MINUTES

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

QUARTERLY BOARD MEETING

JANUARY 16-18, 2018

EMBASSY SUITES BY HILTON AIRPORT
PORTLAND, OR

Summary of Minutes

Issue	Summary	Action	Follow-Up
TUESDAY, JANUARY 16, 2018			
HEALTH POLICY AND LEGISLATIVE UPDATE-PART1, GEOFF STROMMER, PARTNER – HOBBS, STRAUS, DEAN & WALKER	**Update** 2018 Appropriations, Continuing Resolution, Spending caps • SDPI, current CR extends funding through March 31st, Reauthorize for 2 year's Indian Health Legislation for 2018 • Affordable Care Act (ACA) and cap and block-grant the Medicaid program were narrowly defeated last year in the Senate, a win for Indian Country • H.R. 2662 and S. 1250, The bill is intended to increase transparency and accountability within IHS. Improved standards of care, increased congressional oversight of IHS activities. o "Lower Premium through Reinsurance Act of 2017" the bill is designed to stabilize the individual insurance market and reduce increases in the cost of premiums people have to pay in order to obtain coverage. • Redding Rancheria case, the Court ruled in favor of the tribal health care program. ruling as follows: o (1) tribal self-insurance plans are "health programs" operated by tribes/tribal organizations within the meaning of the payer of last resort language in Section 2901(b) of the ACA, and thus themselves have payer of last resort status under that provision. o (2) IHS cannot treat those plans as alternate resources for purposes of CHEF, nor for the underlying PRC program, without specific written permission of the Tribe. • Update on Section 105(l) Lease Proposals, the 2016 court decision in *Maniilaq Association*		

Summary of Minutes

	v. Burwell established the right of tribes and tribal organizations to propose, and be fully compensated for, a lease under section 105(l) of the Indian Self-Determination and Education Assistance Act (ISDEAA). • Contract Support Cost - In a "Dear Tribal Leader" letter dated December 21, 2017, IHS announced its unilateral decision to revoke at least temporarily, a provision tribes and IHS had spent months negotiating before the new CSC policy was finalized in October of 2016. o The policy allows IHS, under certain circumstances, to review a tribe's funding to ensure no duplication exists between indirect CSC and the "Secretarial" or program amount for service unit shares. o IHS CSC Workgroup, submitted a letter to IHS strongly condemning IHS's unilateral policy change. The letter pointed out that the parties agreed that the policy would be amended only after tribal consultation, and that IHS's action "disregards the bargain struck in government-to-government negotiations." • An important court ruling on CSC could soon be put to a federal appeals court. In *Navajo Health Foundation—* *Sage Memorial Hospital, Inc. v. Burwell*, the district court in New Mexico ruled that health care services provided under agreements with IHS but funded by third-party revenues—such as Medicare, Medicaid, and private insurance—are "Secretarial" funds that generate CSC just like IHS-appropriated funds. o If the ruling stands, it could greatly expand the agency's CSC requirements.		
PORTLAND AREA IHS DIRECTOR REPORT, DEAN SEYLER:	**Division of Financial Management** **FY 2018 Continuing Resolutions (CRs)** ❖ CR 1: Public Law 115-56 authorizes funding from October 1 through December 8,		

Summary of Minutes

2017. The CR continues activities authorized in FY17 at the FY17 levels, but reduced by 0.6791%.

- CR 2: Public Law 115-90 authorizes funding through December 22, 2017. The CR continues activities authorized in FY17 at the FY17 levels, but reduced by 0.6791%.
- CR 3: Public Law No. 115-96 authorizes funding through January 19, 2018. The CR continues activities authorized in FY17 at the FY17 levels, but reduced by 0.6791%.

FY 2020 Portland Area Budget Formulation Meeting

- When: November 30, 2017
- Location: Embassy Suites, Portland Airport
- Attendees: Portland Area Tribal Leaders, Health Directors, representatives from the Northwest Portland Area Indian Health Board and leadership of the Indian Health Service - Portland Area Office.

FY 2020 National Budget Formulation Work Session

- When: February 15-16, 2018
- Location: Crystal City, VA
- Portland Area Elected Representatives:
  - Andrew Joseph Jr., The Confederated Tribes of the Colville Reservation
  - Steve Kutz, Cowlitz Indian Tribe
  - CAPT Ann Arnett, Executive Officer – Portland Area

Division of Business Operations Purchase and Referred Care

FY17 Catastrophic Health Emergency Fund

- Total Number of Cases: 56
- Total Number of Amendments: 23

Summary of Minutes

- Current Reimbursement Amount: $1,686,871.00
- Current Pending Reimbursement Amount: $504,221.56
- 81% Reimbursed
- CHEF Balances as of January 9, 2018 $ 9,636,575

Indian Health Service Portland Area

- **Small Ambulatory Program (SAP)**
  - Health Facility Construction Funding Opportunity
  - Applications Were Due December 1, 2017
  - $5.0M Reserved / Max Award is $2.0M
  - 3-5 Awards Anticipated (Highly Competitive)
  - Four Applications Submitted from Portland Area Tribes
  - All Were Reviewed and Endorsed by the Area Office
  - IHS HQ Has Not Yet Established a Timeline for Making Award Decisions
  - Contact CAPT Jason Lovett With Any Questions, jason.lovett@ihs.gov

- **Annual Combined Space Verification**
  - Sent to Tribes in Early November
  - Verify the Amount and Location of Facility Space Used for IHS PSFA's
  - Response Due Date: **December 31, 2017**
  - Please Review the Provided Data and Certify if is Accurate
    - Used to Calculate Share of Equipment and M&I Funds
    - Used to Update and Maintain the CMS Facilities List for Encounter Rate Billing
    - Used to Verify Facility Type and Other Statistical Items

Summary of Minutes

- If Data is Not Accurate, Please Follow Included Instructions to Update
- Questions:
  - Jonathan McNamara – Health Facilities Engineering – jonathan.mcnamara.ihs.gov
  - Peggy Ollgaard – Business Office – peggy.ollgaard@ihs.gov
  - Mary Brickell – Statistics – mary.brickell@ihs.gov
  - Or 503-414-5555 – please ask for one of the three above.

- April 25, 2018- Northwest Tribal Clinicians' Cancer Update
- April 26-27, 2018- Portland Area Spring Clinical Director's Meeting
- Embassy Suites-Washington Square, Tigard, OR

- Key Points Regarding Influenza:
  - It is not too late to get vaccinated
  - Influenza vaccine is still an important public health prevention tool
    - As in past years, washing your hands frequently, covering your cough and staying home when ill are also important measures to help prevent the spread of influenza
  - Influenza Vaccine Effectiveness could be as low as 32% this year for preventing influenza A(H3N2) infections
  - The current influenza vaccine is well matched to prevent influenza A (H1N1) and influenza B infections that are also circulating
  - People at high risk for complications from the flu, including American Indians/Alaska Natives should seek care early to receive the maximum benefit from antiviral medications

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EXECUTIVE DIRECTOR UPDATE, JOE FINKBONNER:	*See PowerPoint*		
INJURY & FALL PREVENTION, DR. DEBORAH BEHRE	*See PowerPoint*		
ELECTION OF OFFICERS:	**Chairman:** Nomination: Nomination of Andy Joseph, by Dan Gleason, Chehalis, 2nd by Cassie Sellards-Reck, Cowlitz. Nominated by acclamation. **Secretary:** Nomination: Nomination of Greg Abrahamson by Cheryle Kennedy, Grand Ronde, 2nd, ---by Nominated by acclamation.	**MOTIONS**	**Nominates by acclamation**
	LUNCH, COMMITTEE MEETINGS (WORKING LUNCH)		
ADVERSE CHILDHOOD EXPERIENCES (ACES) AND RESILIENCE, JULIE HARGRAVES, LCSW, BH MANAGER AND SANDY HENRY, TRAUMA-INFORMED CARE	*See PowerPoint*		

Summary of Minutes

COORDINATOR			
VETERAN AFFAIRS, OFFICE OF TRIBAL GOVERNMENT RELATIONS VETERAN AFFAIRS UPDATE, TERRY BENTLEY, TRIBAL GOVERNMENT RELATIONS SPECIALIST AND WILLIAM MURRAY VISN20	*See PowerPoint*		
ENDOCRINOLOGY ECHO PILOT PROJECT, NANETTE STAR, WEAVE NW PROJECT DIRECTOR AND KATHI MURRAY MS, RDN, CDE, PORTLAND AREA IHS DIABETES CONSULTANT	*See PowerPoint*		
NPAIHB MCH WORKGROUP, TAM LUTZ TOT2TWEEN & CARS PROJECT	*See PowerPoint*		

Summary of Minutes

DIRECTOR AND MONIKA DAMRON, IDEA-NW BIOSTATISTICIAN			
EXECUTIVE SESSION:	End Executive Session: **Motion by Cassie Sellards-Reck, Cowlitz Tribe; 2nd by Cheryl Resar, Swinomish Tribe** NPAIHB to further examine Tribal Retained Shares for NPAIHB Cooperative Agreement in regards to Environmental Health Program**: Motion by Brent Simcosky, Jamestown S'Klallam Tribe; 2nd by Shawna Gavin, Umatilla, MOTION CARRIED**	**MOTION** **MOTION**	**PASSES** **PASSES**
WEDNESDAY JANUARY 11, 2017			
HEALTH POLICY AND LEGISLATIVE UPDATE – PART 2, LAURA PLATERO, GOVERNMENT AFFAIRS/POLICY DIRECTOR	Report Overview 1. Status of IHS Budgets 2. Current & Pending Policy Issues 3. Legislation in 115th Congress **4.** National & Regional Meeting**s** **Status of IHS Budgets** **FY 2018 IHS Budget** • Congress passed another continuing resolution (CR) for FY 2018 budget which funds the government through January 19, 2018.		

Summary of Minutes

- President's budget proposes a 5.2% decrease below FY 2017 enacted level ($4.2B) for services and facilities.
- House bill proposes a $179m increase above FY 2017 enacted level for services and facilities.
- Senate bill proposes less than $1m increase above FY enacted level for services and facilities
- Hill visits advocacy per our FY 2018 analysis.
  - $246.5m for services & facilities

FY 2019/2020 IHS Budgets

- FY 2019 National Tribal Budget Formulation Workgroup's Recommendations
  - Available at: http://www.nihb.org/legislative/budget_formulation.php
- FY 2020
  - Portland Area Budget Formulation Meeting was November 30, 2017
  - National Budget Formulation Meeting is February 15-16, 2018 in Washington, D.C.

Current & Pending Policy Issues

CMS 4 Walls Limitation

- CMS determined that If a Tribal facility is enrolled in the state Medicaid program as a provider of clinical services under 42 CFR 440.90, the Tribal facility may not bill for services furnished by a non-Tribal provider or Tribal employee at the facility rate for services that are provided outside of the facility.
- Per CMS, under FQHC designation there is no requirement that the services be provided within the 4 walls.
- Section 1905 of the SSA recognizes outpatient Tribal clinics as FQHCs.
- CMS FAQ released January 18, 2017.

Summary of Minutes

- *Deadlines*:
  - January 18, 2018: Tribe must notify state of intent to change provider status – clinical provider to FQHC.
  - January 30, 2021: Effective date
  -

CMS Pharmacy Outpatient Rule Implementation

- Covered Outpatient Drug Final Rule (81 FR 517), dated 2/1/16; changes reimbursement methodology of covered outpatient drugs in Medicaid program.
- States may elect to reimburse I/T/U pharmacies through the OMB encounter rate.
- Oregon status:
  - SPA amendment approved 9/20/17 by CMS.
  - "The I/T pharmacy will receive one encounter per prescription filled or refilled and will not be limited to a certain number of prescriptions per day."
  - Tribes will receive AIR from October, 2017; systems need to be updated so reconciliation necessary initially.

CMS Medicare Diabetes Prevention Program (MDPP) Final Rule

- CMS publishes MDPP final rule on 11/15/17.
- MDPP Expanded Model start date is 1/1/18.
- MDPP Supplier enrollment begins in January 2018 and suppliers begin furnishing services and billing Medicare in April 2018.
- Unfortunately, tribal recommendations were not accepted in final rule.

CMS New Medicare Card Project

- CMS New Medicare Project Webinar on 1/23/18

Summary of Minutes

- Removal of SSN-based Health Insurance Claim. Number (HICN) from Medicare cards.
- CMS will send out replacement Medicare cards with a new Medicare Beneficiary Identifier (MBI) by April 2019.
- CMS will begin mailing new Medicare cards to people with Medicare and all systems and processes will able to accept MBI in April 2018.
- Transition period runs from April 2018 through December 31, 2019.
- CMS is working to develop a look-up tool for providers to be able to access a patient's new MBI.

IHS Contract Support Costs Policy Update

- Dear Tribal Leader Letter on 12/21/2017
- Update to temporarily rescind Alternative Methods for Calculating Indirect Costs Associated with Recurring Service Unit Shares, referred to as the 97/3 split.
- 97/3 split is the alternative option to determine the amount in a tribe's indirect cost pool.
- IHS has found that in certain circumstances, the result is inconsistent with statutory authority.
- Next IHS CSC Workgroup meeting is March 6-7, 2018.

IHS Health Information Technology

- Issued a request for information (RFI) on 12/20/2017.
- Assess industry innovations and capabilities to address emerging healthcare delivery and modernization needs.
- Objective is to research clinical and technical approaches and to deliver next generation solutions with modularized software components.
- IHS ISAC workgroup recommended moving to a commercial off-the-shelf system.
- Responses accepted until 2/1/18

Summary of Minutes

IHS Strategic Plan 2018-2022

- Dear Tribal Leader Letter on 11/28/17.
- Comments were due on 10/31/17; NPAIHB submitted comments. IHS received 137 comments.
- Established an IHS Strategic Planning workgroup to review comments and finalize a draft Strategic Plan, including, mission, vision, goals, objectives, strategies, and measures.
- IHS will initiate a 30-day public comment period for tribes to comment on the draft Strategic plan, which is anticipated to be finished by the end of January.
- IHS expects the final IHS Strategic Plan to be completed and published by April 2018

IHS Indian Health Care Improvement Fund (IHCIF)

- Dear Tribal Leader Letter on 11/13/17
- Establishment of IHS/Tribal IHCIF workgroup.
- Workgroup will 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**.**

IHS CHEF

- Proposed rule issued on 1/26/16 (81 Fed. Reg. 4239–44).
  - Added "tribal" resources to the list of alternate resources.
- No Tribal consultation on this rule before it was issued.
- In 2016, several tribal consultations took place.
- Payer of last resort case of *Redding Rancheria v. Burwell*, No. 15-152 (DDC) has delayed IHS from issuing a final rule.

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SAMHSA Confidentiality of Substance Use Disorder Patient Records

- Dear Tribal Leader Letter on 12/28/18.
- Virtual Tribal Consultation Session 1/22/18.
- Addresses prohibition on re-disclosure notice by including an option for an abbreviated notice.
- Addresses circumstances under which lawful holders and their legal representatives may use and disclose patient identifying information.
- Comments due 2/28/18.

Legislation in 115th Congress
Indian Legislative Bills in 115th Congress

- Important Dates
  - FY 2018 IHS Budget
    - CR ends on January 19
  - Children's Health Insurance Program
    - CR ends on January 19
  - Special Diabetes Program for Indians
    - Extended and expires on March 31

Legislation in 115th Congress

- Important Dates
- Affordable Care Act & Marketplace Stabilization
- Children's Health Insurance Program
- Special Diabetes Program for Indians Reauthorization Act of 2017 (S.747 & H.R. 2545)
- Native Health and Wellness Act of 2017 (H.R. 3706)

Summary of Minutes

- Native Health Access Improvement Act of 2017 (H.R. 3704)
- Native American Suicide Prevention Act of 2017 (H.R. 3473)
- Drug Free Indian Health Service Act of 2017 (H.R. 3096)
- Restoring Accountability in the Indian Health Service Act of 2017 (S.1250)
- Independent Outside Audit of the Indian Health Service Act of 2017 (S.465)
- Tribal Veterans Health Care Enhancement Act (S.304)
- NEW: The Mitigating METH Act (S. 2270)
- IHS Advanced Appropriations Act of 2017 (H.R. 235) (no slide)

Indian Legislative Bills in 115th Congress

- Affordable Care Act & Marketplace Stabilization
  - Tax Cuts and Job Act
    - Repeals Individual mandate
    - 12/19/17: Passed House and Senate
  - Bipartisan Healthcare Stabilization Act of 2017
    - Sponsored by Sen. Lamar Alexander (R-TN) and Sen. Patty Murray (D-WA)
  - Lower Premiums Through Reinsurance Act of 2017 (S. 1835)
    - Introduced by Sen. Susan Collins (R-ME) and co-sponsored by Sen. Bill Nelson (D-FL) and Lisa Murkowski (R-AK)
    - 9/19/17: Referred to Senate Finance Committee
- Children's Health Insurance Program – 5-year renewal bills
  - KIDS Act of 2017 (S.1827)
    - Introduced by Sen. Orrin Hatch (R-UT) on 9/18/2017
    - Referred to the Senate Finance Committee on 9/18/2017
    - 10/4/17: Committee hearing

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- 12/20/17: Placed on Senate Legislative Calendar
  - CHAMPION Act (H.R. 3922)
    - Introduced by Rep. Greg Walden (R-OR) on 10/3/17
    - 11/3/17: Passed House
    - 11/6/17: Referred to Senate Finance Committee
  - HEALTHY KIDS Act (H.R. 3921)
    - Introduced by Rep. Michael Burgess (R-TX) on 10/3/17
    - 10/23/17: Placed on Union Calendar
- Native Health and Wellness Act of 2017 (H.R. 3706)
  - Introduced by Rep. Raul Ruiz (D-CA-36) and co-sponsored by Rep. Frank Pallone Jr. (D-NJ-6) on 9/07/2017
  - Creates a tribal health block grant.
  - Creates a grant program to recruit and mentor AI/AN youth and young adults.
  - Referred to the House Energy and Commerce Committee on 9/07/2017
- Native Health Access Improvement Act of 2017 (H.R. 3704)
  - Introduced by Rep. Frank Pallone, Jr. (D-NJ-6) and co-sponsored by Rep. Raul Ruiz (D-CA-36) on 9/7/17.
  - Establishes a grant program similar to the SDPI to increase access to substance abuse prevention and behavioral health services for Tribes and Urban Indians.
  - 9/7/17: Referred to the Energy and Commerce Committee as well as to the Committee on Natural Resources and Ways and Means Committee.
  - 9/13/17: Referred to the Subcommittee on Indian, Insular and Alaska Native Affairs within the Committee on Natural Resources.
- Native American Suicide Prevention Act of 2017 (H.R. 3473)
  - Introduced by Rep. Raul Grijalva (D-AZ-3) on 7/27/17.

