than the Federal Medical Assistance Percentage (FMAP) formula, which could end up transferring the federal government's responsibility for AI/AN individuals to the States' Medicaid programs, unless tribal advocates

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are able to obtain an exception that would retain full federal funding for Medicaid services provided to American Indians and Alaska Natives.

Additionally, it would be beneficial to the IHS and tribal health programs if Sections 2901, 2902 and 9021 of the PPACA could also be retained rather than repealed. Section 2901 makes the IHS and tribal and urban Indian health programs the payor of last resort by statute. Section 2902 grants IHS and tribal health programs permanent authority to collect reimbursements for all Medicare Part B services by removing the "sunset" date that had applied to authority to collect for some Part B services. Section 9021 ensures that the value of health benefits provided by a tribe to its members are not includable as taxable income. Any repeal and/or replacement bills will need to be carefully scrutinized to ensure they do not imperil these important protections for the Indian health system.

Second Continuing Resolution and the IHS Budget for FY 2017

Just as fiscal year 2016 was coming to a close, Congress approved a ten-week continuing resolution (CR) that provided FY 2017 funding for the Indian Health Service and other federal agencies through December 9, 2016. On December 10, 2016, President Obama signed a second CR, which provides FY 2017 funding from December 10, 2016 through April 28, 2017. This second CR will, like the previous CR, largely provide funding on a pro rata basis at the FY 2016 levels and under the authority and conditions of the FY 2016 Appropriations. The second CR also includes the same provision from the first CR providing that it "shall be implemented so that only the most limited funding action of that permitted in the Act shall be taken in order to provide for continuation of projects and activities."

The second CR provides for an accelerated apportionment of funds for up-front needs for a number of programs, including Indian Health Service funding for "the rate of operations necessary to provide for costs of staffing and operating newly constructed facilities" (Section 166). It also provides for $872 million as authorized by the 21st Century Cures Funding Act (PL 114-255) to be divided as follows: $500 million for State Response to the Opioid Crisis; $352 million for biomedical research at the National Institutes of Health, including on brain diseases and President Obama's cancer "moonshot" and Precision Medicine initiatives; and $20 million for the Food and Drug Administration's efforts to speed up approval of drugs and medical devices. These are part of three new "Innovation Accounts" established by the Cures Act whose funds are located in the Treasury Department.

Given that the second CR ends only five months before the end of the fiscal year on September 30, 2017, the IHS is likely to be fairly conservative in its spending. Increases or other changes proposed by the House and/or Senate Appropriations Committees for FY 2017 (for example, IHS Purchased/Referred Care; clinic leases; built-in costs; behavioral health and further increases for Bureau of Indian Education school construction were included in their recommendations) are not in effect during the CR period and their future depends on negotiations on an appropriations bill that will extend through the end of FY 2017.

Update on IHS Reform Bills, S. 2953, H.R. 5406

Several months ago the Senate and the House both introduced bills designed to reform the Indian Health Service: S. 2953, the IHS Accountability Act of 2016 (introduced by Senate Committee on Indian Affairs Chairman John Barrasso (R-WY)) and H.R. 5406, the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare (HEALTTH) Act, introduced by Representative Noem (R-SD). Both bills were amended and then approved by the respective committees on September 21, 2016. While no further committee or floor consideration occurred on S. 2953 before the end of the 114th Congress, the House Ways and Means Committee filed a report on H.R. 5406 on December 20, 2016. The House bill sought to change the Indian Health Care Improvement Act and tax law to exclude from taxable income the amount of the IHS loan repayment a person receives. Normally, a person's "gross income" on which taxes are calculated includes any discharge of indebtedness. The report explains

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that this change to the tax law is a "critical means of promoting economic growth and job creation" and to "eliminate an unfair tax burden" on individuals who are repaying student loans under the IHS loan repayment program. It further explains that the bill is important to helping to provide incentives to individuals to pursue careers in the health professions and to thereafter provide services throughout Indian country. A copy of the report can be found here: https://www.congress.gov/congressional-report/114th-congress/house-report/882.