Summary of Minutes

	– Requires States and their designees receiving grants for development and implementation of statewide suicide and early intervention and prevention strategies to collaborate with Tribes. – 7/17/17: Referred to the House Energy and Commerce Committee on 7/27/17. – 7/Referred to the Subcommittee on Health under the Energy and Commerce Committee on 7/28/2017. • Drug-Free Indian Health Service Act of 2017 (H.R. 3096) – Introduced by Rep. Kristi Noem (R-SD) on 6/28/17; no other co-sponsors. – To implement a mandatory random drug testing program for certain employees of the Indian Health Service, and for other purposes. – 6/28/17: Referred to Committee on Natural Resources and Committee on Energy and Commerce. – 6/30/17: Referred to the Subcommittee on Health. – 7/13/17: Referred to the Subcommittee on Indian, Insular and Alaska Native Affairs. • Restoring Accountability in the Indian Health Service Act of 2017 (S. 1250 & H.R. 2662) – Senate and House bills Introduced by Sen. John Barasso (R-WY) and Rep. Kristi Noem (R-SD) on 5/25/17, respectively. – This bill attempts to address quality of care issues occurring at some IHS-operated hospitals in the Great Plains Area and elsewhere. – 5/25/17: Referred to House Senate and House Committees. – S. 1250- 6/13/17: Senate hearings were held. – H.R. 2662- 6/21/17: House Subcommittee hearing was held; Chairman Andy Joseph, Jr. testified. • Independent Outside Audit of the Indian Health Service Act of 2017 (S. 465)		

Summary of Minutes

	– Introduced by Sen. Mike Rounds (R-SD) on 2/28/17 with co-sponsors Sen. James Lankford (R-OK) and John McCain (R-AZ). – Requires an independent outside audit of the Indian Health Service with report to Congress. – 2/28/17: Referred to Committee on Indian Affairs – 11/8/17: Committee hearing • Tribal Veterans Health Care Enhancement Act (S. 304) – Introduced by Sen. John Thune (R-SD) and Sen. Mike Rounds (R-SD) on 2/3/17. – 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. – 3/29/17: Referred to Committee on Indian Affairs. – 6/15/17: Committee recommended that bill pass. – 6/15/17: Committee created a report to accompany S.304. • House Draft to Establish a Permanent Veterans Choice Program "CARE Act" – 10/24/17: Hearing on the draft bill. • NEW: The Mitigating METH Act (S. 2270) – Introduced by Sen. Steve Daines (R-MT) on 12/21/17 with co-sponsors Sen. Jeff Merkley (D-OR) and others – Amends the 21st Century Act to include funding for tribes for opioid prevention and response. – Authorizes a tribe or state to use grants for prevention and treatment of substances, including methamphetamines, if use of substances is determined by a state or tribe to have a substantial public impact on the state or tribe.		

Summary of Minutes

- 12/21/17: Referred to HELP Committee.

National & Regional Meetings

HHS Secretary's Tribal Advisory Committee (STAC)

- Last meeting was on September 20-21, 2017.
- Next meeting is January 17-18, 2018
- HHS Secretary Update:
  - Eric D. Hargan was sworn into office as Deputy Secretary on Oct. 6, 2017, and was appointed as Acting Secretary of the U.S. Department of Health and Human Services (HHS) on Oct. 10, 2017.
  - President Trump nominated Alex M. Azar II to be HHS Secretary on Nov. 13.

HHS nominee Alex Azar faced a Senate Health Education, Labor and Pensions Committee confirmation hearing on Nov. 29 and a Senate Finance Committee confirmation hearing on January 9, 2018

MMPC & CMS TTAG Update

- Medicare, Medicaid and Health Reform Policy Committee's (MMPC) –last face-to-face meeting was on October 31, 2017.
  - Next conference call is TBD; next MMPC face-to-face is February 20, 2018.
- CMS TTAG – last face-to-face meeting was November 1-2, 2017.
  - Next conference call is on January 10, 2018; and the next TTAG face-to-face meeting is February 21-22, 2018.

MMPC/TTAG Issues

- CMS New Policy Guidance on Work Requirements
- New Waivers in Current Administration
- 100% FMAP/4 Walls Issue

Summary of Minutes

	Future of RPMS		
HEPATITIS C, JESSICA LESTON, HIV/STI/HCV CLINICAL PROGRAM MANAGER	*See PowerPoint*		
WASHINGTON STATE HEALTH CARE AUTHORITY, JESSIE DEAN, TRIBAL AFFAIRS ADMINISTRATOR, OFFICE OF THE DIRECTOR	*See PowerPoint*		
TULALIP HOUSING – REHABILITATION OF METH HOUSES, THOMAS DICKERSON, MAINTENANCE MANAGER TULALIP HOUSING DEPARTMENT	*See PowerPoint*		
CHAIRMAN'S REPORT, ANDY JOSEPH	*See attached report*		

Summary of Minutes

DIVISION OF INFORMATION RESOURCES (DIRM) AND FUTURE OF RPMS *(VIA TELECONFERENCE)* CAPT MARK RIVES, DSC CHIEF INFORMATION OFFICER DIRECTOR, OFFICE OF INFORMATION TECHNOLOGY INDIAN HEALTH SERVICE	*See PowerPoint*		
Tribal Update	*Puyallup*		
NPAIHB/NICWA TRIBAL POLICY TOOLKIT, NORA FRANK-BUCKNER, WEAVE-NW PROJECT COORDINATOR	*See PowerPoint*		
CROSS JURISDICTIONAL COLLABORATION PROJECT: DISTRIBUTING	*See PowerPoint*		

Summary of Minutes

MEDICAL COUNTERMEASURES ACROSS TRIBAL AND NON-TRIBAL JURISDICTIONS, LOU SCHMITZ AND HEATHER ERB, AMERICAN INDIAN HEALTH COMMISSION (AIHC) CONSULTANTS			
DISCUSSION ON YOUTH COUNCILS, STEPHANIE CRAIG-RUSHING, THRIVE & PRT PROJECT DIRECTOR	*See PowerPoint*		
THURSDAY, APRIL 23, 2014			
COMMITTEE REPORTS	**Elders Committee – Patti Kinswa-Gaiser, Cowlitz Tribe** (A copy of the report is attached) **Veterans – Nate Tyler, Makah Tribe** (A copy of the report is attached) **Public Health – Kelle Little, Coquille Tribe** (A copy of the report is attached)		

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	Behavioral Health – Leta Campbell, Coeur d'Alene (A copy of the report is attached) **Personnel – Cassie Sellards-Reck, Cowlitz Tribe** (A copy of the report is attached) **Youth Committee** - **Nanette Star, NPAIHB Staff** (A copy of the report is attached) **Legislative Committee** - **Laura Platero, NPAIHB Governmental Affairs/Policy Director** (A copy of the report is attached)		
FINANCE REPORT	**Eugen Mostifi, NPAIHB Fund Accounting Manager:**		
MINUTES:	**MOTION BY JULIE REID, SNOQUALMIE; SECOND BY SAM PENNY, NEZ PERCE TRIBE, MOTION PASSES**	**MOTION**	**PASSED**
RESOLUTIONS:	**#18-02-01** *Tribal Practices for Wellness in Indian Country* **MOTION BY BRENT SIMCOSKY JAMESTOWN S'KLALLAM; SECOND BY LETA CAMPBELL; MOTION PASSES**		
	#18-02-02 *Request that U.S. Department of Health and Human Services and Its Agencies Make Hepatitis C Medications a Clinical Priority and Request for Congressional Appropriation of Funding to Indian Health Service for Hepatitis C Medications in Parity with U.S. Department of Veterans Affairs Funding* **MOTION BY LETA CAMPBELL; SECOND BY KIM THOMPSON, SHOALWATER BAY TRIBE; MOTION PASSES**	**MOTION**	**PASSED**

Summary of Minutes

	#18-02-03 *Request that State Medicaid Agencies Make Hepatitis C Medications a Clinical Priority* **MOTION BY CHERYL RASER; SECOND BY BRENT SIMCOSKY, JAMESTOWN S'KLALLAMTRIBE; MOTION PASSES**	**MOTION**	**PASSED**
ADJOURN	**MOTION TO ADJOURN: BY LETA CAMPBELL; SECOND BY BRENT SIMCOSKYY JAMESTOWN S'KLALLAM; ADJOURN AT 9:41 A.M**	**MOTION**	**PASSED**

QUARTERLY BOARD MEETING

Embassy Suites by Hilton Portland Airport
7900 NE 82nd Avenue Portland OR 97220
January 16-18, 2018
MINUTES

TUESDAY, JANUARY 16, 2018

Call to Order: Andy Joseph, Chairman,

Invocation: Tanna Engdahl, Spiritual Leader, Cowlitz Tribe

Posting of Flags: Cowlitz Color Guard

Welcome: Cowlitz Council, Steve Kutz

Roll Call: Shawna Gavin, Secretary, called roll:

Burns Paiute Tribe – **Present**	Nisqually Tribe – **Absent**
Chehalis Tribe – **Present**	Nooksack Tribe – **Absent**
Coeur d'Alene Tribe – **Present**	NW Band of Shoshone – **Absent**
Colville Tribe – **Present**	Port Gamble Tribe – **Present**
Grand Ronde Tribe – **Present**	Puyallup Tribe – **Present**
Siletz Tribe – **Present**	Quileute Tribe – **Absent**
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 – **Present**
Jamestown S'Klallam Tribe – **Present**	Spokane Tribe – **Present**
Kalispel Tribe – **Present**	Squaxin Island Tribe – **Absent**
Klamath Tribe – **Present**	Stillaguamish Tribe – **Present**
Kootenai Tribe – **Absent**	Suquamish Tribe – **Present**
Lower Elwha Tribe – **Present**	Swinomish Tribe – **Present**
Lummi Nation – **Present**	Tulalip Tribe – **Absent**
Makah Tribe – **Present**	Upper Skagit Tribe – **Absent**
Muckleshoot Tribe – **Absent**	Yakama Nation – **Absent**
Nez Perce Tribe – **Present**	

There were 27 delegates present, a quorum is established.

HEALTH POLICY AND LEGISLATIVE UPDATE-PART1, GEOFF STROMMER, PARTNER – HOBBS, STRAUS, DEAN & WALKER

Update

2018 Appropriations, Continuing Resolution, Spending caps

- SDPI, current CR extends funding through March 31st, Reauthorize for 2 year's Indian Health Legislation for 2018
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    - (1) tribal self-insurance plans are "health programs" operated by tribes/tribal organizations within the meaning of the payer of last resort language in Section 2901(b) of the ACA, and thus themselves have payer of last resort status under that provision.
    - (2) IHS cannot treat those plans as alternate resources for purposes of CHEF, nor for the underlying PRC program, without specific written permission of the Tribe.
- Update on Section 105(l) Lease Proposals, the 2016 court decision in *Maniilaq Association v. Burwell* established the right of tribes and tribal organizations to propose, and be fully compensated for, a lease under section 105(l) of the Indian Self-Determination and Education Assistance Act (ISDEAA).
- Contract Support Cost - In a "Dear Tribal Leader" letter dated December 21, 2017, IHS announced its unilateral decision to revoke at least temporarily, a provision tribes and IHS had spent months negotiating before the new CSC policy was finalized in October of 2016.
    - The policy allows IHS, under certain circumstances, to review a tribe's funding to ensure no duplication exists between indirect CSC and the "Secretarial" or program amount for service unit shares.
    - IHS CSC Workgroup, submitted a letter to IHS strongly condemning IHS's unilateral policy change. The letter pointed out that the parties agreed that the policy would be amended only after tribal consultation, and that IHS's action "disregards the bargain struck in government-to-government negotiations."
- An important court ruling on CSC could soon be put to a federal appeals court. In *Navajo Health Foundation—*

Sage Memorial Hospital, Inc. v. Burwell, the district court in New Mexico ruled that health care services provided under agreements with IHS but funded by third-party revenues—such as Medicare, Medicaid, and private insurance—are "Secretarial" funds that generate CSC just like IHS-appropriated funds.

- If the ruling stands, it could greatly expand the agency's CSC requirements.

PORTLAND AREA IHS DIRECTOR REPORT, DEAN SEYLER:

Division of Financial Management

FY 2018 Continuing Resolutions (CRs)

- CR 1: Public Law 115-56 authorizes funding from October 1 through December 8, 2017. The CR continues activities authorized in FY17 at the FY17 levels, but reduced by 0.6791%.
- CR 2: Public Law 115-90 authorizes funding through December 22, 2017. The CR continues activities authorized in FY17 at the FY17 levels, but reduced by 0.6791%.
- CR 3: Public Law No. 115-96 authorizes funding through January 19, 2018. The CR continues activities authorized in FY17 at the FY17 levels, but reduced by 0.6791%.

FY 2020 Portland Area Budget Formulation Meeting

- When: November 30, 2017
- Location: Embassy Suites, Portland Airport
- Attendees: Portland Area Tribal Leaders, Health Directors, representatives from the Northwest Portland Area Indian Health Board and leadership of the Indian Health Service - Portland Area Office.

FY 2020 National Budget Formulation Work Session

- When: February 15-16, 2018
- Location: Crystal City, VA
- Portland Area Elected Representatives:
  - Andrew Joseph Jr., The Confederated Tribes of the Colville Reservation
  - Steve Kutz, Cowlitz Indian Tribe
  - CAPT Ann Arnett, Executive Officer – Portland Area

Division of Business Operations Purchase and Referred Care

FY17 Catastrophic Health Emergency Fund

- Total Number of Cases: 56
- Total Number of Amendments: 23
- Current Reimbursement Amount: $1,686,871.00
- Current Pending Reimbursement Amount: $504,221.56
- 81% Reimbursed
- CHEF Balances as of January 9, 2018 $ 9,636,575

Indian Health Service Portland Area

- **Small Ambulatory Program (SAP)**
  - Health Facility Construction Funding Opportunity
  - Applications Were Due December 1, 2017
  - $5.0M Reserved / Max Award is $2.0M
  - 3-5 Awards Anticipated (Highly Competitive)
  - Four Applications Submitted from Portland Area Tribes
  - All Were Reviewed and Endorsed by the Area Office
  - IHS HQ Has Not Yet Established a Timeline for Making Award Decisions
  - Contact CAPT Jason Lovett With Any Questions, jason.lovett@ihs.gov

- **Annual Combined Space Verification**
  - Sent to Tribes in Early November
  - Verify the Amount and Location of Facility Space Used for IHS PSFA's
  - Response Due Date: **December 31, 2017**
  - Please Review the Provided Data and Certify if is Accurate
    - Used to Calculate Share of Equipment and M&I Funds
    - Used to Update and Maintain the CMS Facilities List for Encounter Rate Billing
    - Used to Verify Facility Type and Other Statistical Items
  - If Data is Not Accurate, Please Follow Included Instructions to Update
  - Questions:
    - Jonathan McNamara – Health Facilities Engineering – jonathan.mcnamara.ihs.gov
    - Peggy Ollgaard – Business Office – peggy.ollgaard@ihs.gov
    - Mary Brickell – Statistics – mary.brickell@ihs.gov
    - Or 503-414-5555 – please ask for one of the three above.

- April 25, 2018- Northwest Tribal Clinicians' Cancer Update
- April 26-27, 2018- Portland Area Spring Clinical Director's Meeting
- Embassy Suites-Washington Square, Tigard, OR

- Key Points Regarding Influenza:
  - It is not too late to get vaccinated
  - Influenza vaccine is still an important public health prevention tool
    - As in past years, washing your hands frequently, covering your cough and staying home when ill are also important measures to help prevent the spread of influenza

- ❖ Influenza Vaccine Effectiveness could be as low as 32% this year for preventing influenza A(H3N2) infections
- ❖ The current influenza vaccine is well matched to prevent influenza A (H1N1) and influenza B infections that are also circulating
- ❖ People at high risk for complications from the flu, including American Indians/Alaska Natives should seek care early to receive the maximum benefit from antiviral medications

BREAK

EXECUTIVE DIRECTOR UPDATE, JOE FINKBONNER:

PERSONNEL

- **NEW HIRES:**
  - **Ethan Newcomb,** WEAVE-NW Project Assistant
  - **Joshua Smith,** NWTEC Health Communication Specialist
  - **Tana Atchley,** Youth Engagement Coordinator
  - **Danica Brown,** Health Communication Coordinator
- **PROMOTIONS:**
  - **Colbie Caughlan**, THRIVE Project Director
  - **Ticey Mason**, Dental Support Center Project Director/EpiCenter Project Coordinator
- **RECOGNITION:**
  - **Kerri Lopez**, 15 Years of Service
  - **David Stephens**, Employee of the Year
  - **Marilyn Scott**, 2016 Delegate of the Year

MEETINGS

November

- PHAB Executive Committee meeting, Washington, DC (11/1-11/2)
- Idaho Tribes/State Meeting, Lewiston, ID (11/8)
- Indigenous Faculty Forum, PSU (11/17)
- Determinants of Health, Seattle, WA (11/28)

December

- Arcora Board Meeting, Seattle, WA (11/30 – 12/1)
- PHAB Board Meeting, Washington, DC (12/5-12/7)
- AIHC Meeting, Squaxin, Island (12/14)

Other Activities

- OFB Hot Dog Feed (11/15)
- NPAIHB Holiday Party (12/8)

Upcoming

January

- ATNI, Portland, OR (1/22 – 1/25)

February

- AIHC Meeting (2/8)
- NCAI, Washington, DC (2/12-2/15)

March

- Arcora Foundation Board Meeting, Seattle, WA (3/9)
- PHAB Board of Directors Meeting, Washington, DC (3/21-3/22)

April

- Medicare & Medicaid ITU Outreach & Education, Seattle, WA (4/4-4/5)

INJURY & FALL PREVENTION, DR. DEBORAH BEHRE

- EVERY SECOND COUNTS (every second, every day) - FALL
- EVERY 20 MINUTES - DEATH
- 1 OUT OF 3 PEOPLE 65 Y.O. OR OLDER FALL (1 IN 4 REPORT)
- 1 OUT OF 5 IS SERIOUS (TBI, FRACTURES, DEATH)
- OVER 50% OF PEOPLE WHO SURVIVE HOSPITALIZATION FOR A FALL NEVER RETURN HOME

AMERICAN INDIAN/ALASKA NATIVE ELDERS REPORT THE GREATEST PERCENTAGE OF FALLS (34.2%) OF ALL RACES/ETHNICITIES

- FALLS ARE THE 3RD LEADING CAUSE OF UNINTENTIONAL INJURY RELATED DEATHS OF AMERICAN INDIANS OF ALL AGES, BEHIND POISONING AND MOTOR VEHICLE TRAFFIC INJURIES

2013 – total fall injury cost - $34 billion
2020 – expected to increase (may reach $67.7 billion)

FALLS ARE PREVENTABLE - YOU CAN MAKE A DIFFERENCE

- THE RECOMMENDATION IS THAT EVERYONE 65 YEARS OR OLDER HAVE A YEARLY FALLS RISK ASSESSMENT

THE TEAM APPROACH WORKS BEST

6 Steps to reduce falls in AI/AN Elders

- 1. Talk to your health care provider – to assess risk
- 2. Find a good balance and exercise program
- 3. Review medications with doctor or pharmacist – regularly
- 4. Have vision and hearing checked annually

- 5. Keep home safe
- 6. Talk to family members – inform and teach family members about risks
- Developed by Natl Council on Aging, CDC and IHS Injury Prevention

SAVE

- Safety
- Appt (PCP and DPM)
- Vision
- Exercise

Why a lower extremity examination?
LOWER EXTREMITY RISK FACTORS

RISK FACTORS

- VISION
- MEDICATIONS
- MUSCLE WEAKNESS
- BALANCE
- HISTORY OF A FALL (FEAR OF FALLING)
- PERIPHERAL NEUROPATHY
- PRE DISPOSING DISEASES (CVA, Parkinson's)
- LOW VIT D LEVELS
- FOOTWEAR – SHOES & SOCKS
- FOOT PAIN
- OTHER FOOT/ANKLE CONDITIONS
- HEARING
- DEPRESSION

RISK FACTORS
MODIFIABLE

- MEDICATIONS
- VIT D LEVEL
- MUSCLE WEAKNESS
- BALANCE
- FOOTWEAR - SHOES & SOCKS
- FOOT PAIN
- FOOT CONDITIONS
- SAFETY (HOME)
- FEAR OF FALLING
- VISION (if treatable)
- HEARING (if treatable)
- DEPRESSION (if treated)

NON MODIFIABLE

- AGE
- GENDER (WOMEN – FALLS; MEN – DEATH AS RESULT OF A FALL)
- PREVIOUS FALLS
- PRE EXISTING CONDITIONS (MEDICAL)

2 Falls Risk Assessments
Primary Care Physician
Podiatric Physician

WHY 2 ASSESSMENTS?