Contract Support Cost Developments

Following almost a year of intensive negotiations, the IHS has finalized and published its new contract support cost (CSC) policy. As a positive development, the new policy will use the Office of Management and Budget (OMB) medical inflation rate for annual adjustments to direct CSC, which was a major priority for tribes and required the IHS to obtain the OMB's approval. Tribal representatives were able to negotiate a number of other beneficial provisions, such as not requiring any compacts or contracts to undergo duplication analysis unless one of three limited circumstances triggers a review. Some areas of disagreement remain between the tribal and federal CSC workgroup members, however, most notably the issue of the duplication of administrative costs within the Secretarial amount and CSC. Tribal representatives took the position that a dollar-for-dollar offset should be used to guarantee there would be no duplication of funding between the two pools, while the federal workgroup members took the position that duplication is prohibited on a categorical basis (e.g., if the Secretarial amount provides even $1.00 for a certain activity, no additional funding for that activity could be provided as CSC). This disagreement was not resolved in the final policy and is a question currently being litigated. The IHS CSC workgroup plans to continue to meet into the future to discuss ways in which the policy can be improved.

In another development, the IHS has—for the first time in many years—released data on its distribution of CSC. The new report contains four years' worth of partial data. The Indian Self-Determination and Education Assistance Act (ISDEAA) requires the IHS to annually report to Congress on direct program costs, CSC, indirect cost rates and any deficiencies in funding. 25 U.S.C. § 5325(c). Over the past several years, however, the IHS has failed to release this information, which used to be known as the CSC "shortfall reports." The most recent one had been the FY 2012 shortfall report, containing data for FY 2011. This new report is for FY 2015 and includes CSC distribution data for every tribe and tribal organization with an ISDEAA agreement for FY 2014 and FY 2015. The report also includes data for FYs 2012 and 2013 on an Area-wide basis only. The report shows the extreme difference in funding from the "shortfall era," when almost all of the tribes and tribal organizations were underfunded in their CSC, and what is now the "full-funding era" that began in FY 2014. For a copy of the report, visit: https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/RepCong_2016/CSC_Report.pdf.

Another important CSC development arises out of a court case in *Navajo Health Foundation – Sage Memorial Hospital, Inc. v. Burwell.* On November 3, 2016, the court held that third-party revenues, such as reimbursements tribes and tribal organizations receive from Medicare, Medicaid and third-party insurance, that are used to provide health care services under an ISDEAA agreement, are to be considered "Secretarial funds" that generate CSC to the same extent as IHS funds appropriated by Congress. In the same decision, the court upheld the tribal interpretation of the ISDEAA non-duplication provision, as described above, rejecting IHS's "categorical" approach. Then, on November 23, 2016, the court ruled that the IHS had unlawfully declined Sage Memorial's FY 2016 Annual Funding Agreement (AFA), given that the FY 2016 AFA was substantially similar to the FY 2015 AFA (which the court had already deemed to have been approved). The court thus ordered the IHS to approve the FY 2016 AFA and fund it as proposed. The court's decision includes a helpful survey of the history of the ISDEAA and the development of CSC provisions, and confirms that an AFA substantially similar to the previous one,

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regardless of whether the previous AFA was approved by IHS or deemed approved as a matter of law, is not subject to being declined by the IHS and must be approved. Last month the parties settled the case, and it is possible that these favorable decisions will remain unpublished or even be withdrawn.

IHS Headquarters Realignment

The Indian Health Service has extended the comment period on its proposed realignment of Headquarters. In October, 2016, the Indian Health Service proposed to realign its Headquarters staff in an effort to improve the clarity of duties and operation of the agency. The realignment would have made several changes, including the reduction of the number of Deputy Directors from six to one and renaming the other five as "Associate Directors;" adding a new Associate Director for Health Workforce Development; and changing the specific program responsibilities of the IHS senior leadership team.

The IHS had planned to have the realignment in place by the end of the calendar year, and accepted tribal comments on its initial proposal until November 5, 2016. Then, on November 15, 2016, the IHS issued a second Dear Tribal Leader letter to extend the comment period until January 13, 2017.

The IHS's letter clarifies that the realignment would not change the structure of the IHS Area offices or the relationship between tribes and their respective Area offices, and that it would not affect any tribal shares of funding under the Indian Self-Determination and Education Assistance Act. A copy of the November 15, 2016 Dear Tribal Leader letter can be found here: https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2016_Letters/DTLLSigned111516.pdf.