RISK FACTORS

- MEDICATIONS
- VIT D LEVEL
- VISION (if treatable)
- HEARING (if treatable)
- DEPRESSION

MUSCLE WEAKNESS

- BALANCE
- FOOTWEAR - SHOES & SOCKS
- FOOT PAIN
- FOOT CONDITIONS
- SAFETY (HOME)
- FEAR OF FALLING

HOW IS THAT DONE?

- HISTORY
- PHYSICAL EXAMINATION
- FORMULATE A PLAN
- ONE YOU CAN LIVE WITH AND ACCOMPLISH

HISTORY (QUESTIONS AND ANSWERS)

- QUESTIONNAIRE +/OR IN PERSON
- RECENT FALLS/FEAR OF FALLING
- ASSISTIVE DEVICES (CANE, WALKER)
- LOSS OF BALANCE
- TRIPPING
- UNSTEADY WHILE WALKING
- RISING FROM A CHAIR
- USING FURNITURE TO KEEP STEADY
- RUSHING TO THE BATHROOM
- DIMINISHED FEELING
- DIZZINESS
- LIGHT HEADEDNESS W/RISING
- VIT D
- DO YOU EXERCISE – WHAT TYPE?
- SAFETY IN YOUR HOME
- MEDICATIONS – NAMES, DOSE, CHG
- VISION (GLASSES, EXAM)
- MEDICAL CONDITIONS (PARKINSON'S, STROKE, HTN)

PHYSICAL EXAMINATION

- MUSCLE STRENGTH
- RANGE OF MOTION
- FOOT PAIN
- FOOTWEAR (SHOES AND SOCKS)
- FOOT CONDITIONS (HAMMERTOES, BUNIONS)
- CORNS OR CALLUSES
- PULSES, COLOR, SWELLING
- SPECIFIC TESTS (TUG, 30 SEC CHAIR STAND, 4 STAGE BALANCE)

GOAL

FORMULATE A PLAN FOR A Pt (a personal prevention plan)

WHAT CAN PODIATRY DO

- EVALUATE YOUR FALL RISK
- PRESCRIBE WALKING AIDS
- MOORE BALANCE BRACES
- SHOES AND SOCKS
- TRIM CALLUSES AND TRIM NAILS
- INJECTIONS
- SURGERY
- REFERRALS (PT,OT,PCP)

EXERCISE

EXERCISE CHOICES

- SELF PROGRAM
- EXERCISE CLASS: TAI JI QUAN, YMCA MOVING FOR BETTER BALANCE, SAIL (stay active and independent for life), STEPPING ON
- PT CONSULT
- (OTAGO EXERCISE PROGRAM - dec falls 35-40%)

SELF PROGRAM

- CHAIR RISE EXERCISE
- TOWEL CURLS
-

SAFETY

WISDOM WARRIORS

- Developed by Northwest Regional Council (NWRC)
- NWRC partnered with tribal communities in Wa State

- TRIBAL PREVENTIVE HEALTH PROGRAM
- Uses culturally appropriate materials and a culturally relevant approach
- Wa State Dept of Health is talking with Wisdom Warriors about
- Falls Prevention opportunities for Tribal Elders
- Including culturally appropriate materials in partnership with Tribes and Tribal organizations
- If you are interested, contact Carolyn Ham
- (360) 236-9204; carolyn.ham@doh.wa.gov

Effective Evidence based Falls Prevention in Tribal Communities

- Webinar # 1 March 2017 Dr Bruce Finke
- Webinar # 2 June 29 2017 – 4 speakers

Fall Prevention Webinar # 1 - overview

- Dr Bruce Finke
- Community Based intervention, included Exercise, Home Assessment, Medication Review, Vision Exam, screening to identify those at risk for a fall, Multifactorial Risk Assessment, Vit D for those at risk of deficiency, Education in community and clinical settings about falls, falls risk and ability to prevent a fall

Falls Prevention Webinar # 2

- Ponca Tribe of OK
- Jocelyn Jackson
- Injury Prevention Coordinator, White Eagle Health Center
- Injury Prevention Program Application
- 55 + y.o. (Why – DM)
- Partners: Healthcare Provider, Optometrist, X Ray Tech, Pharmacy, Community Health Rep, Administration, IT Site Manager, Billing
- Winnebago Tribe of Nebraska
- Jennifer Straub
- Injury Prevention Coordinator
- Injury Prevention Project
- Home Assessment (Extensive Safety Assessment)
- Salt River Maricopa Indian Community
- Monte Yazzie
- Matter of Balance Master, Injury Prevention Coordinator
- Tai Chi, Yoga, 'Grandparents Day'

3 components

- A) Community Component
- B) Client Responsibility
- C) Culturally Appropriate

- Works at AASTEC (Albuquerque)
- Matter of Balance Master, Injury prevention Coordinator
- Sent out 268 Surveys
- Annual Foot Exams for Pts with DM and 65 y.o or older
- Annual Vision Assessment
- Ca and Vit Supplement for Elders
- Regular Exercise
- A Matter of Balance workshop – 8 session workshop 1x/wk or 2x/4wks
- Tai Chi
- STEADI Fall Prevention Toolkit Training

4 "best practice" tribes highlighted (NCOA)

1. ABSENTEE SHAWNEE TRIBE, Oklahoma
   - implementing TAI CHI to reduce falls in Elders
2. Gila River Indian Community, Arizona
   - implemented a MATTER OF BALANCE program
3. Match-E-Be-Nash-Wish Band of Pottawatomi Indians, Michigan
   - Gun Lake Tribe implemented a Stay Safe, Stay Active program
4. Sokaogon Chippewa Community, Wisconsin
   - implemented a Stepping On program

Good Sources of Information

- CDC – Center for Disease Control
- NICOA – Natl Indian Council on Aging
- NCOA – Natl Council on Aging

ELECTION OF OFFICERS:

Chairman:

Nomination: Nomination of Andy Joseph, by Dan Gleason, Chehalis, 2nd by Cassie Sellards-Reck, Cowlitz. **Nominated by acclamation**.

Secretary:

Nomination: Nomination of Greg Abrahamson by Cheryle Kennedy, Grand Ronde, 2nd, ---by **Nominated by acclamation**.

LUNCH, COMMITTEE MEETINGS (WORKING LUNCH)

ADVERSE CHILDHOOD EXPERIENCES (ACES) AND RESILIENCE, JULIE HARGRAVES, LCSW, BH MANAGER AND SANDY HENRY, TRAUMA-INFORMED CARE COORDINATOR

Why Focus On The Trauma?

What is Trauma:

- Trauma, deeply distressing or disturbing experience.
- The impact of trauma can be subtle, insidious, or outright destructive.

SAMHSA defines trauma

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effect on the individuals functioning and mental, physical, social, or spiritual well-being.

Trauma is **the leading** determinant of the health and social well-being of our nation.
The past decade has seen an increased focus on the ways in which trauma, psychological distress, quality of life, health, mental illness, and substance abuse are linked.

Trauma is Universal

- Stigma around Mental Health
- Most don't want to talk about it or listen to trauma…
- Care giving systems – Most health, mental health and social services have not incorporated knowledge about trauma – neither have school systems or courts….

Trauma increases the risk of:

- Heart disease
- Chronic Lung disease
- Liver disease
- Suicide - Injuries
- HIV and STDs

Effects of Traumatic Experiences Depend on…

Coping

- Supports
- Skills

Adversity

- Low Resources
- Stress
- Exposure
- Events

Trauma affects everyone differently…
People who go through traumatic experiences often have symptoms and problems afterward. How serious the symptoms and problems are depended on many things including a person's life experiences before the trauma, a person's own natural ability to cope with stress, how serious the trauma was, and what kind of help and support a person gets from family, friends, and professionals immediately following the trauma.
And because we now know with clarity that our experiences growing up deeply impact a young person and have a profound effect on physical and emotional health throughout one's entire life.
Those negative experiences are called Adverse Childhood experiences.

WHAT IS AN Adverse Childhood Experience? (ACEs)

- Adverse Childhood Experiences (ACEs) is a term used to describe neglect, abuse, violence and/or distressed family environments that children under the age of 18 years may experience. The cumulative effect of ACEs can be traumatic, especially if experienced repeatedly beginning at a young age.

Ten Categories of Adverse Childhood Experiences all similar and all toxic stress

Household Dysfunction:

- **1. Battered mother**
- **2. Substance abuse**
- **3. Mental illness**
- **4. Parental sep/divorce**
- **5. Criminal behavior**

Abuse:

- **6. Emotional**
- **7. Physical**
- **8. Sexual**

Neglect:

- **9. Emotional**
- **10. Physical**

Adverse Childhood Experiences Have a Strong Influence on:

- adolescent health
- smoking
- reproductive health
- alcohol abuse
- illicit drug abuse
- sexual behavior
- mental health
- risk of revictimization
- stability of relationships
- homelessness
- performance in the workforce

The ACE Study shows evidence that the more Adverse Childhood Experiences the more likely one would be at greater risk.
One in six people had an ACE score of 4 or more.
The short and long-term outcomes of these childhood exposures include a multitude of problems throughout life that result from disruptions in normal developmental pathways.
Compared with people with no ACEs, those with 4+ ACEs were…

- Twice as likely to smoke, have cancer or heart disease
- 7x as likely to be alcoholics
- 6x as likely to have had sex before age 15
- 12x more likely to have attempted suicide
- Men with 6+ ACEs were 46x more likely to have injected drugs than men with no history of adverse childhood experiences
- AND IPV (Domestic Violence) = 3X as likely to be a victim or perpetrator

What can we do? What's the next steps?

- A Changing Understanding of Medical Disease
- Routine screening for trauma is needed
- Referrals and Treatment
- Mass education about child development & parenting
- Media, Schools, health clinics

What is the role of primary care?

- **ACE screenings are essential:**
- Ask all patients about any possible history of trauma
- Do not require clients to describe emotionally overwhelming traumatic events in detail.
- A positive screening calls for more action.
- Be aware that some clients will not make the connection between trauma in their histories and their current patterns of behavior (e.g., alcohol and drug use and/or avoidant behavior).

The Road to Resilience

See PowerPoint for additional graphics

2016 Oregon Student Wellness Survey Cow Creek Tribal Youth

- 12% higher than peers for feelings of hopelessness
- 29.2% higher rate of attempted suicides
- 30% binge drank in the last 30 days

- 50% reported illicit drug use

Resilience
"the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress"

Developmental Assets
a set of skills, experiences, relationships, and behaviors that enable young people to develop into successful and contributing adults.

- Support
- Empowerment
- Boundaries and Expectations
- Constructive use of Time
- Commitment to Learning
- Positive values
- Social Competencies
- Positive Identity

Vision Statement

- After more than a century of intergenerational trauma Cow Creek Health & Wellness will utilize ***trauma informed practices*** to identify those Tribal youths in need, initiate new and ***relevant trauma informed*** programs, and strengthen the ***trauma awareness*** of our existing programs. All of these efforts will **enhance the resiliency** of our tribal youth; and promote a strong sense of cultural identity for all Tribal members.

Trauma Informed Practices….
…….is a strengths-based framework that is responsive to the impact of trauma, emphasizing physical, psychological, and emotional safety for both service providers and survivors; and creates opportunities for survivors to rebuild a sense of control and empowerment.

Question
Persuade
Refer
QPR (Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention is a 1-2-hour educational program designed to teach lay and professional "gatekeepers" the warning signs of a suicide crisis and how to respond.

HOPE Squad students are trained to be active listeners so they may help and respond to peers who are struggling with emotional issues such as depression and suicide. HOPE Squad members

are trained to share concerns with an adult. The goals of the HOPE Squad Program are to: Prevent suicide and reduce suicidal behaviors.

Developmental Assets

- Support
- Empowerment
- Boundaries and Expectations
- Constructive use of Time
- Commitment to Learning
- Positive values
- Social Competencies
- Positive Identity

Vision- a pairing of active Tribal Elders with Tribal Youth who are participating in activities together, making a connection.

VETERAN AFFAIRS, OFFICE OF TRIBAL GOVERNMENT RELATIONS VETERAN AFFAIRS UPDATE, TERRY BENTLEY, TRIBAL GOVERNMENT RELATIONS SPECIALIST AND WILLIAM MURRAY VISN20

VA Secretary's Five Priorities - VA's Strategic Framework

Community Care Coordination

- Existing reimbursement agreements will expire on June 30th 2019 – discussions on follow-on agreements will be conducted.
- Care coordination is largely a local matter – we need to know where this is not working well. Building relationships between tribes/IHS and VA is key.
- Only direct care is reimbursed under existing agreements. Future ability to reimburse for purchased care is unknown; we welcome collaboration with one or more tribes to improve coordination of VA purchased care.

Tribal Health Program

- Contract with Cerner to purchase a new Electronic Health Record is being pursued (no estimated award date)
- Eligibility for VA healthcare benefits is defined in legislation; we can only apply those criteria to assess whether a Veteran is eligible. Enrollment staff at the local VA Medical Center can assist with this www.va.gov is a good resource
- Pharmacy billing questions
- GAO reports on VA-IHS MOU
    - VA training for coordinating services - addressed at local levels
    - Cultural Competency – OTGR office working on training module

- Veterans Choice Program (VCP) – describe and update
  - On Dec 22nd VCP funding was extended ($2.1 billion); should last until mid-2018
  - Emergency MH care expanded to OTH-discharged Vets last spring
  - Latest EO offers 1 year MH care to all newly discharged Vets
  - Pending legislation: CARE Act
  - Congressional interest in expanding VA Caregiver Support Program to earlier Vet cadres (earlier than 9/11 gen)

VA Office of Tribal Government Relations Update

- VA releasing their 2017 Executive Summary Report regarding engagement with Indian Country
  - Going through concurrence process now
- Nationwide Outreach Campaign in Indian Country for Veterans with presumptive disabilities
  - DTLL sent out October 30, 2017
  - 20 Tribes responded – 6 within my region (AK, CA, NV, OR, WA)
  - VA OTGR engaging in 2018 outreach across Indian Country
  - Veteran Summits, Regional Tribal Meetings, Veteran Training, Tribal Site Visits

Questions Regarding Reimbursement Agreements

- Bill Murray, VISN 20 Strategic Planner, William.Murray3@va.gov, 360-567-4684
- Terry Bentley, Tribal Government Relations Specialist, Pacific District (OR, WA, CA, ID, NV, CA, AK) Terry.Bentley@va.gov, 541-440-1271
- VHA Chief Business Office for Purchased Care, tribal.agreements@va.gov

ENDOCRINOLOGY ECHO PILOT PROJECT, NANETTE STAR, WEAVE NW PROJECT DIRECTOR AND KATHI MURRAY MS, RDN, CDE, PORTLAND AREA IHS DIABETES CONSULTANT

***Please PowerPoint for additional graphics

Tribal Endo ECHO Project

ECHO is…

Extension for **C**ommunity **H**ealthcare **O**utcomes

Purpose

- ✓ Improve quality of clinical services
- ✓ Enhance community-clinical relationships
- ✓ Increase experts in the field
- ✓ Adopt cultural practices

Tribal Endo ECHO Pilot: Your Clinic's Role

1. **Submit a case**
2. Join our Endo ECHO as a participant or to learn more about ECHO
   2nd Thursday of every month April – October 2018

- Physicians
- Physician Assistants (PAs)
- Nurse Practitioners
- Registered Dieticians
- Medical Assistants
- Community Health Workers
- Other Health Providers
- SDPI Grantees
- Medicine Person/Tribal Leaders
- Behavioral Health Specialist

Tribal Endo ECHO Pilot
2nd Thursday of every month April – October

First Clinic:
- April 12, 2018 from 10-11am PST

Evaluation:
- April – October 2018
  Process Evaluation Results shared at each QBM

Final Report & Continuation Plan: November 2018

For more information or to submit a case please contact weave@npaihb.org 503.416.3254

NPAIHB MCH WORKGROUP, TAM LUTZ TOT2TWEEN & CARS PROJECT DIRECTOR AND MONIKA DAMRON, IDEA-NW BIOSTATISTICIAN

Maternal and Child Health Guiding Framework for the Northwest Portland Area Indian Health Board

A SUMMARY OF QUALITATIVE DATA COLLECTED BY NPAIHB

Overview

- MCH Core inquiry
- Process
- Share Key themes
- Discussion
- Application to Framework and Strategic Plan
- Discussion

A start

- We wanted to understand Maternal Child Health (MCH) efforts provided to NW Tribes both internally and externally
- We wanted to elicit MCH priorities for NW Tribes
- We wanted to understand how MCH fits into the NPAIHB overall strategic plan
- We wanted to elicit Tribal input in the direction of how we should approach improving MCH.
- Before developing a guiding frameworks or specific statement relating to MCH and the NPAIHB's mission or and goals, the MCH Core decided to employ a student intern to conduct interviews of those who work in MCH and serve Tribal people.