The IHS also posted copies of fourteen (14) tribal comment letters that it had already received during the previous comment period. A copy of the letters can be obtained here: https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2016_Letters/Enclosure_SummaryofHQProposedRealignment.pdf

Reimbursements from The Veterans Administration

Previous articles in this newsletter have discussed the agreements that many tribal programs have with the Veterans Administration (VA) to provide for the VA to reimburse those programs for direct care services provided to eligible veterans. As last reported, many of the existing reimbursement agreements are set to expire over the upcoming months, so tribes and tribal organizations have been working with the VA to try to extend the agreements for an additional term.

Related to those efforts is the ongoing tribal consultation the VA has been carrying out relative to its idea of combining all of the VA's multiple reimbursement programs—including the IHS and tribal programs—into one community care program. The VA has explained that its goal is to streamline its procedures and establish standard reimbursement rates that would be based on Medicare rates. The VA previously held an in-person tribal consultation session on September 28, 2016 in Washington, D.C. and accepted written tribal comments on the proposal through November 5, 2016. Many tribes voiced opposition to the proposal, both at the in-person meeting and through written comments.

On November 15, 2016, the VA again proposed tribal consultation on its same proposal to consolidate reimbursement for multiple community care programs, including IHS and tribal programs, into one standard program with standard rates. Comments were due to the VA on November 30, 2016. At this time, there is no indication as to the VA's position or how it intends to proceed with respect to the proposed, standard program and extension of the tribal reimbursement agreements.

Department of Health and Human Services Proposed Rule Adding New Regulatory Requirements to ISDEAA

On November 10, 2016, the Department of Health and Human Services (DHHS) sent a letter to tribal leaders

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regarding its proposed rule to add new regulatory requirements to agreements under the Indian Self-Determination and Education Assistance Act. The letter announced DHHS's intent to hold a tribal consultation teleconference to discuss the proposal.

DHHS initially proposed the rule on July 13, 2016 and had requested tribal comments by August 12, 2016. The rule would make DHHS regulations governing audits and cost principles for federal grants applicable to the ISDEAA, which would directly conflict with the ISDEAA. The DHHS did not carry out any formal tribal consultation prior to announcing the proposed rule, and the publication of a proposed rule affecting tribes and tribal organizations without adequate consultation violates the President's Executive Order and Department policies. For example, Executive Order 13175 requires federal agencies to consult with tribal officials in the development of "Federal policies that have tribal implications."

Tribal comments submitted in response to the proposed rule had requested tribal consultation, so the November 10, 2016 letter announcing a tribal consultation call is a direct response to those requests. DHHS held the conference call with tribal participants on December 9, 2016. DHHS representatives on the call announced that the provisions of the proposed rule that made Subparts E and F of the grant regulation (audits and cost principles) applicable to ISDEAA contracts and compacts, to which tribes had objected, would be deleted from the final rule. This is a victory for tribes. There remains, however, a question whether the HHS decision includes deleting a provision in the proposed rule that would restrict application of the one-year limitation on remedies for cost disallowances in § 450j-1(f) of the ISDEAA. This issue was identified and discussed on the call, but HHS gave no response. Additional comments should be submitted by January 6. For a copy of the notice of proposed rulemaking, visit:
https://www.regulations.gov/document?D=HHS_FRDOC_0001-0637

MAKING SPACES FOR FASD IN EDUCATION

By Jacqueline Left Hand Bull
Administrative Officer
Northwest Portland Area
Indian Health Board

The NPAIHB contracted with the University of Washington to prepare and conduct, through its Fetal Alcohol and Drug Unit (FADU) work, four webinars focused on FASD and Education to help school personnel support students with an FASD during FY2017. The first one was live on-line on January 11, presented by Robin Harwick, Ph. D. Its specific topic was about understanding how an FASD may be contributing to challenges for students, learning about how to develop productive relationships with families to support students with an FASD, and learn about resources.

Three more webinars will be prepared. Two will be on-line during the remaining months of this school year, and one will be on-line in the early fall, after school starts. The webinars continue an effort of the past three years to provide information and promote understanding of how FASDs occur, and also how to promote understanding of how to be inclusive of those living with an FASD in community life, including educational opportunity.

ZERO SUICIDE

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the tribe's leaders and stakeholders believed strongly that the model had the potential to help decrease suicide attempts among the clinics' patient population. Clinic leadership allowed site coordinators to organize suicide prevention trainings for nearly all clinic staff, and in last 6-8 months, the sites have also started to train staff on depression and suicide assessments such as the Patient Health Questionnaire 9 (PHQ-9) and the Columbia Suicide Severity Rating Scale (C-SSRS). These are two of the assessments recommended in the "Identify" phase of the ZS model that can be used in conjunction with an electronic health record (EHR) to identify at-risk patients.

Language around Suicide Matters

*Died **by** Suicide or Died **of** Suicide*
not ~~Committed Suicide~~
Suicide Death not ~~Successful Attempt~~
Suicide Attempt not ~~Unsuccessful Attempt~~
Suicide not completed Suicide
Described the Behavior not ~~Manipulative~~
Working with not ~~Dealing with~~ Suicidal Patients

After implementing universal screening, several clinics noticed that without a policy in place describing how and when staff should use the assessments, staff did not fully understand how and when to use the assessments. This is where the ZS element "Improve" showed its importance. The clinics identified gaps in their screening protocols and began drafting policies describing how and when to use the depression and suicide screening assessments. Engage is another element of ZS, and training staff on how to talk to patients about their assessment score(s) has helped ease patient concerns about being screened.

Engaging the patient in a conversation about their score(s) and why those scores move up and down is very important, it can even reveal some risk factors or situations that increase one's anxiety or suicidality. The policies and trainings on the assessment procedures helped providers understand why discussing the assessments at each visit is so important, and how it can be used as a tool when treating patients. We also found that formal policies helped align clinic staff to support ZS strategies.

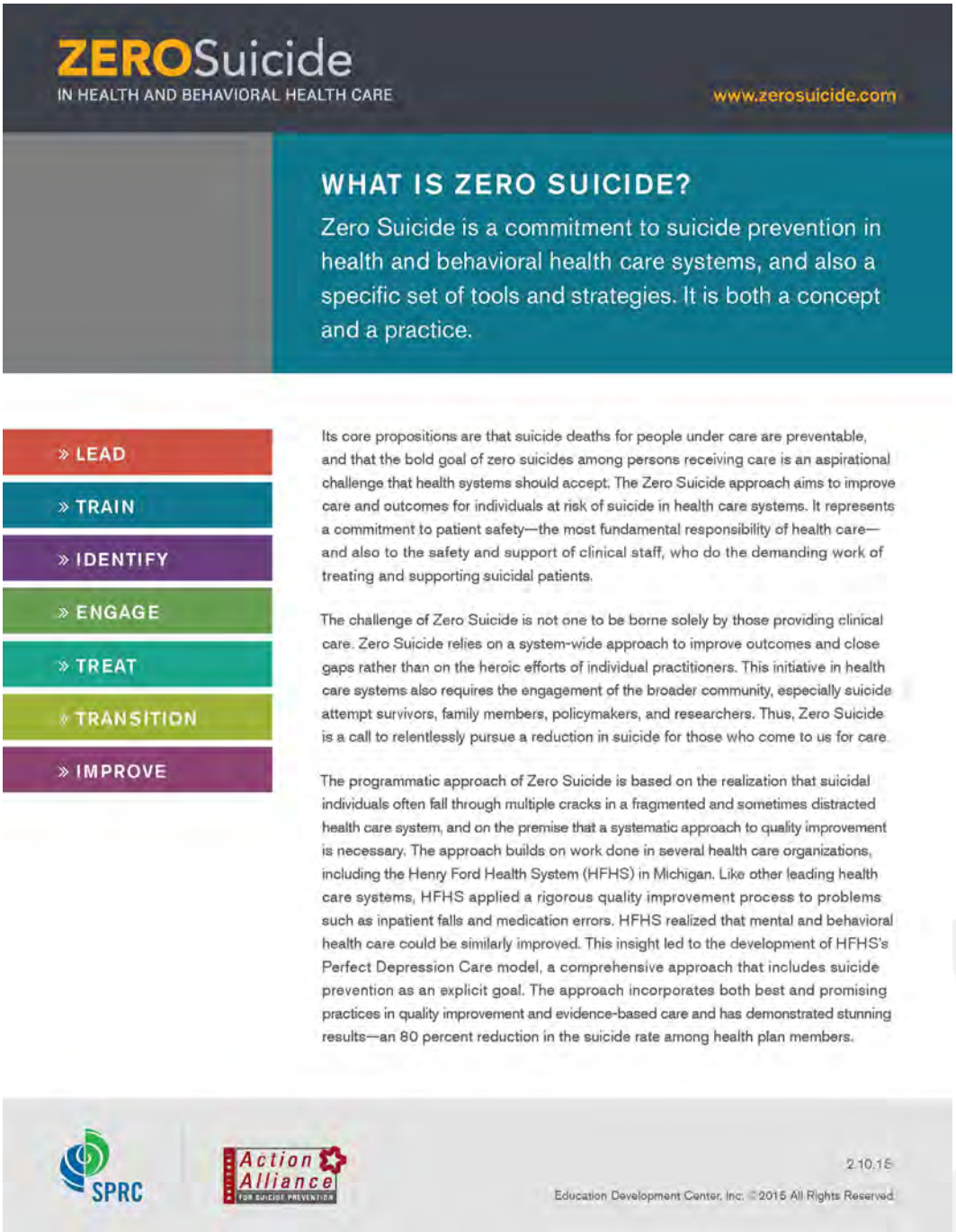
Treat is another important element of the ZS model, and all three clinics have identified culture-based, evidence-based treatments to utilize with their suicidal patients (now or as funding allows). Dialectical Behavior Therapy (DBT) is a treatment shown to target and treat suicidality and behavioral health disorders, and our clinics all chose to take part in this training that was hosted by THRIVE in March of 2016. We encourage clinics interested in ZS to emphasize culture-based treatments, to honor the treatment and prevention strategies that have worked for thousands of years for their members.