Purpose of the MCH Inquiry

- Identify priority areas in MCH for NPAIHB Tribal Epidemiology Center
- Not comprehensive
- Identifies key MCH issues and NPAIHB internal capacity
- Create road map for NPAIHB MCH efforts
- Link to NPAIHB Strategic Plan

PROCESS
Who did we speak with?

- Conversational, open-ended interviews
- MCH definition, priorities, supporting wellness
- 23 interviews, 29 participants
- 17 organizations: NPAIHB, clinics (IHS, Tribal), tribal health and human services, community-based organizations in urban areas, state/regional level organizations
- Feedback from a tribal clinic and the Native American Rehabilitation Association of the Northwest

FINDINGS
What is MCH?
"The beginning [of MCH] is difficult because some things are important for a healthy pregnancy, before you are planning to become pregnant. I see the separation between adolescent health because that is such a huge beast of its own. I would say [MCH] goes up to maybe age 12, but the cutoff is not firm, or as important"

"We should be able to define what [MCH] means to us firstly; but…programs have specific funding for specific populations. We are reactive in that sense. We work in the areas that are funded"

*"I would like to see no age restraint on MCH—a child is a child until age 18; [I see it as] more of a continuum of support for whole wellness (beyond just clinical care) throughout life***"**

"There are multiple generations involved in support; and the community and systems impact the mother and child. There are circles of involvement"

What is MCH?

- Mothers and children at the core
- Fathers, elders, communities play a role
- Distinct challenges at different ages and stages of life, but fluidity and overlap between stages
- Focus areas (often in response to funding priorities) but whole picture view is necessary

Support
Support: Quotes
Focus on Specific Groups:
"There is a tendency for us to focus more on women…Indian mothers pass along cultural and traditional teachings to women and have high expectations…We sometimes tend to let men slide. We don't hold young men to the responsibility of being community leaders and fathers…In some ways we have let our men down"

Culturally Relevant Support:
"[We need] support systems for parents. [We] need support that is delivered in a culturally and socially appropriate way, respectful and non-judgmental. [We need to] serve people with open minds and open hearts"

Support: Topics
Childcare
Home visiting
    Delivered in an integrated way
Gatherings or support groups
    Culturally relevant
    In collaboration with medical providers (prenatal care, pediatricians)
Breastfeeding support
    Especially for young moms
Need for reaching specific groups
    Fathers, young mothers, connection between elders and younger generations

Education

Education: Quotes

"In the US there is not always support for parents, and that can be isolating. Many Native people are still reeling from a time when kids were taken away from parents and put in boarding schools. There was a break in parenting and it comes up today and is traumatic. People feel they do not know how to parent; so encouraging traditional ways in parenting is very important. There is a lot of focus on pregnancy and delivery, but less focus on parenting"

"The hospitals have training for parents and support groups, but something more local or regional and culturally relevant would be better. Parents may want to have support groups with people they have grown up with, and have something more meaningful and relevant to them"

Education: Topics

- Education for parents that is culturally relevant and tribally specific
    - Understanding childhood and adolescent milestones
    - Education for mothers and fathers

Mental Health and Substance Use

Mental Health & Substance Abuse: Quotes

"The timing of this conversation is crucial considering challenges with drug abuse in Indian Country, and the many disparities faced. Children [are] facing struggles with meth, suicide, bullying, gangs, and drugs. Moms and dads don't know how to cope with these challenges. MCH is a way to make a difference"

"Many problems in pregnancy, birth, and development are related to addiction. The health of the baby is connected to the health of the mother and the community. Trauma, stress, and depression are passed in utero, and trauma is ongoing, not just historical. Early intervention at the start of pregnancy and before pregnancy, and intervention after birth is critical"

Mental Health & Substance Abuse: Topics

Mental Health:

- Mental health for families
- Postpartum depression
- Strong behavioral health programs
- Trauma, grief, and loss and a need for opportunities for healing
- Connection between reproductive health and mental health

Substance abuse:

- Drugs (general)
- Alcohol

- Other
- FASD
- Tobacco
- Addiction Support

Connection to Culture & Holistic Health
Holistic Health: Quotes
"[I would like a] facility or wing with a full healthcare team, including a nurse, dietician, primary care provider. A comprehensive wellness and care team for mothers and their partners, and for children. It would offer the full spectrum of care: nutrition, fitness, healthy eating, parenting, healthy relationships, housing, case management. It would be a one-stop-shop for everyone"

"People don't come in pieces"

Holistic Health: Topics
- Upstream approaches to disease prevention
- Incorporation holistic health information and holistic health care to clinical settings

For example:
  - Clinics incorporating exercise and birth classes
  - Information on cultural, traditional, and spiritual teachings

Culture: Quotes
"Culture is Prevention"

Culture: Topics
- Not a "one size fits all" approach
- Making traditional practices an accessible option by supporting culture through health and social systems and education
- Traditional foods, language programs, spirituality, traditional medicine and healing

COMMON DATA COLLECTION ISSUES AND SUGGESTIONS
Suggestions
- Collecting local, tribal-specific baseline data for comparison across tribes or between communities within a reservation.
- Building community-level metrics, looking at connectedness and wellness.

Measuring attendance at well-child, prenatal, and dental appointments

Issue: Statistical Significance

"There is also this idea of 'statistical significance' and populations with small sample sizes do not get reported because they are not 'significant'. [This] leads to exclusion of populations and 'statistical significance' drives funding"

Suggestions & Next Steps for NPAIHB
Suggestions

- Information sharing
- Advocacy
- Partnerships and creative thinking
- Regular needs assessment including community members

SPECIFIC DATA COLLECTION ISSUES AND SUGGESTIONS

CLINICS	NPAIHB	COMMUNITY
Care coordination and tracking of attendance at appointments	Indicators to measure connection to culture or tradition	Indicators to measure connection to culture or tradition
Better follow up after delivery	Qualitative data and story telling	Qualitative data and story telling
Lost data on patients when mothers referred out for OB care, or when children attending private pediatric appointments	Data linkage across sectors	Data linkage across sectors
Lack of data sharing between systems	Creating shared metrics	Creating shared metrics

Discussion

- Do these themes resonate in the community(s) you serve?
- Is there anything about these topics that surprises you?
- Are topics we haven't heard that you think are important?
- Are there other questions you think we should ask?

Next Steps
Facilitating opportunities for information sharing:

- Developed and publishing MCH Guiding Framework online

- Developing our Vision, Mission Statement, and Goals that blend with the NPAIHB Strategic Plan
- Determining How Board Delegates would like to be engaged in the process
- Deciding how NPAIHB and other organizations should collaborate moving forward

Acknowledgements

Respondents
HRSA Maternal Child Health Board Graduate Student Epidemiology Program
Alyssa Bosold

Executive Session:

End Executive Session: **Motion by Cassie Sellards-Reck, Cowlitz Tribe; 2nd by Cheryl Resar, Swinomish Tribe**

NPAIHB to further examine Tribal Retained Shares for NPAIHB Cooperative Agreement in regards to Environmental Health Program**: Motion by Brent Simcosky, Jamestown S'Klallam Tribe; 2nd by Shawna Gavin, Umatilla, MOTION CARRIED**

RECESS

WEDNESDAY, JANUARY 17, 2018

Call to Order: Cheryle Kennedy, Vice-Chair

Invocation: Dan Gleason, Chehalis

HEALTH POLICY AND LEGISLATIVE UPDATE – PART 2, LAURA PLATERO, GOVERNMENT AFFAIRS/POLICY DIRECTOR

Report Overview

1. Status of IHS Budgets
2. Current & Pending Policy Issues
3. Legislation in 115th Congress
4. National & Regional Meetings

Status of IHS Budgets

FY 2018 IHS Budget

- Congress passed another continuing resolution (CR) for FY 2018 budget which funds the government through January 19, 2018.
- President's budget proposes a 5.2% decrease below FY 2017 enacted level ($4.2B) for services and facilities.
- House bill proposes a $179m increase above FY 2017 enacted level for services and facilities.
- Senate bill proposes less than $1m increase above FY enacted level for services and facilities
- Hill visits advocacy per our FY 2018 analysis.
  - $246.5m for services & facilities

FY 2019/2020 IHS Budgets

- FY 2019 National Tribal Budget Formulation Workgroup's Recommendations
  - Available at: http://www.nihb.org/legislative/budget_formulation.php
- FY 2020
  - Portland Area Budget Formulation Meeting was November 30, 2017
  - National Budget Formulation Meeting is February 15-16, 2018 in Washington, D.C.

Current & Pending Policy Issues

CMS 4 Walls Limitation

- CMS determined that If a Tribal facility is enrolled in the state Medicaid program as a provider of clinical services under 42 CFR 440.90, the Tribal facility may not bill for

services furnished by a non-Tribal provider or Tribal employee at the facility rate for services that are provided outside of the facility.

- Per CMS, under FQHC designation there is no requirement that the services be provided within the 4 walls.
- Section 1905 of the SSA recognizes outpatient Tribal clinics as FQHCs.
- CMS FAQ released January 18, 2017.
- *Deadlines*:
    - January 18, 2018: Tribe must notify state of intent to change provider status – clinical provider to FQHC.
    - January 30, 2021: Effective date
    -

CMS Pharmacy Outpatient Rule Implementation

- Covered Outpatient Drug Final Rule (81 FR 517), dated 2/1/16; changes reimbursement methodology of covered outpatient drugs in Medicaid program.
- States may elect to reimburse I/T/U pharmacies through the OMB encounter rate.
- Oregon status:
    - SPA amendment approved 9/20/17 by CMS.
    - "The I/T pharmacy will receive one encounter per prescription filled or refilled and will not be limited to a certain number of prescriptions per day."
    - Tribes will receive AIR from October, 2017; systems need to be updated so reconciliation necessary initially.

CMS Medicare Diabetes Prevention Program (MDPP) Final Rule

- CMS publishes MDPP final rule on 11/15/17.
- MDPP Expanded Model start date is 1/1/18.
- MDPP Supplier enrollment begins in January 2018 and suppliers begin furnishing services and billing Medicare in April 2018.
- Unfortunately, tribal recommendations were not accepted in final rule.

CMS New Medicare Card Project

- CMS New Medicare Project Webinar on 1/23/18
- Removal of SSN-based Health Insurance Claim. Number (HICN) from Medicare cards.
- CMS will send out replacement Medicare cards with a new Medicare Beneficiary Identifier (MBI) by April 2019.
- CMS will begin mailing new Medicare cards to people with Medicare and all systems and processes will able to accept MBI in April 2018.
- Transition period runs from April 2018 through December 31, 2019.
- CMS is working to develop a look-up tool for providers to be able to access a patient's new MBI.

IHS Contract Support Costs Policy Update

- Dear Tribal Leader Letter on 12/21/2017
- Update to temporarily rescind Alternative Methods for Calculating Indirect Costs Associated with Recurring Service Unit Shares, referred to as the 97/3 split.
- 97/3 split is the alternative option to determine the amount in a tribe's indirect cost pool.
- IHS has found that in certain circumstances, the result is inconsistent with statutory authority.
- Next IHS CSC Workgroup meeting is March 6-7, 2018.

IHS Health Information Technology

- Issued a request for information (RFI) on 12/20/2017.
- Assess industry innovations and capabilities to address emerging healthcare delivery and modernization needs.
- Objective is to research clinical and technical approaches and to deliver next generation solutions with modularized software components.
- IHS ISAC workgroup recommended moving to a commercial off-the-shelf system.
- Responses accepted until 2/1/18

IHS Strategic Plan 2018-2022

- Dear Tribal Leader Letter on 11/28/17.
- Comments were due on 10/31/17; NPAIHB submitted comments. IHS received 137 comments.
- Established an IHS Strategic Planning workgroup to review comments and finalize a draft Strategic Plan, including, mission, vision, goals, objectives, strategies, and measures.
- IHS will initiate a 30-day public comment period for tribes to comment on the draft Strategic plan, which is anticipated to be finished by the end of January.
- IHS expects the final IHS Strategic Plan to be completed and published by April 2018

IHS Indian Health Care Improvement Fund (IHCIF)

- Dear Tribal Leader Letter on 11/13/17
- Establishment of IHS/Tribal IHCIF workgroup.
- Workgroup will 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**.**

IHS CHEF

- Proposed rule issued on 1/26/16 (81 Fed. Reg. 4239–44).
  - Added "tribal" resources to the list of alternate resources.
- No Tribal consultation on this rule before it was issued.

- In 2016, several tribal consultations took place.
- Payer of last resort case of *Redding Rancheria v. Burwell*, No. 15-152 (DDC) has delayed IHS from issuing a final rule.

SAMHSA Confidentiality of Substance Use Disorder Patient Records

- Dear Tribal Leader Letter on 12/28/18.
- Virtual Tribal Consultation Session 1/22/18.
- Addresses prohibition on re-disclosure notice by including an option for an abbreviated notice.
- Addresses circumstances under which lawful holders and their legal representatives may use and disclose patient identifying information.
- Comments due 2/28/18.

Legislation in 115th Congress
Indian Legislative Bills in 115th Congress

- Important Dates
  - FY 2018 IHS Budget
    - CR ends on January 19
  - Children's Health Insurance Program
    - CR ends on January 19
  - Special Diabetes Program for Indians
    - Extended and expires on March 31

Legislation in 115th Congress

- Important Dates
- Affordable Care Act & Marketplace Stabilization
- Children's Health Insurance Program
- Special Diabetes Program for Indians Reauthorization Act of 2017 (S.747 & H.R. 2545)
- Native Health and Wellness Act of 2017 (H.R. 3706)
- Native Health Access Improvement Act of 2017 (H.R. 3704)
- Native American Suicide Prevention Act of 2017 (H.R. 3473)
- Drug Free Indian Health Service Act of 2017 (H.R. 3096)
- Restoring Accountability in the Indian Health Service Act of 2017 (S.1250)
- Independent Outside Audit of the Indian Health Service Act of 2017 (S.465)
- Tribal Veterans Health Care Enhancement Act (S.304)
- NEW: The Mitigating METH Act (S. 2270)
- IHS Advanced Appropriations Act of 2017 (H.R. 235) (no slide)

Indian Legislative Bills in 115th Congress

- Affordable Care Act & Marketplace Stabilization
  - Tax Cuts and Job Act
    - Repeals Individual mandate
    - 12/19/17: Passed House and Senate
  - Bipartisan Healthcare Stabilization Act of 2017
    - Sponsored by Sen. Lamar Alexander (R-TN) and Sen. Patty Murray (D-WA)
  - Lower Premiums Through Reinsurance Act of 2017 (S. 1835)
    - Introduced by Sen. Susan Collins (R-ME) and co-sponsored by Sen. Bill Nelson (D-FL) and Lisa Murkowski (R-AK)
    - 9/19/17: Referred to Senate Finance Committee
- Children's Health Insurance Program – 5 year renewal bills
  - KIDS Act of 2017 (S.1827)
    - Introduced by Sen. Orrin Hatch (R-UT) on 9/18/2017
    - Referred to the Senate Finance Committee on 9/18/2017
    - 10/4/17: Committee hearing
    - 12/20/17: Placed on Senate Legislative Calendar
  - CHAMPION Act (H.R. 3922)
    - Introduced by Rep. Greg Walden (R-OR) on 10/3/17
    - 11/3/17: Passed House
    - 11/6/17: Referred to Senate Finance Committee
  - HEALTHY KIDS Act (H.R. 3921)
    - Introduced by Rep. Michael Burgess (R-TX) on 10/3/17
    - 10/23/17: Placed on Union Calendar
- Native Health and Wellness Act of 2017 (H.R. 3706)
  - Introduced by Rep. Raul Ruiz (D-CA-36) and co-sponsored by Rep. Frank Pallone Jr. (D-NJ-6) on 9/07/2017
  - Creates a tribal health block grant.
  - Creates a grant program to recruit and mentor AI/AN youth and young adults.
  - Referred to the House Energy and Commerce Committee on 9/07/2017
- Native Health Access Improvement Act of 2017 (H.R. 3704)
  - Introduced by Rep. Frank Pallone, Jr. (D-NJ-6) and co-sponsored by Rep. Raul Ruiz (D-CA-36) on 9/7/17.
  - Establishes a grant program similar to the SDPI to increase access to substance abuse prevention and behavioral health services for Tribes and Urban Indians.
  - 9/7/17: Referred to the Energy and Commerce Committee as well as to the Committee on Natural Resources and Ways and Means Committee.
  - 9/13/17: Referred to the Subcommittee on Indian, Insular and Alaska Native Affairs within the Committee on Natural Resources.
- Native American Suicide Prevention Act of 2017 (H.R. 3473)

  - Introduced by Rep. Raul Grijalva (D-AZ-3) on 7/27/17.
  - Requires States and their designees receiving grants for development and implementation of statewide suicide and early intervention and prevention strategies to collaborate with Tribes.
  - 7/17/17: Referred to the House Energy and Commerce Committee on 7/27/17.
  - 7/Referred to the Subcommittee on Health under the Energy and Commerce Committee on 7/28/2017.
- Drug-Free Indian Health Service Act of 2017 (H.R. 3096)
  - Introduced by Rep. Kristi Noem (R-SD) on 6/28/17; no other co-sponsors.
  - To implement a mandatory random drug testing program for certain employees of the Indian Health Service, and for other purposes.
  - 6/28/17: Referred to Committee on Natural Resources and Committee on Energy and Commerce.
  - 6/30/17: Referred to the Subcommittee on Health.
  - 7/13/17: Referred to the Subcommittee on Indian, Insular and Alaska Native Affairs.
- Restoring Accountability in the Indian Health Service Act of 2017 (S. 1250 & H.R. 2662)
  - Senate and House bills Introduced by Sen. John Barasso (R-WY) and Rep. Kristi Noem (R-SD) on 5/25/17, respectively.
  - This bill attempts to address quality of care issues occurring at some IHS-operated hospitals in the Great Plains Area and elsewhere.
  - 5/25/17: Referred to House Senate and House Committees.
  - S. 1250- 6/13/17: Senate hearings were held.
  - H.R. 2662- 6/21/17: House Subcommittee hearing was held; Chairman Andy Joseph, Jr. testified.
- Independent Outside Audit of the Indian Health Service Act of 2017 (S. 465)
  - Introduced by Sen. Mike Rounds (R-SD) on 2/28/17 with co-sponsors Sen. James Lankford (R-OK) and John McCain (R-AZ).
  - Requires an independent outside audit of the Indian Health Service with report to Congress.
  - 2/28/17: Referred to Committee on Indian Affairs
  - 11/8/17: Committee hearing
- Tribal Veterans Health Care Enhancement Act (S. 304)
  - Introduced by Sen. John Thune (R-SD) and Sen. Mike Rounds (R-SD) on 2/3/17.
  - 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.
  - 3/29/17: Referred to Committee on Indian Affairs.

  - 6/15/17: Committee recommended that bill pass.
  - 6/15/17: Committee created a report to accompany S.304.
- House Draft to Establish a Permanent Veterans Choice Program "CARE Act"
  - 10/24/17: Hearing on the draft bill.
- NEW: The Mitigating METH Act (S. 2270)
  - Introduced by Sen. Steve Daines (R-MT) on 12/21/17 with co-sponsors Sen. Jeff Merkley (D-OR) and others
  - Amends the 21st Century Act to include funding for tribes for opioid prevention and response.
  - Authorizes a tribe or state to use grants for prevention and treatment of substances, including methamphetamines, if use of substances is determined by a state or tribe to have a substantial public impact on the state or tribe.
  - 12/21/17: Referred to HELP Committee.

National & Regional Meetings

HHS Secretary's Tribal Advisory Committee (STAC)

- Last meeting was on September 20-21, 2017.
- Next meeting is January 17-18, 2018
- HHS Secretary Update:
  - Eric D. Hargan was sworn into office as Deputy Secretary on Oct. 6, 2017, and was appointed as Acting Secretary of the U.S. Department of Health and Human Services (HHS) on Oct. 10, 2017.
  - President Trump nominated Alex M. Azar II to be HHS Secretary on Nov. 13.

HHS nominee Alex Azar faced a Senate Health Education, Labor and Pensions Committee confirmation hearing on Nov. 29 and a Senate Finance Committee confirmation hearing on January 9, 2018

MMPC & CMS TTAG Update

- Medicare, Medicaid and Health Reform Policy Committee's (MMPC) –last face-to-face meeting was on October 31, 2017.
  - Next conference call is TBD; next MMPC face-to-face is February 20, 2018.
- CMS TTAG – last face-to-face meeting was November 1-2, 2017.
  - Next conference call is on January 10, 2018; and the next TTAG face-to-face meeting is February 21-22, 2018.

MMPC/TTAG Issues

- CMS New Policy Guidance on Work Requirements
- New Waivers in Current Administration
- 100% FMAP/4 Walls Issue
- Future of RPMS

HEPATITIS C, JESSICA LESTON, HIV/STI/HCV CLINICAL PROGRAM MANAGER

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

"We need to all work together as a nation of one tribe, the tribe of Human Kind, to make this world a good place for all." – Howard Lyons, Mohawk

Nation to Nation: Treaties Between the United States and American Indian Nations
National Congress of American Indians (NCAI) president Walter Wetzel, Senator Lee Metcalf, and Senator Mike Mansfield, 1963 – meeting with President John F. Kennedy

What is Hepatitis C? Why do we Care?
What are we trying to prevent?

- Ascites
- Esophageal varices
- End stage liver disease
- Liver Cancer
- Death

HCV Burden in American Indians/Alaska Natives

- Highest incidence rate of acute HCV
- Highest HCV related mortality, nearly 3x national average
- Highest rates hepatocellular cancer
- Estimated 40,000 persons infected with the hepatitis C virus

How do you treat Hepatitis C?
HCV new treatments

- Highly effective: up to 95% cure rate
- Short course: most treatments only require 12 weeks, 1-2 pills per day
- During treatment, visit clinic 1/month, plus final follow up
- Minimal side effects

Why do we need to treat Hepatitis C?

- SVR (cure) of HCV is associated with:
    - 90% Reduction in Liver Failure
    - 70% Reduction of Liver Cancer
    - 50% Reduction in All-cause Mortality

Current Treatment in Indian Country

- Most I/T/U clinics are not currently treating systematically

- About 1% of total positives were treated last year
- What can we do to ensure treatment of our patients?

What does the cost of Hepatitis C look like?
Breakdown of Hepatitis C Medication Regimens

- The most common medications are $15,000 – $37,000
- These have the potential to decrease in 2018

What about effectiveness? Savings?
Cost-effectiveness (ICER≤$100,000/QALY)
Cost-saving (ICER<$0)

- The median threshold prices at which first-generation and second-generation DAAs became cost-effective were estimated as $120,000 and $277,200.
- At a discounted price of $60,000, a total of 71% of the analysis found second generation DAAs to be cost-saving and 22% to be cost-effective.

What are the policy options?
Policy Option A – No Change
Policy Option A is our base-cause or status-quo. Under this option, we assume the current treatment percentage of 0.7% of the total 40,000. Under this policy, the cost of overall treatment will be $4.7-11 million (depending on a price range of 17-39 thousand per treatment course), $0 is programming, a lifetime cost of $8 billion (with 39,000 patients left untreated at a cost of $200,000/lifetime/individual), and $56 million in cost savings (treatment of 280 patients at a cost savings of $200/lifetime/individual).

Policy Option B – Treat Urgent Cases
Policy Option B assumes the treatment of persons with advanced liver disease, with accounts for 11% percent the total 40,000. Under this policy, the cost of overall treatment will be $78-180 million (depending on a price range of 17-39 thousand per treatment course), $1 million is programming (infrastructure/training/coordination), a lifetime cost of $7 billion (with 35,400 patients left untreated at a cost of $200,000/lifetime/individual), and $920 million in cost savings (treatment of 4,600 patients at a cost savings of $200,000/lifetime/individual).
Policy Option C – New "Treat All"
Policy Option C assumes a "treat all" policy. Under this policy, the cost of overall treatment will be $680 million -1.6 billion (depending on a price range of 17-39 thousand per treatment course), $50 million is programming (infrastructure/training/coordination), a lifetime cost of $0 (with 0 patients left untreated at a cost of $200,000/lifetime/individual), and $8 billion in cost savings (treatment of 40,000 patients at a cost savings of $200,000/lifetime/individual).

What does this mean for Indian Country?
Financial Disparities in Indian Country
Per patient annual health care spending:

Medicare	$12,042
National	$7,713
Veterans Affairs	$6,980
Bureau of Prisons	$5,010
IHS	$2,849

FY 2019 National Tribal Budget Formulation Workgroup's recommendation is $32B to fully fund IHS

A HCV Success Story – Department of Veterans Affairs

- The VA has treated more than 92,000 HCV-infected veterans since all-oral DAAs became widely available in January 2014, with cure rates exceeding 90%*
- At current treatment rate, VA will have treated all its HCV patients in approximately 3 more years*

A HCV Success Story – Department of Veterans Affairs

- The VA has treated more than 92,000 HCV-infected veterans since all-oral DAAs became available in January 2014, with cure rates exceeding 90%*
- At current treatment rate, VA will have treated all its HCV patients in approximately 3 more years*
- The VA has had special allocation of funding of over 3 billion dollars

What needs to be done?

- Leadership support
- Policy
- Strategy
- Collaborative work
- A careful analysis and decision to move forward with one of the policy options.
    - If coming from an evidence and practice-based best practice – the "treat all" policy would be the best for the system and the patients**.**

WASHINGTON STATE HEALTH CARE AUTHORITY, JESSIE DEAN, TRIBAL AFFAIRS ADMINISTRATOR, OFFICE OF THE DIRECTOR

Medicaid Transformation Waiver
Tribal/IHCP Protocol

- CMS reviewing – Hope to have response by mid-February

Tribal/IHCP Planning Funds Plan

- Submitted to HCA on December 28, 2017
- Will become the basis for a report to be prepared in 2018
- After protocol approved, $5.4 million to be disbursed:
  - On or after May 18 if in part
  - Before May 18 if in full amount of $5.4 million

Tribal/IHCP-Specific Projects Plan

- Anticipated deadline: September 30, 2018

Amendments to 1115 Waiver for:

- SUD IMD
- Technical corrections for Medicaid Transformation

Tribal Consultation on January 22, 2018

Medicaid SPA: Covered Outpatient Drug AIR

Under review for:

- Fiscal impacts
- ProviderOne capabilities

Medicaid SPA 17-0042: All-Inclusive Rate

SPA 17-0042: Update of All-Inclusive Rate

- Submitted to CMS on September 28, 2017
- Approved by CMS: December 6, 2017
- Effective: September 29, 2017

Services provided by or through facilities of the Indian Health Service (IHS) which includes, at the option of the tribe, facilities operated by a tribe or tribal organization and funded by Title I or III of the Indian Self Determination and Education Assistance Act (also known as Tribal 638 facilities), are paid at the applicable rates published in the Federal Register or Federal Register Notices.

The applicable published outpatient per visit rate (also known as the outpatient all-inclusive rate) is paid for up to five (5) outpatient visits per Medicaid beneficiary per calendar day for professional services.

An outpatient visit is, “A face-to-face or telemedicine contact between any health care professional authorized to provide services under the State Plan and a Medicaid beneficiary for the provision of Title XIX defined services, as documented in the patient's record.”

Included in the outpatient per visit rate are laboratory and x-ray services provided on-site and medical supplies incidental to the services provided to the patient. Pharmaceuticals/drugs are outside the all- inclusive rate and are reimbursed under the fee-for-service system at the applicable fee-for-service rate.

Tribal FQHC: CMS Guidance

1. Scope of Service: May the State Plan reimburse FQHCs and Tribal FQHCs for different provider services?
    1. The State Plan provides for a single set of FQHC services.
2. Pharmacy: May the State Plan reimburse Tribal FQHCs for pharmacy dispensing at the encounter rate if FQHCs are not eligible for reimbursement of pharmacy dispensing at the encounter rate?
3. The State Plan provides for a single set of FQHC services.
4. Different Facilities: May a tribal health program have both an tribal clinic and an FQHC at the same address?
    1. No response: CMS is researching.
5. HRSA-Funded Tribal FQHCs: May a HRSA-funded FQHC operated by a tribe choose to be designated and reimbursed at the Tribal FQHC encounter rate?
6. Yes – The tribe has the option to request Medicaid FQHC designation.
7. Encounter Rate for Any Health Care Professional: May the State Plan authorize the encounter rate for any health care professional (see SPA 17-0042)?
    1. The State Plan provides for a single set of rules for all FQHC services.
8. Encounter Rate for Services Under Supervision: If the answer to Question 5 is "No", may the State Plan authorize the encounter rate for services "under the supervision".
9. The State Plan provides for a single set of rules for all FQHC services.

Web: http://www.hca.wa.gov/tribal/Pages/index.aspx

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BREAK

TULALIP HOUSING – REHABILITATION OF METH HOUSES, THOMAS DICKERSON, MAINTENANCE MANAGER TULALIP HOUSING DEPARTMENT

METHAMPHETAMINE CONTAMINATION

- INTRODUCTION
- ACCEPTABLE LEVELS OF CONTAMINATION
- COST AND INDUSTRY REQUIREMENTS
- TRAINING
- CLEANUP PROCESS
- POLICY EVOLUTION

TENANT REACTION AND RESPONSE
TESTING AND CLEANUP ACCURACY AND EFFICIENCY
WHAT WE SEE TODAY
EVOLUTION OF THE METH LAB
MOVING FORWARD

INTRODUCTION

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ACCEPTABLE LEVELS OF CONTAMINATION

WHAT WE CAN DETECT
WHAT BECOMES A HEALTH HAZARD
DEFINING THE HAZARD

COST AND INDUSTRY REQUIREMENTS

COST AT DIFFERENT CONTAMINATION LEVELS
SUBCONTRACTOR VERSUS IN HOUSE

METH CLEANUP BECAME BIG BUCKS
https://www.npr.org/templates/story/story.php?storyId=5059893

TRAINING

HAZWOPER
CDL REMEDIATION WORKER
CDL REMEDIATION SUPERVISOR

CLEANUP PROCESS
TESTING
CLEANING
DEMOLITION
DISPOSAL

POLICY EVOLUTION
WASHINGTON STATE LAW IN 1999
WASHINGTON STATE LAW IN 2014
POLICY TODAY

TENANT REACTION AND RESPONSE
DENIAL
ATTEMPTED CLEANUPS

TESTING AND CLEANUP ACCURACY AND EFFICIENCY
IT ISN'T…
UNIVERSITY OF WASHINGTON STUDY
CONTRACTOR CONFLICT OF INTEREST
POSSIBLE MANIPULATION

WHAT WE SEE TODAY
METHAMPHETAMINE
HEROIN
PILLS
FENTANYL

EVOLUTION OF THE METH LAB
BREAKING BAD
SHAKE AND BAKE

'Shake and bake' meth lab explodes in man's pants during scuffle with state trooper
By Daily Mail Reporter
Published: 14:56 EST, 27 April 2012 | Updated: 15:33 EST, 27 April 2012

Read more: http://www.dailymail.co.uk/news/article-2136304/Shake-bake-meth-lab-explodes-mans-pants-scuffle-state-trooper.html#ixzz53zdqtBjw

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'Shake and bake' meth lab explodes in man's pants during scuffle with state trooper
By Daily Mail Reporter
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Read more: http://www.dailymail.co.uk/news/article-2136304/Shake-bake-meth-lab-explodes-mans-pants-scuffle-state-trooper.html#ixzz53zdqtBjw
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MOVING FORWARD
FENTANYL CRISIS: OHIO COP ACCIDENTALLY OVERDOSES DURING DRUG CALL

https://www.nbcnews.com/storyline/americas-heroin-epidemic/fentanyl-crisis-ohio-cop-accidentally-overdoses-during-drug-call-n759741

CHAIRMAN'S REPORT, ANDY JOSEPH

OCTOBER 2017 - JANUARY 2018
This past quarter I attended 5 events as Board chair.

On October 16 through October 19, I attended the NCAI 74th Annual Convention in Milwaukee, Wisconsin. Lt. Governor Jefferson Keel (Chickasaw Nation) was elected as NCAI President at this meeting. Three of NPAIHB's joint resolutions with CRIHB were supported and enacted by NCAI: Support for Adoption of CDC Guideline for Prescribing Opioids for Chronic Pain and Support for Hepatitis C Elimination, and Support for the CHAP Expansion.

On October 23, 2017, I attended the Direct Service Tribes Advisory Committee in Washington, D.C.

On October 31 to November 1, I attended the Director's Workgroup on Improving Purchased and Referred Care in Phoenix.

On November 28 through December 1, I attended the NIHB Board Retreat & Strategic Planning meeting in South Lake Tahoe. We accomplished a lot at this meeting. I had to miss the FY 2020 Portland Area Budget Formulation meeting because it was at the same time. I heard that the meeting went well.

I was also able to attend the NPAIHB Holiday Party on December 8 at Grand Central Bowl in Portland, Oregon. It was great to celebrate the holidays with the staff!

LUNCH

DIVISION OF INFORMATION RESOURCES (DIRM) AND FUTURE OF RPMS *(VIA TELECONFERENCE)* CAPT MARK RIVES, DSC CHIEF INFORMATION OFFICER DIRECTOR, OFFICE OF INFORMATION TECHNOLOGY INDIAN HEALTH SERVICE

Recent Cybersecurity Events

Cybersecurity events

- Ransomware outbreaks
  - WannaCry
  - Petya
  - Not-Petya
  - Impacted many organizations around the globe
  - IHS and Tribal IT organizations worked together to address vulnerabilities
- Meltdown and Spectre
  - 10 year old vulnerability
  - All Devices with processors
  - DHS reporting
  - Impacted cloud-service providers most

Recent Health IT Events

VA announcement to leave VistA

- VA Sec Shulkin announced in June 2017
  - 18 months before first implementation
  - 8-9 years' transition

IHS response

- Already planning a Health IT modernization effort
- Working closely with stakeholders
- Working closely with HHS

RPMS EHR History

The Indian Health Service has long been a pioneer in using computer technology to capture clinical and public health data.

The IHS clinical information system is called the Resource and Patient Management System (RPMS).

RPMS development began nearly 30 years ago, and many facilities have access to decades of personal health information and epidemiological data on local populations.

The primary clinical component of RPMS, Patient Care Component (PCC), was launched in 1984.

The RPMS EHR graphical user interface represents the next phase of clinical software development for the IHS and was launched in 2004.

RPMS EHR and MU

In April 2011, the IHS Resource and Patient Management System (RPMS) was certified according to standards established by the Office of the National Coordinator for Health Information Technology (ONC).

This accomplishment allowed Eligible Professionals (EPs) and Eligible Hospitals (EHs) to participate in the Centers for Medicare and Medicaid Services (CMS) EHR Incentive Program.

With the release of the 2014 ONC Rule and the 2014 CMS Stage 2 Rule, the scope of requirements for demonstrating Meaningful Use were greatly increased, and new certified electronic health technology (CEHRT) became necessary.

As of August 22, 2014, the 2014 RPMS EHR was certified according to the 2014 ONC standards

Veterans Administration & VistA

IHS RPMS and VA VistA had shared start
RPMS and VistA are "open source" software
IHS relies on VA for some software development
IHS adapts VA software code then adds additional code for additional capabilities
VA Announcement to leave VistA means that IHS loses a source of software code development that we did not have to fund

Impact on the Resource and Patient Management System (RPMS) and IHS stakeholder engagement

Held four listening sessions and gathered comments.

- Plus, received 22 sets of comments via email and mail

Engagement at all levels within HHS.

- VA, HHS OCTO, HHS ONC, USCG, DoD MHS, tribal health programs, TSGAC, DSTAC, HHS ASFR, and numerous industry analysts.