Transition is a component of ZS that reminds us that systems of care need to support patients who are transitioning from one care facility or provider to another. This includes transitioning from an emergency department visit for a suicide attempt to regular visits with a behavioral health provider. The NW Tribes implementing ZS have all began looking at care transitions made by their patients and have started to review and improve, if necessary, the various transitions that one might make while being cared for at each clinic. Some clinics have chosen to put memorandums of understanding (MoU) in place with local hospitals that refer patients to the tribal clinic, and one has also developed a MoU with a local hospital, which states that hospital staff will contact the clinic anytime a tribal member presents to the emergency department. This is important information for the Tribe's behavioral health team, so the Tribe's clinic can provide the best and responsive follow-up with that person and their family.

ZERO SUICIDE

Last spring, staff at the three NW tribal clinics were asked to complete a brief survey about their experience implementing the ZS Model at their clinics. Overall, 86% of respondents believed that the ZS Model was a very good fit for their community. Over a quarter (29%) reported having positive engagement from their leadership and community as their most notable accomplishment in the first year and a half of implementation. Over one-third (36%) mentioned successful implementation of the PHQ-9 screen, and half felt that training their clinical staff and community members about the Zero Suicide Model was a major accomplishment

All in all, the Zero Suicide Model has been a useful tool for our NW tribal clinics, and we encourage you to review the ZS toolkit and give the model a try. We look forward to continuing this journey with our GLS partners in 2017!



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www.zerosuicide.com

Using these successful approaches as the basis for its recommendations, the Clinical Care and Intervention Task Force of the National Action Alliance for Suicide Prevention identified essential elements of suicide prevention for health care systems (i.e., health care plans or care organizations serving a defined population of consumers, such as behavioral health programs, integrated delivery systems, and comprehensive primary care programs). These elements include:

1. **LEAD** » Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.
2. **TRAIN** » Develop a competent, confident, and caring workforce.
3. **IDENTIFY** » Systematically identify and assess suicide risk among people receiving care.
4. **ENGAGE** » Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.
5. **TREAT** » Use effective, evidence-based treatments that directly target suicidality.
6. **TRANSITION** » Provide continuous contact and support, especially after acute care.
7. **IMPROVE** » Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

If we do not set big goals, we will never achieve them. In the words of Thomas Priselac, president and CEO of Cedars-Sinai Medical Center:

"It is critically important to design for zero even when it may not be theoretically possible. When you design for zero, you surface different ideas and approaches that if you're only designing for 90 percent may not materialize. It's about purposefully aiming for a higher level of performance."