Developed Request for Information (RFI)

- Goal: Ask industry what they would propose as a solution
- Anticipated outcome: Good understanding of HIT as a foundation for a larger strategy
- Status – Published in FedBizOps / Response due date: Feb 1

RPMS

Pros

Historically focused on Population Health and improving clinical outcomes
Designed by and for use in AI/AN healthcare delivery
Designed to meet specific functionality (i.e. PRC)
Multiple SureScripts White Coat of Quality awards, two Davies awards, two ComputerWorld awards, and an HHSInovates Award.
Mega-suite EHR platform – "Does it all"

Cons

Increased functionality demands/requirements outpacing development capabilities
Source of software development limited to IHS/OIT
Limited sources of training and support
Heavy reliance on local system administration and configuration
Heavy reliance on contracted development
Doing it all strains priorities for update/development

Information Systems Advisory Committee (ISAC)

Purpose: Established to guide the development of a co-owned and co-managed Indian health information infrastructure and information systems.
Goal: assure the creation of flexible and dynamic information systems that assist in the management and delivery of health care and contribute to the elevation of the health status of Indian people.
Charter: Located on IHS.GOV/ISAC

- Note: Being revised to simplify membership nomination and expand tribal participation

Meetings & Calls

- Last: Oklahoma City – Sept 2017
- Next call: December 8, 2017
- Next meeting: Phoenix Area – March 2018

Update from ISAC Meeting, September 19-20, 2017
Recommendations

The ISAC recommends the IHS Chief Information Officer (CIO) provide a standing report on the monthly All Tribes conference call for transparency in Information Technology (IT)/Health IT (HIT) programs, services, functions, and activities.
The ISAC advocates for continued collaboration between IHS and the Veterans Affairs (VA) and the Department of Health and Human Services (HHS) on HIT modernization efforts, acknowledging the initiative is in early discovery right now.
The ISAC recommends the IHS go forward with a budget request for HIT modernization as soon as feasibly possible.
The ISAC recommends that the IHS and OIT strategic plans include reference to the OIT Human Capital Management Plan.

Update from ISAC Meeting, September 19-20, 2017 – Actions

The ISAC continues to work on updates to the ISAC Charter.
The ISAC continues to work on updates to the OIT Human Capital Management Plan to place more emphasis on Informatics positions and updating IT position descriptions.
The ISAC will continue work on revising the FY 2018-2019 IT Priorities to add HIT modernization, infrastructure, a phased approach for modernization, and process improvement.

The IT priorities will be shared with IHS management, Areas, Tribes, and other stakeholder groups

Factors to consider

IHS is taking an advanced posture to plan for Health Information Technology Systems modernization.

RPMS and VISTA will continue to be supported in the near term only.

RPMS development to date has always been supported by and dependent upon the VISTA platform.

There is the potential for significant cost savings and efficiencies by moving to a common Federal
EHR platform.

IHS has unique needs for patient care, population health management, and referral management and many of those are different from the VA and DoD- but a common federal platform may allow for the type of local flexibility many areas may desire.

IHS clinicians, administrators, tribes and tribal organizations and other stakeholders will be very involved in how the process moves forward and in the implementation of the system.

In many ways IHS is well ahead of peers in clinical IT innovations and we will not discard our past work. And our work will help other partners in turn.

Furthermore, IHS must obtain interoperability with VA, DoD, tribal and urban programs, academic affiliates, and community partners, many of whom are on different IT platforms.

We must consider an integrated product that will require a meaningful integration with other vendors to create a system that serves IHS, tribal, and urban beneficiaries in the best possible way.

Vision

We need technology to support the IHS mission… to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.
This includes (but is not limited to) support for:

- Patient and family centered medical home
- Patient access to the medical record
- Interoperability
- Behavioral health / integrated care / traditional approaches
- Specialty care coordination / referrals
- Population health approaches
- Creative and innovative solutions with a look to the future
- Data analytics
- Data reporting
- Billing / revenue generation…

Near term Plans for IHS HIT Platform

Must continue to develop interoperability functionality to ensure access to patient data.
Continuing development for

- EPCS
- New Medicare Cards (NMC)
  - 8 RPMS applications that will require modifications
  - Expected to release in Feb 20, 2018 (FY18Q2 release)
  - Other minor application updates for reporting will occur throughout 2018 to address reports.
- Routine Updates
  - Update schedule to be published on IHS.Gov

All options are still in consideration.

- Working towards a broader HIT Modernization initiative

Tribal Updates

1. Puyallup Tribe, Jennifer LaPointe

NPAIHB/NICWA TRIBAL POLICY TOOLKIT, NORA FRANK-BUCKNER, WEAVE-NW PROJECT COORDINATOR

Presentation Objectives

- Preview of the policy toolkit content, resources and tools
- Discuss:
  - Purpose and use of the guide
  - Theory and methodologies used
  - Policy phases
  - Discussion Questions

Tribal Customary Policy

- Natural and customary law established by traditional beliefs & values
- Tribal perspective:
  - Guided tribal people in maintaining traditions, surviving inconceivable events, and thriving

Policy Toolkit Team

Team Origin Story

- How our group came together
- Why we came together
- Importance

Community Introductions

- Name
- Tribal affiliation/current homestead
- What is your experience with policy?
- What does policy mean in your community**?**

Purpose

- Support tribal community driven policy
- Provide a guide for tribal nations/communities in the policy making process

- Offer ideas, concepts, and structure relating to how tribal communities may approach policy
- Highlight and honor tribal perspective for policy development

Utilization of Guide

- Practical step-by-step guide
- Course of action
- Address community need
- Advocacy/education for non-native partnership
- Tribal framework
- Tribal Sovereignty

Audience

- Tribal community
- Resource for State/County/Federal agencies
- Based on need

Traditional Forms of Policy

- Customary law, tribal protocol, community norm
- Philosophy/belief systems
- Traditional roles
- Application to modern day context

Theoretical Framework

- Relational World View
- Benefits
- Application

Relational Worldview Model Individual/Family Level
Community Quadrants
Community Environment/Context: Social, political, economic, cultural, spiritual, community dynamics, relationships of community members to systems, institutions/organizations, or agencies. History of the community (e.g. boarding schools, BIA, & federal Indian policy).

Community Infrastructure/Mind: System/services in community, formal/informal governing bodies, capacity of community organizing, community protocol/taboos, and community policies/procedures.

Community Resources/Physical: Formal/informal leaders within the community, expertise, education, & experience of community members, community readiness/capacity, identity of the community, elders, youth, medicine men/woman, cultural practices/traditions, community partnerships, and community space.

Community Mission/Spirit: Culture of community, tradition of community, community norms, roles of men/women in community, community practice, values of community, philosophy of the community, influences include both positive/negative learned teachings and practices, as well as positive/negative metaphysical or innate forces.

Balance/Harmony

- How will your policy holistically incorporate the community level quadrants (e.g. environment, infrastructure, mission, and resource)?
- How does your policy consider the variables (e.g. quadrants) that may disturb the balance within the community?
- What factors can come into harmony and allow the community to achieve its goals and perform with excellence?

Tribal Example
Policy: Traditional Tobacco Program & Policy
Re-introduce the use of traditional tobacco through education on the difference between Traditional and Commercial Tobacco. In addition, this policy is aimed to reduce and prevent the use of commercial tobacco to improve the health of the community.

Environment: policy helps to balance the use of tobacco by the community

Infrastructure: policy balances the relationship between community protocol and the health standards

Resources: policy is community driven with the voice and experience of the people

Mission: policy honors cultural traditions and community norms

Policy Process

- Thought behind our approach
- Structure
- Policy phases

Tools for the Community

- Environmental scan
- Community readiness
- Writing considerations
- Policy templates/Resolutions
- Policy checklist
- Evaluation & research
- Stakeholder engagement
- Roles within the community

Challenges to Policy

- Diverse tribal communities
- Is policy the right approach
- Collaboration/inclusion
- Lack of resources/capacity
- Conflicts with traditional values
- Merging frameworks

Moving Forward

- Feedback
- Revisions
- Timeline
- Pilot
-

Thank You!

CROSS JURISDICTIONAL COLLABORATION PROJECT: DISTRIBUTING MEDICAL COUNTERMEASURES ACROSS TRIBAL AND NON-TRIBAL JURISDICTIONS, LOU SCHMITZ AND HEATHER ERB, AMERICAN INDIAN HEALTH COMMISSION (AIHC) CONSULTANTS

**Please see PowerPoint for additional graphics

Distributing Medical Countermeasures Across Tribal and Non-Tribal Jurisdictions

Today's Presentation

PART 1: Understanding Medical Countermeasures and Medical Materiel
PART 2: Protecting Your Community through Cross-Jurisdictional Collaboration
PART 3: Overview of 2017-2018 Cross-Jurisdictional Collaboration Project
PART 4: The Asks

American Indian Health Commission for Washington State

About Us

Pulling Together for Wellness
We are a Tribally-driven, non-profit organization providing a forum for the twenty-nine tribal governments and two urban Indian health programs in Washington State to work together to improve health outcomes for American Indians and Alaska Natives.

Part 1
Understanding Medical Countermeasures and Medical Materie
Chemical Biological Radiological Nuclear
Emerging Diseases
Pandemic Influenza

Medical Countermeasures
Medical treatments or prophylaxes for public health threats

Medical Materiel
Supplies, equipment and other items needed to treat or protect against public health threats

Our Mission
We must assure that Tribes receive appropriate and sufficient medical countermeasures and materiel in a timely manner during public health emergencies

Part 2
Protecting Your Community through Cross-jurisdictional Collaboration
Why is collaboration between Tribes, Local Governments, and the State vital to community health and safety?

Every emergency and public health incident is experienced first and is responded to first by local, tribal, and state personnel.

Public health issues, emergencies and disasters know no boundaries

capacity
No federal, state, local, or tribal government has the capacity to respond to every public health incident or emergency that may occur within its jurisdiction without assistance

Cascadia Rising Exercise 2016
During a catastrophic event, some areas of Washington State may have to wait up to 7 days for state and/or federal assistance

Collaboration + preparedness

Part 3
Overview of 2017-2018 AIHC Cross-Jurisdictional Collaboration Project

Project Goal
Assure the appropriate amount and type of medical countermeasures and materiel reach every Tribe quickly during public health emergencies

Project Objectives
- Strengthen collaboration and mutual aid between Tribes and non-Tribal partners
- Enhance each region's ability to manage and distribute medical countermeasures and materiel
- ***Prevent problems like those experienced during 2009-2010 H1N1 response***

Important
Regional Meeting Dates
Mark Your Calendar

Meeting 1 – Desired Outcomes
- Increase partners' understanding of each other's capacity, organization, resources, etc.
- Plan a tabletop exercise

Meeting 2 – Desired Outcomes
- Test each region's ability to effectively distribute medical countermeasures and materiel across Tribal and non-Tribal jurisdictions
- Identify potential legal issues/challenges
- Document and provide actionable insight on strengths and areas for improvement
- Test and compare performance in partners who are signatories to Mutual Aid Agreements versus partners who are not

Project Products
- Partner profile template
- Partner profiles
- Tabletop exercise scenario
- After-Action Reports
- Final project report
- Recommendations to address Tribal issues in the 2019 statewide full-scale exercise

Part 4 - The Asks
The Asks

1. Please send tribal representatives to the two CJC meetings:

(Tribal Leaders, Tribal Health Directors, Medical Directors, CHRs, Clinic Managers, Emergency Managers, YOU)

2. If your jurisdiction has not yet signed the "*Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State,"* please consult with your legal counsel to finalize the agreement for your tribe

http://www.aihc-wa.com/aihc-health-projects/emergency-preparedness/mutual-aid-project/

DISCUSSION ON YOUTH COUNCILS, STEPHANIE CRAIG-RUSHING, THRIVE & PRT PROJECT DIRECTOR

I-LEAD

- 3-year project
- Partnerships with:
  - OHSU
  - We Are Healers
  - EngenderHealth

I-LEAD AIMS

- Improve resilience and life skills among AI/AN youth (14 to 24 years-old)
- Increase AI/AN youth participation and success in leadership positions
- Prepare AI/AN youth to join the public health workforce

I-LEAD Goals

- Improve resilience and life skills among AI/AN youth by increasing their participation and success in leadership positions and by preparing them to join the public health workforce.
  1. Create a year-long training program for We R Native's Youth Ambassadors and a newly-formed NPAIHB Youth Council
  2. Build an interactive text mentorship platform for AI/AN youth interested in the health professions.

Training program
Youth Ambassador & Youth Council Training Program

- NPAIHB will partner with EngenderHealth to create and launch a year-long training program for We R Native's Youth Ambassadors and a newly-formed NPAIHB Youth Council.

- The trainings will be delivered using Facebook, text messaging, and Zoom video-conferencing. Throughout the year, participants will use We R Native's communication channels to amplify their voice, promoting healthy social norms in their local communities and beyond.

Text mentoring

- Enhance workforce readiness among 100 AI/AN youth by partnering with Oregon Health and Sciences University and We Are Healers to build an interactive text message-based mentorship platform for AI/AN youth interested in the health professions.
- Participants will be matched to paid internships and professional mentorship opportunities, and will receive training in research and evaluation methods, community-based participatory research strategies, and data literacy.

Creating the NPAIHB youth council
NPAIHB Youth Council Creation

- Recruitment
  - Ages
  - Recommendations (referrals) from Delegates?
  - From current Tribal Youth Councils
  - Other ideas?
- Meetings
  - Virtual
  - At Summer QBM?
  - At THRIVE Conference?
  - Based on host location?
- Involvement with the Board
  - Interact with Delegates?
  - Just at QBMs?
- Skills/experience you would like them to have?
  - Write and pass a resolution
  - Others?

RECESS

THURSDAY, JANUARY 18, 2016

Call to Order: Andy Joseph, Chairman, called meeting to order at 9:05am.

Invocation: Janice Clements, Warm Springs

Committee Reports

Elders Committee – -Patti Kinswa-Gaiser, Cowlitz Tribe (A copy of the report is attached)

Veterans – Nate Tyler, Makah Tribe (A copy of the report is attached)

Public Health – Kelle Little, Coquille Tribe (A copy of the report is attached)

Behavioral Health – Leta Campbell, Coeur d'Alene (A copy of the report is attached)

Personnel – Cassie Sellards-Reck, Cowlitz Tribe (A copy of the report is attached)

Youth – **Nanette Star, NPAIHB Staff** (A copy of the report is attached)

Minutes
MOTION BY JULIE REID, SNOQUALMIE; SECOND BY SAM PENNY, NEZ PERCE TRIBE, MOTION PASSES

Finance Report – Eugene Mostofi, NPAIHB Fund Accounting Manager

Legislative/Resolution Committee – Laura Platero: (A copy of the report is attached)
MOTION BY BRENT SIMCOSKY JAMESTOWN S'KLALLAM; SECOND BY CHERYL RASER, SWINOMISH TRIBE; MOTION PASSES

Resolutions
#18-02-01 *Tribal Practices for Wellness in Indian Country*
MOTION BY BRENT SIMCOSKY JAMESTOWN S'KLALLAM; SECOND BY LETA CAMPBELL; MOTION PASSES

#18-02-02 *Request that U.S. Department of Health and Human Services and Its Agencies Make Hepatitis C Medications a Clinical Priority and Request for Congressional Appropriation of Funding to Indian Health Service for Hepatitis C Medications in Parity with U.S. Department of Veterans Affairs Funding*
MOTION BY LETA CAMPBELL; SECOND BY KIM THOMPSON, SHOALWATER BAY TRIBE; MOTION PASSES

#18-02-03 *Request that State Medicaid Agencies Make Hepatitis C Medications a Clinical Priority*
MOTION BY CHERYL RASER; SECOND BY BRENT SIMCOSKY, JAMESTOWN S'KLALLAMTRIBE; MOTION PASSES

Upcoming Board meetings

April 2018
Coquille 9; Port Gamble 3

October 201
Shoshone-Bannock 13; Umatilla –

January 2019
Skipped

April 2019
Swinomish Tribe

MOTION TO ADJOURN: BY LETA CAMPBELL; SECOND BY BRENT SIMCOSKYY JAMESTOWN S'KLALLAM; ADJOURN AT 9:41 A.M

_____ _____

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

_____ _____

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

_____ _____

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

QUARTERLY BOARD MEETING

Embassy Suites by Hilton Portland Airport
7900 NE 82nd Avenue Portland OR 97220

January 16-18, 2018

AGENDA

TUESDAY, JANUARY 16, 2018 (PINE & SPRUCE ROOMS)

7:30 AM	**Executive Committee Meeting**	***Juniper Boardroom***
9:00 AM	Call to Order Invocation Welcome Posting of Flags Roll Call	Andy Joseph, Chairman Tanna Engdahl, Spiritual Leader, Cowlitz Tribe Cowlitz Chairman, Bill Iyall Cowlitz Color Guard Shawna Gavin, Treasurer
9:15 AM	Health Policy and Legislative Update – Part 1 **(1)**	Geoff D. Strommer, Partner – Hobbs, Straus, Dean & Walker, LLP
10:00 AM	Area Director Report **(2)**	Dean Seyler, Portland Area IHS Director
10:30 AM	**BREAK**	
10:45 AM	Executive Director Report **(3)**	Joe Finkbonner, NPAIHB Executive Director
11:15 AM	Injury & Fall Prevention **(4)**	Dr. Deborah Behre, Podiatrist with Skokomish Tribe
11:45 AM	Election of Officers • Chairman • Secretary	
12:00 PM	**LUNCH** ***Committee Meetings (working lunch)***	
	1. Elders	Staff: Clarice Charging
	2. Veterans	Staff: Don Head
	3. Public Health	Staff: Victoria Warren-Mears
	4. Behavioral Health	Staff: Stephanie Craig
	5. Personnel	Staff: Andra Wagner
	6. Legislative/Resolution	Staff: Laura Platero
	7. Youth	Staff: Nanette Star

QUARTERLY BOARD MEETING

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January 16-18, 2018

AGENDA

1:30 PM	Adverse Childhood Experiences (ACEs) and Resilience **(5)**	Cow Creek Behavioral Health Team, Julie Hargraves, LCSW, BH Manager and Sandy Henry, Trauma-Informed Care Coordinator
2:00 PM	Veteran Affairs, Office of Tribal Government Relations Veteran Affairs Update **(6)**	Mrs. Terry R. Bentley, Tribal Government Relations Specialist - Pacific District (OR, WA, ID, NV, CA, AK) U.S. Department of Veterans Affairs, Office of Government Relations and William Murray, VISN20
3:00 PM	Fetal Alcohol Syndrome Disorders (FASD) Wrap-up **(7)**	Carolyn Hartness BA, FAS Contractor and Suzie Kuerschner BA, FAS Contractor
3:15 PM	**BREAK**	
3:30 PM	Endocrinology ECHO Pilot Project **(8)**	Nanette Star, WEAVE NW Project Director and Kathi Murray MS, RDN, CDE, Portland Area IHS Diabetes Consultant
4:00 PM	NPAIHB MCH Workgroup **(9)**	Tam Lutz, Tot2Tween & CARS Project Director and Monika Damron, IDEA NW Biostatistician
4:30 PM	Executive Session – *if needed*	
6:30 PM	***Cultural Dinner and Presentation hosted by Cowlitz Tribe***	***Ilani Casino Resort (Transportation provided and valet services at Casino)***

QUARTERLY BOARD MEETING

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January 16-18, 2018

AGENDA

WEDNESDAY JANUARY 17, 2018 (PINE & SPRUCE ROOMS)

9:00 AM	Call to Order Invocation	Cheryle Kennedy, Vice-Chairman
9:15 AM	Health Policy and Legislative Update – Part 2 **(10)**	Laura Platero, Government Affairs/Policy Director
9:30 AM	Hepatitis C **(11)**	Jessica Leston, HIV/STI/HCV Clinical Program Manager
10:00 AM	US Department of Health and Human Services, Region 10	Barbara Greene, Acting Regional Director
10:30 AM	**BREAK**	
10:45 AM	Tulalip Housing – Rehabilitation of Meth houses **(12)**	Thomas Dickerson, Maintenance Manager Tulalip Housing Department
11:00 AM	NPAIHB/NICWA Tribal Policy Toolkit **(13)**	Nora Frank-Buckner, WEAVE-NW Project Coordinator
12:00 PM	**LUNCH**	
1:30 PM	Division of Information Resources (DIRM) and future of RPMS ***(via teleconference)*** **(14)**	CAPT Mark Rives, DSc Chief Information Officer Director, Office of Information Technology Indian Health Service
2:15 PM	**Tribal Updates** 1. Nisqually Tribe 2. Puyallup 3. Quileute Tribe	

QUARTERLY BOARD MEETING

Embassy Suites by Hilton Portland Airport
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January 16-18, 2018

AGENDA

3:00 PM	American Indian Health Commission – Emergency Preparedness Project **(15)**	Lou Schmitz and Heather Herb, AIHC Consultants
3:30 PM	**BREAK**	
3:45 PM	Discussion on Youth Councils **(16)**	Stephanie Craig-Rushing, THRIVE & PRT Project Director

THURSDAY, OCTOBER 12, 2017 (PINE & SPRUCE ROOMS)

8:30 AM	Call to Order Invocation	Andy Joseph, Chairman
8:45 AM	Chair's Report	Andy Joseph, Chairman
9:00 AM	Committee Reports: 1. Elders 2. Veterans 3. Public Health 4. Behavioral Health 5. Personnel 6. Legislative/Resolution 7. Youth 8. Any National Committee Updates	
10:30 AM	Unfinished/New Business 1. Finance Report 2. Approval of Minutes • October 2017	Eugene Mostifi, NPAIHB Fund Account Manager

QUARTERLY BOARD MEETING

Embassy Suites by Hilton Portland Airport
7900 NE 82nd Avenue Portland OR 97220

January 16-18, 2018

AGENDA

3. Resolutions

4. Future Board Meeting Sites:
   - *April 17-19, 2018 – TBD*
   - *July 17-19, 2018 – Bellingham, WA (Lummi)*
   - *October 16-18, 2018 - TBD*
   - *January 2019- TBD*

12:00 PM | **ADJOURN** | Safe travels

INDIAN HEALTH SERVICE PORTLAND AREA DIRECTOR'S UPDATE

Dean M Seyler - Area Director
January 16, 2018
Embassy Suites – Portland Airport
NPAIHB Quarterly Board Meeting

Division of Financial Management

FY 2018 Continuing Resolutions (CRs)

- CR 1: Public Law 115-56 authorizes funding from October 1 through December 8, 2017. The CR continues activities authorized in FY17 at the FY17 levels, but reduced by 0.6791%.
- CR 2: Public Law 115-90 authorizes funding through December 22, 2017. The CR continues activities authorized in FY17 at the FY17 levels, but reduced by 0.6791%.
- CR 3: Public Law No. 115-96 authorizes funding through January 19, 2018. The CR continues activities authorized in FY17 at the FY17 levels, but reduced by 0.6791%.

Division of Financial Management

FY 2020 Portland Area Budget Formulation Meeting

- When: November 30, 2017
- Location: Embassy Suites, Portland Airport
- Attendees: Portland Area Tribal Leaders, Health Directors, representatives from the Northwest Portland Area Indian Health Board and leadership of the Indian Health Service - Portland Area Office.

Division of Financial Management

Summary of Portland Area National Budget Recommendations		
	National +36%	*National +36% with reduction to HCFC*
Current Services (Fixed Costs)	+$189.1 million	+$189.1 million
Binding Obligations	+$275 million	+$175 million
Purchased and Referred Care	+$922.7 million	+$1.056 billion
Affordable Care Act & Indian Healthcare Improvement Act	+$173.1 million	+$198.2 million
Long Term Care	+$92.1 million	+$105.5 million
Restoration of Pay Act	+$90 million	+$103.1 million
Facilities	+$97.3 million	-$110.3 million
Regional Referral Center	+$57.4 million	+$65.7 million
Information Technology & Electronic Health Record	+$32.3 million	+$37 million
Behavioral Health	+$61.1 million	+$70 million
Total Current Service and Program Increases	***$1.9 billion***	***$1.9 billion***

Division of Financial Management

FY 2020 National Budget Formulation Work Session

- When: February 15-16, 2018
- Location: Crystal City, VA
- Portland Area Elected Representatives:
  - Andrew Joseph Jr., The Confederated Tribes of the Colville Reservation
  - Steve Kutz, Cowlitz Indian Tribe
  - CAPT Ann Arnett, Executive Officer – Portland Area

Division of Business Operations Purchase and Referred Care

FY17 Catastrophic Health Emergency Fund

- Total Number of Cases: 56
- Total Number of Amendments: 23
- Current Reimbursement Amount: $1,686,871.00
- Current Pending Reimbursement Amount: $504,221.56
- 81% Reimbursed

CHEF Balances as of January 9, 2018 $ 9,636,575

Indian Health Service Portland Area

- **Small Ambulatory Program (SAP)**
  - Health Facility Construction Funding Opportunity
  - Applications Were Due December 1, 2017
  - $5.0M Reserved / Max Award is $2.0M
  - 3-5 Awards Anticipated (Highly Competitive)
  - Four Applications Submitted from Portland Area Tribes
  - All Were Reviewed and Endorsed by the Area Office
  - IHS HQ Has Not Yet Established a Timeline for Making Award Decisions
  - Contact CAPT Jason Lovett With Any Questions, jason.lovett@ihs.gov

Indian Health Service Portland Area

- **Annual Combined Space Verification**
  - Sent to Tribes in Early November
  - Verify the Amount and Location of Facility Space Used for IHS PSFA's
  - Response Due Date: **December 31, 2017**
  - Please Review the Provided Data and Certify if is Accurate
    - Used to Calculate Share of Equipment and M&I Funds
    - Used to Update and Maintain the CMS Facilities List for Encounter Rate Billing
    - Used to Verify Facility Type and Other Statistical Items
  - If Data is Not Accurate, Please Follow Included Instructions to Update
  - Questions:
    - Jonathan McNamara – Health Facilities Engineering – jonathan.mcnamara.ihs.gov
    - Peggy Ollgaard – Business Office – peggy.ollgaard@ihs.gov
    - Mary Brickell – Statistics – mary.brickell@ihs.gov
    - Or 503-414-5555 – please ask for one of the three above.

Indian Health Service Portland Area

- April 25, 2018- Northwest Tribal Clinicians' Cancer Update
- April 26-27, 2018- Portland Area Spring Clinical Director's Meeting
- Embassy Suites-Washington Square, Tigard, OR

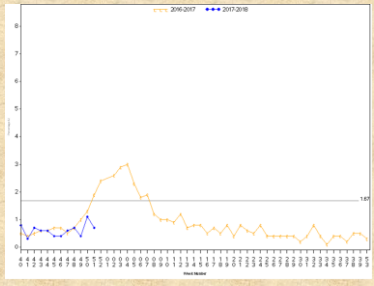
PROVIDENCE Health & Services · OREGON HEALTH & SCIENCE UNIVERSITY · INDIAN HEALTH SERVICE · PHS · 1955 · Northwest Portland Area Indian Health Board

Indian Health Service Portland Area

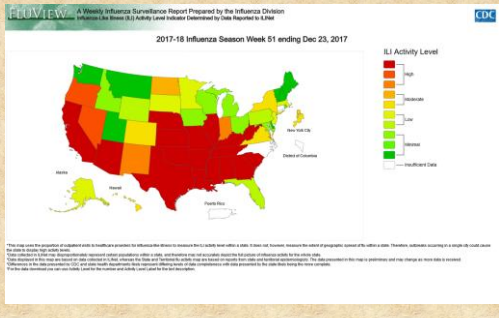
- Influenza Vaccine Coverage, Portland Area IHS

Indian Health Service Portland Area

- Influenza-like Illness, Portland Area IHS



Indian Health Service Portland Area



Indian Health Service
Portland Area

- Key Points Regarding Influenza:
  - It is not too late to get vaccinated
  - Influenza vaccine is still an important public health prevention tool
    - As in past years, washing your hands frequently, covering your cough and staying home when ill are also important measures to help prevent the spread of influenza
  - Influenza Vaccine Effectiveness could be as low as 32% this year for preventing influenza A(H3N2) infections
  - The current influenza vaccine is well matched to prevent influenza A (H1N1) and influenza B infections that are also circulating
  - People at high risk for complications from the flu, including American Indians/Alaska Natives should seek care early to receive the maximum benefit from antiviral medications

Questions or Comments

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.

Executive Director Report

Embassy Suites
by Hilton Portland Airport
January 16, 2018

Joe Finkbonner, RPh, MHA

Personnel

- **New Hires:**
  - **Nathan Newcomb,** WEAVE-NW Project Assistant
  - **Joshua Smith,** NWTEC Health Communication Specialist
  - **Tana Atchley,** Youth Engagement Coordinator
  - **Danica Brown,** Health Communication Coordinator

Personnel

- **Promotions:**
  - **Colbie Caughlan**, THRIVE Project Director
  - **Ticey Mason**, Dental Support Center Project Director/EpiCenter Project Coordinator

Personnel

Recognition:

- **Kerri Lopez**, 15 Years of Service
- **David Stephens**, Employee of the Year
- **Marilyn Scott**, 2016 Delegate of the Year

Meetings

November

- PHAB Executive Committee meeting, Washington, DC (11/1-11/2)
- Idaho Tribes/State Meeting, Lewiston, ID (11/8)
- Indigenous Faculty Forum, PSU (11/17)
- Determinants of Health, Seattle, WA (11/28)

December

- Arcora Board Meeting, Seattle, WA (11/30 – 12/1)
- PHAB Board Meeting, Washington, DC (12/5-12/7)
- AIHC Meeting, Squaxin, Island (12/14)

Other Activites

OFB Hot Dog Feed (11/15)

NPAIHB Holiday Party (12/8)

Upcoming

January

- ATNI, Portland, OR (1/22 – 1/25)

February

- AIHC Meeting (2/8)
- NCAI, Washington, DC (2/12-2/15)

Upcoming

March

- Arcora Foundation Board Meeting, Seattle, WA (3/9)
- PHAB Board of Directors Meeting, Washington, DC (3/21-3/22)

April

- Medicare & Medicaid ITU Outreach & Education, Seattle, WA (4/4-4/5)

Questions…?

FALLS PREVENTION

Deborah Behre, DPM
db.foot@comcast.net

- NO DISCLOSURES

- EVERY SECOND COUNTS (every second, every day) - FALL
- EVERY 20 MINUTES - DEATH
- 1 OUT OF 3 PEOPLE 65 Y.O. OR OLDER FALL (1 IN 4 REPORT)
- 1 OUT OF 5 IS SERIOUS (TBI, FRACTURES, DEATH)

- OVER 50% OF PEOPLE WHO SURVIVE HOSPITALIZATION FOR A FALL NEVER RETURN HOME

AMERICAN INDIAN/ALASKA NATIVE ELDERS REPORT THE GREATEST PERCENTAGE OF FALLS (34.2%) OF ALL RACES/ETHNICITIES

- FALLS ARE THE 3RD LEADING CAUSE OF UNINTENTIONAL INJURY RELATED DEATHS OF AMERICAN INDIANS OF ALL AGES, BEHIND POISONING AND MOTOR VEHICLE TRAFFIC INJURIES

2013 – total fall injury cost - $34 billion

2020 – expected to increase (may reach $67.7 billion)

FALLS ARE PREVENTABLE

YOU CAN MAKE A DIFFERENCE

- THE RECOMMENDATION IS THAT EVERYONE 65 YEARS OR OLDER HAVE A YEARLY FALLS RISK ASSESSMENT

THE TEAM APPROACH WORKS BEST

6 Steps to reduce falls in AI/AN Elders

- 1. Talk to your health care provider – to assess risk
- 2. Find a good balance and exercise program
- 3. Review medications with doctor or pharmacist – regularly
- 4. Have vision and hearing checked annually
- 5. Keep home safe
- 6. Talk to family members – inform and teach family members about risks

- Developed by Natl Council on Aging, CDC and IHS Injury Prevention

SAVE

- Safety
- Appt (PCP and DPM)
- Vision
- Exercise

Why a lower extremity examination?

LOWER EXTREMITY
RISK FACTORS

RISK FACTORS

- VISION
- MEDICATIONS
- MUSCLE WEAKNESS
- BALANCE
- HISTORY OF A FALL (FEAR OF FALLING)
- PERIPHERAL NEUROPATHY
- PRE DISPOSING DISEASES (CVA, Parkinson's)
- LOW VIT D LEVELS
- FOOTWEAR – SHOES & SOCKS
- FOOT PAIN
- OTHER FOOT/ANKLE CONDITIONS
- HEARING
- DEPRESSION

RISK FACTORS

MODIFIABLE

- MEDICATIONS
- VIT D LEVEL
- MUSCLE WEAKNESS
- BALANCE
- FOOTWEAR - SHOES & SOCKS
- FOOT PAIN
- FOOT CONDITIONS
- SAFETY (HOME)
- FEAR OF FALLING
- VISION (if treatable)
- HEARING (if treatable)
- DEPRESSION (if treated)

NON MODIFIABLE

- AGE
- GENDER (WOMEN – FALLS; MEN – DEATH AS RESULT OF A FALL)
- PREVIOUS FALLS
- PRE EXISTING CONDITIONS (MEDICAL)

RISK FACTORS

MODIFIABLE

- MEDICATIONS
- VIT D LEVEL
- MUSCLE WEAKNESS
- BALANCE
- FOOTWEAR - SHOES & SOCKS
- FOOT PAIN
- FOOT CONDITIONS
- SAFETY (HOME)
- FEAR OF FALLING
- VISION (if treatable)
- HEARING (if treatable)
- DEPRESSION (if treated)

2 Falls Risk Assessments

Primary Care Physician

Podiatric Physician

WHY 2 ASSESSMENTS ?

RISK FACTORS

MODIFIABLE

- MEDICATIONS
- VIT D LEVEL
- VISION (if treatable)
- HEARING (if treatable)
- DEPRESSION

MUSCLE WEAKNESS

- BALANCE
- FOOTWEAR - SHOES & SOCKS
- FOOT PAIN
- FOOT CONDITIONS
- SAFETY (HOME)
- FEAR OF FALLING

RISK FACTORS

MODIFIABLE

MUSCLE WEAKNESS

- BALANCE
- FOOTWEAR - SHOES & SOCKS
- FOOT PAIN
- FOOT CONDITIONS

- FEAR OF FALLING

MODIFIABLE

- MEDICATIONS
- VIT D LEVEL
- VISION (if treatable)
- HEARING (if treatable)
- SAFETY (HOME)
- DEPRESSION

- FEAR OF FALLING

LOWER EXTREMITY FALLS RISK ASSESSMENT

- 1. DETERMINE LEVEL OF RISK (LOW, MED, HIGH)
- 2. DETERMINE THE FACTORS CAUSING RISK
- 3. MAKE A PERSONAL PREVENTION PLAN

HOW IS THAT DONE?