Better performance and accountability for suicide prevention and care should be core expectations of health care programs and systems. While we do not yet have proof that suicide can be eliminated in health systems, we do have strong evidence that system-wide approaches are more effective.

To assist health and behavioral health plans and organizations, the Suicide Prevention Resource Center (SPRC) offers an evolving online toolkit that includes modules and resources to address each of the elements listed above. SPRC also provides technical assistance for organizations actively implementing this approach.

Learn more at **www.zerosuicide.com**.

FOR MORE INFORMATION, PLEASE CONTACT:

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

By Dr. Tom Becker
NW NARCH & Cancer Project Director

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

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

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

Dr. Beatriz Oralia Reyes (Navajo)
NW NARCH Fellow
Doctor of Public Health (Dr. PH) in Health Policy and Social Justice

How did I learn about the NW NARCH Fellowship?

A friend of mine who is an Indigenous scholar sent me an email with the announcement for the NW NARCH Fellowship and she encouraged me to apply.

Why did I choose my specific degree?
I saw the doctor of public health degree as an opportunity to gain practice-based skills and experiences. In addition, when I was searching for doctoral programs the Dornsife School of Public Health at Drexel University stood out to me because of the emphasis on health and human rights.

After graduating, what are my career goals and/or educational goals?
Since graduating, my goals are to complete my postdoc here at Northwestern University in the Global Health Studies Program and at the Foundations of Health Research Center. It is my intent to continue engaging in work that contributes to improving the health of communities through teaching in higher education and implementing prevention programs through a community-based participatory research approach.

How did the NW NARCH fellowship help in furthering my education?
This NW NARCH fellowship was instrumental in allowing me to complete the last year of my dissertation, it provided me with the time and resources to complete data collection, analysis, and developing my manuscripts.

What would you share with others who are seeking financial assistance?
Yes, I believe this is a great opportunity for students pursuing degrees in public health. In addition, I believe the Summer Research Training Institute for American Indian and Alaska Native Health Professionals was a wonderful experience and a chance to meet other Indigenous scholars and practitioners.

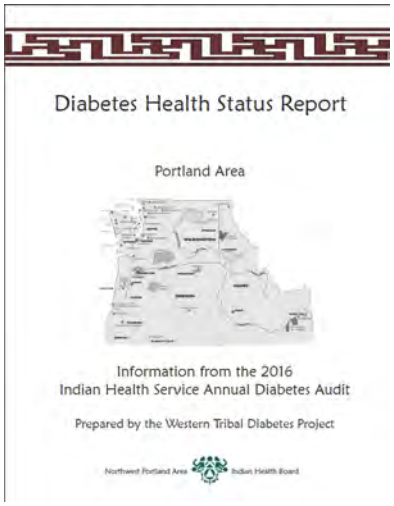
2017 DIABETES IHS AUDIT AND SOS

By Don Head
Erik Kakuska
WTDP Specialist
NPAIHB

SOS! SOS! The 2017 Diabetes Care and Outcome Audit Season is Here! But first, SOS Submission!

The Western Tribal Diabetes Project (WTDP) is taking this moment to remind grantees of the Special Diabetes Programs for Indians (SDPI) in the Portland Area that the 2017 IHS Diabetes Care and Outcomes Audit deadline is fast approaching. Programs will have until March 15, 2017 to submit data for the care that their patients received in 2016 to the Division of Diabetes Treatment and Prevention (DDTP). Submitting the Audit to DDTP is a grant requirement, and therefore very important to complete in a timely fashion. Because of the importance of the Audit, WTDP Specialists have begun scheduling site visits for programs in the Portland Area. The site visits' main goal is to assist in making sure that the data is accurate and any errors are addressed, and that the files get uploaded and accepted before the deadline.

Tribes and organizations in the Portland Area can call or email the WTDP at 800-862-5497, wtdp@npaihb.org to schedule a site visit or to request technical assistance. The update, or patch, for the Diabetes Management System of the Resource and Patient Management System will not be available until February 1, 2017. Portland Area programs requesting site visits for Audit assistance should plan on the visit occurring in February and the beginning of March.



This year, the only addition to the Audit are the tracking of patients that use an Electronic Nicotine Delivery System (ENDS), and the status of that indicator, whether they are using ENDS or not, or if it's not documented. There are a few other minor modifications involving formatting of the report, and adding patients that are allergic to statins to the denominator for that indicator, but no change that will seriously impact program Audits from last year. In order to obtain a PDF of this year's Audit instructions, you can visit DDTP website.

SPDI grantees also need to be aware, if they are not already, that the SDPI Outcomes System (SOS) Required Key Measures (RKM) submission deadline is coming up even before the Audit! The SOS measures how well programs have done in addressing the Best Practice that their program is following. Last year, SPDI grantees uploaded files to WebAudit, to pull their RKM from that application into SOS, for a baseline measurement. Another audit file will need to be created with an audit date of December 31, 2016, and uploaded to WebAudit. Once this is accomplished, it only takes a few steps to check for errors, and pull the data over to the SOS. This data is then sent to DDTP to determine the efficacy of the program in addressing their Best Practice. WTDP Specialists are available to assist programs with submitting the file to the WebAudit and pulling the RKM over to SOS. The deadline for submitting the SOS RKM is January 31, 2017.

Here's a poem to help SPDI grantees to remember what to do if you need Audit or SOS assistance:

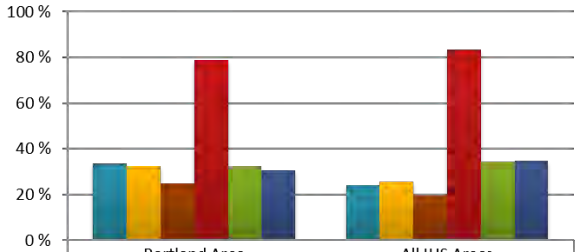
If with data you hit a wall,
Please give WTDP a call!
We'll swoop right in and give assist
Our customer service you cannot resist!

Remember that number, and email address!
We can help with the Audit and the SOS!
Our contact information is below,
To call us for assistance is apropos!

800-862-5497 or wtdp@npaihb.org

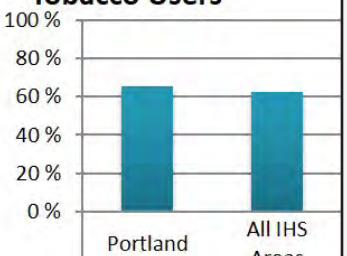
DIABETES HEALTH STATUS REPORT FOR NORTHWEST PROGRAMS COMPLETED

Comorbidities



	Portland Area	All IHS Areas
Active Depression	33 %	24 %
Current tobacco user	32 %	26 %
Severly Obese [BMI 40+]	25 %	20 %
DX'd hypertension	79 %	83 %
DX'd CVD	33 %	34 %
Chronic Kidney Disease in Adults (18+)	31 %	35 %

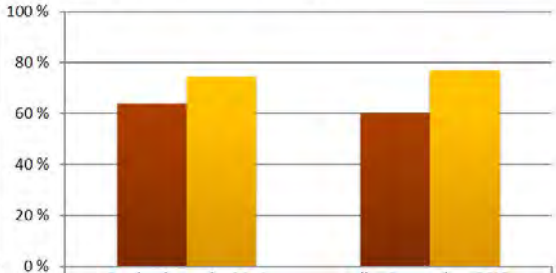
Tobacco Cessation Counseling for Current Tobacco Users



	Portland Area (n=2174 Patients)	All IHS Areas (n=31380 Patients)
Counseled - Yes	66 %	63 %

Chronic Kidney Disease in Adults (18+)

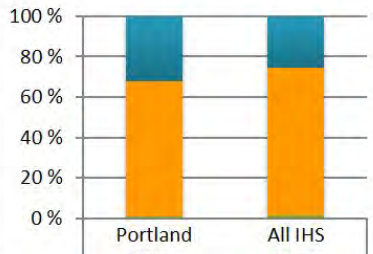
Screening includes an assessment of eGFR and a measurement of urinary protein excretion – the spot UACR. These tests should be done at diabetes diagnosis and repeated at least annually – more often, if results are changing rapidly or to assess the effectiveness of interventions.



	Portland Area (n=2049 Patients)	All IHS Areas (n=42637 Patients)
CKD & BP<140/<90 in Adults (18+)	64 %	60 %
CKD & ACE or ARB use in Adults (18+)	74 %	77 %

Tobacco Use

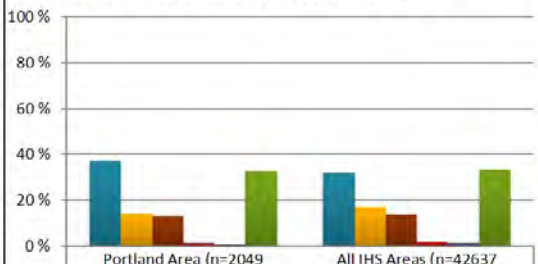
Tobacco use increases the already elevated risk of cardiovascular and microvascular complications in people with diabetes. Research shows that a brief tobacco dependence treatment intervention delivered by one provider can increase quit rates by as much as 80%.



	Portland Area	All IHS Areas
Current tobacco user	32 %	26 %
Not a current tobacco user	67 %	73 %
Tobacco use not documented	1 %	1 %

Stages in Patients diagnosed with CKD

In adults with diabetes, the most likely cause of CKD is the diabetes itself. However, not all CKD in patients with diabetes is due to diabetic nephropathy and it is important to look out for patients whose CKD pattern (e.g., significant albuminuria early in the course of diabetes, a rapid rise in urine albumin excretion) suggests another etiology. These patients should be referred to a nephrologist for further testing (e.g., kidney biopsy) for a definitive diagnosis and treatment plan.



	Portland Area (n=2049 Patients)	All IHS Areas (n=42637 Patients)
Normal: eGFR≥60 & UACR <30	37 %	32 %
Stage 1/2: eGFR≥60 & UACR≥30	14 %	17 %
Stage 3: eGFR 30-59	13 %	14 %
Stage 4: eGFR 15-29	2 %	2 %
Stage 5: eGFR <15	1 %	1 %
CKD stage undetermined	33 %	34 %

For more information on these reports, please contact WTDP at wtdp@npaihb.org, or 1-800-862-5497.

UPCOMING EVENTS

JANUARY 2017 - HAPPY NEW YEAR!

January 23-27
RPMS / EHR training
Portland, OR

January 24-26
Tribal Self-Governance Advisory Committe 1st Quarterly Meeting
Washington, DC

January 23-26
ATNI Winter Convention 2017
Centralia, WA

FEBRUARY

February 13
2017 State of Indian Nations
Washington, DC

February 13-16
NCAI Executive Council Winter Session
Washington, DC

February 14-15
IHS Direct Service Tribes Advisory Committe Quarterly Meeting
Arlington, VA

February 14-17
Climate and Health Summit
Atlanta, GA

February 21-23
Oregon Health Authority - SB 770 Quarterly Health & Human Services Cluster meeting
Washington, DC

February 28 - March 1-2
RPMS/DMS training
Portland, OR

UPCOMING EVENTS

MARCH

March 14-23
UN Commission on the Status of Women, Focus Area: Empowerment of Indigenous Women
New York City, NY

March 28-30
Tribal Self-Governacne Advisory Committee 2nd Quarterly meeting
Washington, DC

APRIL

April 2-5
NICWA Annual Conference
San Diego, CA

April 18-20
NPAIHB Quarterly Board Meeting
Ocean Shores, WA

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

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

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
JANUARY 2017 RESOLUTIONS

RESOLUTION #17-01-01
Supporting Standing Rock

RESOLUTION #17-01-02
Support of CHAP National Exchange

RESOLUTION #17-01-03
Support Engagement of Youth and Development of Youth Track