- HISTORY
- PHYSICAL EXAMINATION
- FORMULATE A PLAN
- ONE YOU CAN LIVE WITH AND ACCOMPLISH

HISTORY (QUESTIONS AND ANSWERS)

- QUESTIONNAIRE +/OR IN PERSON

- RECENT FALLS/FEAR OF FALLING
- ASSISTIVE DEVICES (CANE, WALKER)
- LOSS OF BALANCE
- TRIPPING
- UNSTEADY WHILE WALKING
- RISING FROM A CHAIR
- USING FURNITURE TO KEEP STEADY
- RUSHING TO THE BATHROOM
- MEDICAL CONDITIONS (PARKINSON'S, STROKE,HTN)
- DIMINISHED FEELING
- DIZZINESS
- LIGHT HEADEDNESS W/RISING
- VIT D
- DO YOU EXERCISE – WHAT TYPE?
- SAFETY IN YOUR HOME
- MEDICATIONS – NAMES, DOSE, CHG
- VISION (GLASSES,EXAM)

PHYSICAL EXAMINATION

- MUSCLE STRENGTH
- RANGE OF MOTION
- FOOT PAIN
- FOOTWEAR (SHOES AND SOCKS)
- FOOT CONDITIONS (HAMMERTOES, BUNIONS)
- CORNS OR CALLUSES
- PULSES, COLOR, SWELLING
- SPECIFIC TESTS (TUG, 30 SEC CHAIR STAND, 4 STAGE BALANCE)

GOAL

FORMULATE A PLAN FOR A Pt
(a personal prevention plan)

SHOES

WHAT CAN PODIATRY DO

EVALUATE YOUR FALL RISK
PRESCRIBE WALKING AIDS
MOORE BALANCE BRACES
SHOES AND SOCKS
TRIM CALLUSES AND TRIM NAILS
INJECTIONS
SURGERY
REFERRALS (PT,OT,PCP)

EXERCISE

EXERCISE CHOICES

- SELF PROGRAM
- EXERCISE CLASS: TAI JI QUAN, YMCA MOVING FOR BETTER BALANCE, SAIL (stay active and independent for life), STEPPING ON
- PT CONSULT
- (OTAGO EXERCISE PROGRAM - dec falls 35-40%)

SELF PROGRAM

- CHAIR RISE EXERCISE
- TOWEL CURLS

SAFETY

WISDOM WARRIORS

- Developed by Northwest Regional Council (NWRC)
- NWRC partnered with tribal communities in Wa State
- TRIBAL PREVENTIVE HEALTH PROGRAM
- Uses culturally appropriate materials and a culturally relevant approach

WISDOM WARRIORS

- Wa State Dept of Health is talking with Wisdom Warriors about
- Falls Prevention opportunities for Tribal Elders
- Including culturally appropriate materials in partnership with Tribes and Tribal organizations
- If you are interested, contact Carolyn Ham
- (360) 236-9204; carolyn.ham@doh.wa.gov

Effective Evidence based Falls Prevention in Tribal Communities

Webinar # 1 March 2017 Dr Bruce Finke

- Webinar # 2 June 29 2017 – 4 speakers

Fall Prevention Webinar # 1 - overview

- Dr Bruce Finke
-
- Community Based intervention , included Exercise, Home Assessment, Medication Review, Vision Exam, Screening to identify those at risk for a fall, Multifactorial Risk Assessment, Vit D for those at risk of deficiency, Education in community and clinical settings about falls, falls risk and ability to prevent a fall

Falls Prevention Webinar # 2

- Ponca Tribe of OK
- Jocelyn Jackson
- Injury Prevention Coordinator, White Eagle Health Center
- Injury Prevention Program Application
- 55 + y.o. (Why – DM)

- Partners: Healthcare Provider, Optometrist, X Ray Tech, Pharmacy, Community Health Rep, Administration, IT Site Manager, Billing

Falls Prevention Webinar # 2

- Winnebago Tribe of Nebraska
- Jennifer Straub
- Injury Prevention Coordinator
- Injury Prevention Project
- Home Assessment (Extensive Safety Assessment)

Falls Prevention Webinar # 2

- Salt River Maricopa Indian Community
- Monte Yazzie
- Matter of Balance Master, Injury Prevention Coordinator
- Tai Chi, Yoga, 'Grandparents Day'

- 3 components
- A) Community Component
- B) Client Responsibility
- C) Culturally Appropriate

Falls Prevention Webinar # 2

- Works at AASTEC (Albuquerque)
- Matter of Balance Master, Injury prevention Coordinator

- Sent out 268 Surveys
- Annual Foot Exams for Pts with DM and 65 y.o or older
- Annual Vision Assessment
- Ca and Vit Supplement for Elders
- Regular Exercise
- A Matter of Balance workshop – 8 session workshop 1x/wk or 2x/4wks
- Tai Chi
- STEADI Fall Prevention Toolkit Training

4 "best practice" tribes highlighted (NCOA)

- 1. ABSENTEE SHAWNEE TRIBE, Oklahoma
- implementing TAI CHI to reduce falls in Elders

- 2. Gila River Indian Community, Arizona
- implemented a MATTER OF BALANCE program

- 3. Match-E-Be-Nash-Wish Band of Pottawatomi Indians, Michigan
- Gun Lake Tribe implemented a Stay Safe, Stay Active program

- 4. Sokaogon Chippewa Community, Wisconsin
- implemented a Stepping On program
-

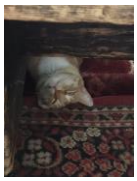
Good Sources of Information

- CDC – Center for Disease Control
- NICOA – Natl Indian Council on Aging
- NCOA – Natl Council on Aging

- REFERENCES
- 1. CENTER FOR DISEASE CONTROL ATLANTA, GA
- 2. J AM GERIATRIC SOCIETY 64:425-431,2016
- 3. BMC GERIATRIC 2011; 11-51
- 4. AM J LIFESTYLE MEDICINE 2016; JAN-FEB: 10(1)
- 5. APMA FALLS PREVENTION WEBINAR
- 6. MENZ et al FOOT & ANKLE RISK FACTORS FOR FALLS IN OLDER PEOPLE; A PROSEPECTIVE STUDY; JL OF GERONTOLOGY 2006;8:866
- 7. NATIONAL COUNCIL ON AGING (NCOA) ARLINGTON, VA
- 8. KOBYASHI et al; J PHYS THER SCI 1999, 11:31-34
- 9. WWW.MOOREBALANCEBRACE.COM
- 10. SAFESTEP.NET
- 11. GUIDELINE FOR THE PREVENTION OF FALLS IN OLDER PERSONS; JAGS May 2001-Vol. 49, No 5 pp 664-672
- 12. EFFICACY OF A MULTIFACETED PODIATRY INTERVENTION TO IMPROVE BALANCE AND PREVENT FALLS IN OLDER PEOPLE; STUDY PROTOCOL FOR A RANDOMISED TRIAL pp 1-16 Spink, Mens, Lord (Australia) BMC Geriatrics 2008
- 13. GAIT AND BALANCE DISORDERS IN OLDER ADULTS SALZMAN, MD AMERICAN FAMILY PHYSICIANS July 1, 2010 Vol 82 # 1 pp61-68

Thank you!

SIMBA BOOTS REX LEO !




Why Focus On The Trauma?

Cow Creek Health & Wellness Clinic & Behavioral Health

What is Trauma:

- Trauma, deeply distressing or disturbing experience.
- The impact of trauma can be subtle, insidious, or outright destructive.

Trauma is **the leading** determinant of the health and social well-being of our nation.

Trauma is Universal

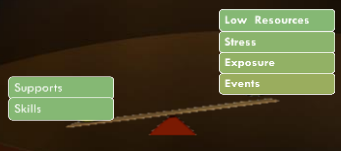
- Stigma around Mental Health
- Most don't want to talk about it or listen to trauma…
- Care giving systems – Most health, mental health and social services have not incorporated knowledge about trauma – neither have school systems or courts….

Trauma increases the risk of:

- **Heart disease**
- **Chronic Lung disease**
- **Liver disease**
- **Suicide - Injuries**
- **HIV and STDs**

Effects of Traumatic Experiences Depend on…

Coping **Adversity**



WHAT IS AN Adverse Childhood Experience? (ACEs)

- Adverse Childhood Experiences (ACEs) is a term used to describe neglect, abuse, violence and/or distressed family environments that children under the age of 18 years may experience. The cumulative effect of ACEs can be traumatic, especially if experienced repeatedly beginning at a young age.

Ten Categories of Adverse Childhood Experiences
all similar and all toxic stress

- **Household Dysfunction:**
  - 1. Battered mother
  - 2. Substance abuse
  - 3. Mental illness
  - 4. Parental sep/divorce
  - 5. Criminal behavior
- **Abuse:**
  - 6. Emotional
  - 7. Physical
  - 8. Sexual
- **Neglect:**
  - 9. Emotional
  - 10. Physical

Adverse Childhood Experiences Have a Strong Influence on:

- adolescent health
- smoking
- reproductive health
- alcohol abuse
- illicit drug abuse
- sexual behavior
- mental health
- risk of revictimization
- stability of relationships
- homelessness
- performance in the workforce

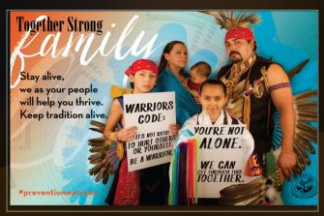
What can we do? What's the next steps?

- A Changing Understanding of Medical Disease
- Routine screening for trauma is needed
- Referrals and Treatment
- Mass education about child development & parenting
- Media, Schools, health clinics

What is the role of primary care?

- ACE screenings are essential:
- Ask all patients about any possible history of trauma
- Do not require clients to describe emotionally overwhelming traumatic events in detail.
- A positive screening calls for more action.
- Be aware that some clients will not make the connection between trauma in their histories and their current patterns of behavior (e.g., alcohol and drug use and/or avoidant behavior).

Together we can heal



The Road to Resilience

Cow Creek Band of Umpqua Tribe of Indians

Definition

"Individual trauma results from an **event**, series of events, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or life threatening and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

Examples of trauma include, but are not limited to:

- Experiencing or observing physical, sexual, and emotional abuse;
- Childhood neglect;
- Having a family member with a mental health or substance use disorder;
- Experiencing or witnessing violence in the community or while serving in the military; and
- Poverty and systemic discrimination.

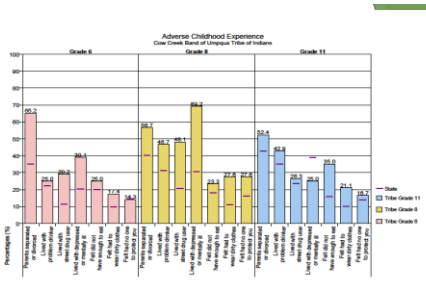


Figure 12: Adverse Childhood Experience

2016 Oregon Student Wellness Survey
Cow Creek Tribal Youth

- 12% higher than peers for feelings of hopelessness
- 29.2% higher rate of attempted suicides
- 30% binge drank in the last 30 days
- 50% reported illicit drug use

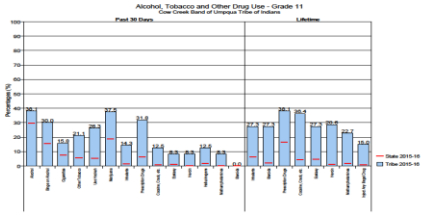


Figure 19: Alcohol, Tobacco and Other Drug Use - Grade 11

46

So now what…..?

Resilience

"the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress"

Developmental Assets

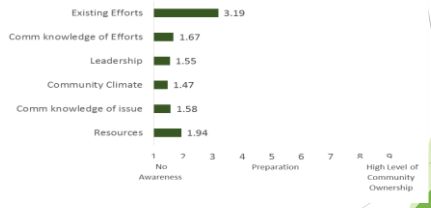
a set of skills, experiences, relationships, and behaviors that enable young people to develop into successful and contributing adults.

- Support
- Empowerment
- Boundaries and Expectations
- Constructive use of Time
- Commitment to Learning
- Positive values
- Social Competencies
- Positive Identity

SAMHSA native CONNECTIONS

SAMHSA

Community Readiness



Vision Statement

- After more than a century of intergenerational trauma Cow Creek Health &Wellness will utilize *trauma informed practices* to identify those Tribal youth in need, initiate new and *relevant trauma informed* programs, and strengthen the *trauma awareness* of our existing programs. All of these efforts will **enhance the resiliency** of our tribal youth; and promote a strong sense of cultural identity for all Tribal members.

Trauma Informed Practices…..

…….is a strengths-based framework that is responsive to the impact of trauma, emphasizing physical, psychological, and emotional safety for both service providers and survivors; and creates opportunities for survivors to rebuild a sense of control and empowerment.

Sanctuary Model- Organizational Transformation

QPR Ask A Question, Save A Life
For Suicide Prevention

Question
Persuade
Refer

QPR (Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention is a 1-2 hour educational program designed to teach lay and professional "gatekeepers" the warning signs of a suicide crisis and how to respond.

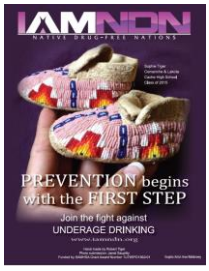
HOPE SQUAD
HOLD ON. PERSUADE. EMPOWER.
Hope Squad

HOPE Squad students are trained to be active listeners so they may help and respond to peers who are struggling with emotional issues such as depression and suicide. HOPE Squad members are trained to share concerns with an adult. The goals of the HOPE Squad Program are to: Prevent suicide and reduce suicidal behaviors.

HOPE SQUAD
HOLD ON. PERSUADE. EMPOWER.

You matter. Choose Life

Social Media Campaign
Utilizing the Cow Creek Facebook page



Strengthening the Elder/Youth Connection

Developmental Assets

- Support
- Empowerment
- Boundaries and Expectations
- Constructive use of Time
- Commitment to Learning
- Positive values
- Social Competencies
- Positive Identity

Vision- a pairing of active Tribal Elders with Tribal Youth who are participating in activities together, making a connection.

Culture is Prevention

VA Update

NPAIHB
Indian Leadership for Indian Health

Northwest Portland Area Indian Health Board Quarterly Meeting
Portland, OR

January 16, 2018

VA Secretary's Five Priorities - VA's Strategic Framework

1. Greater Choice	• Redesign the 40/30 Rule • Build a High Performing Integrated Network of Care • Empower Veterans Through Transparency of Information
2. Modernize Systems	• Infrastructure Improvements and Streamlining • EMR Interoperability and IT Modernization
3. Focus Resources	• Strengthening Foundational Services in VA • VA/DoD/Community Coordination • Deliver on Accountability and Effective Management Practices
4. Improve Timeliness	• Access to Care and Wait Times • Decisions on Appeals • Performance on Disability Claims
5. Suicide Prevention	• Getting to Zero

Community Care Coordination

- Existing reimbursement agreements will expire on June 30th 2019 – discussions on follow-on agreements will be conducted.
- Care coordination is largely a local matter – we need to know where this is not working well. Building relationships between tribes/IHS and VA is key.
- Only direct care is reimbursed under existing agreements. Future ability to reimburse for purchased care is unknown; we welcome collaboration with one or more tribes to improve coordination of VA purchased care.

Tribal Health Program

- Contract with Cerner to purchase a new Electronic Health Record is being pursued (no estimated award date)
- Eligibility for VA healthcare benefits is defined in legislation; we can only apply those criteria to assess whether a Veteran is eligible. Enrollment staff at the local VA Medical Center can assist with this www.va.gov is a good resource
- Pharmacy billing questions

Tribal Health Program (continued)

- GAO reports on VA-IHS MOU
  - VA training for coordinating services - addressed at local levels
  - Cultural Competency – OTGR office working on training module
- Veterans Choice Program (VCP) – describe and update
  - On Dec 22nd VCP funding was extended ($2.1 billion); should last until mid-2018
  - Emergency MH care expanded to OTH-discharged Vets last spring
  - Latest EO offers 1 year MH care to all newly discharged Vets
  - Pending legislation: CARE Act
  - Congressional interest in expanding VA Caregiver Support Program to earlier Vet cadres (earlier than 9/11 gen)

VA Office of Tribal Government Relations Update

- VA releasing their 2017 Executive Summary Report regarding engagement with Indian Country
  - Going through concurrence process now
- Nationwide Outreach Campaign in Indian Country for Veterans with presumptive disabilities
  - DTLL sent out October 30, 2017
  - 20 Tribes responded – 6 within my region (AK, CA, NV, OR, WA)
- VA OTGR engaging in 2018 outreach across Indian Country
  - Veteran Summits, Regional Tribal Meetings, Veteran Training, Tribal Site Visits

Questions Regarding Reimbursement Agreements

- Bill Murray, VISN 20 Strategic Planner, William.Murray3@va.gov, 360-567-4684
- Terry Bentley, Tribal Government Relations Specialist, Pacific District (OR, WA, CA, ID, NV, CA, AK) Terry.Bentley@va.gov, 541-440-1271
- VHA Chief Business Office for Purchased Care, tribal.agreements@va.gov

NPAIHB
Indian Leadership for Indian Health

Northwest Portland Area Indian Health Board

To:	Tribal Delegates, Tribal Health Directors, and Tribal Clinic Directors
From:	Northwest Portland Area Indian Health Board
Date:	January 16, 2018
Re:	VA Issues Briefing for VA Presentation/Discussion at NPAIHB Quarterly Board Meeting January 16-18,2018

I. VA's Community of Care Consolidation Effort - Dear Tribal Leader Letter on 9/28/2016

- **REQUEST: The Board requests that VA leadership hold a tribal roundtable this year in the Northwest with tribal leaders, tribal health directors, and tribal clinic directors. VA has renewed existing IHS and tribal health program reimbursement agreements through June 30, 2019**
- Currently, the VA has 16 reimbursement agreements in the Northwest (1 in ID, 6 in OR, and 9 in WA) with Tribal health programs (THPs) in the Northwest and the program is growing so there is a need to improve the relationship between the VA and THPs as well as the experience of the veteran.
- VA has held a tribal consultation in Washington D.C. in September 2016; a roundtable in Phoenix, AZ. In July 2017; and is rescheduling a roundtable in Alaska (was scheduled for August 2017).
- VA is seeking tribal input on a new payment structure. VA has suggested a value-based rate structure instead of the all-inclusive rate payment methodology, which could decrease payments reimbursed to Tribes for health care services rendered to AI/AN veterans. The OMB all-inclusive rate is recent, established annually and based on cost reports from Tribal hospitals and IHS. It was set when Tribal facilities received authorization to bill Medicare and Medicaid services.
- Not all tribes have equal capability to get their veteran tribal members access to VA health benefits. Voice the barriers for tribes who do not have reimbursement agreements with the VA (i.e. negotiation process, training, limited personnel, minimal resources to support program)

II. Care Coordination

- It is a barrier to constantly refer AI/AN Veteran patients back to the VA because it is time consuming and, ultimately delays services.
- Care coordination can be difficult in more rural tribal communities.

- The current process often leads to the tribe utilizing PRC dollars to pay for the specialist care of the AI/AN veteran. However, tribes do not get reimbursed for care coordination because of the restriction of reimbursement to direct care.
- There seems to not be adequate guidelines or trainings for staff coordinating veteran services at tribal clinics. This issue was brought up in a 2013 GAO report, what has the VA headquarters and the VA regional office done to address the lack of implementation guidelines and training?

III. Effects of the New VA Electronic Health Record (EHR) System with Cerner on Indian health care providers and the Reimbursement Agreements

- How will the new EHR system effect the sharing of patient records with the VA and tribes?
- When will we know if the tribal EHR system comply and are able to share information across our systems when the new system is implemented.
- Is there at timeline in place for when the VA will transition from the VistA EHR system to the full utilization of the new VA EHR system will be?
- What decisions have come out of the discussions between VA and IHS? We have not been provided any updates and our tribal clinics need to understand the impacts and be prepared.
- Is the VA and all tribes with reimbursement agreements able to exchange patient health information on the Health Information Exchange?

IV. Enrollment and Eligibility of AI/AN Veterans

- There is a need to improve eligibility and service eligibility determinations. There is a need to streamline training so that eligibility requirements and benefits can be made quickly available.
- There is a need for expanding direct care services for care provided to all veterans regardless if they are eligible for IHS funding or not. There needs to be improvements in how to identify the veterans and make them eligible. When you a have a veteran in a rural community they are going to go to the facility that they know they will receive care and that they won't have to spend time and money, the VA system can be a barrier to this process.
- Tribes should voice if they have beneficial ways or barriers at the tribal clinics for determining what services their veterans are eligible for.

V. Other Potential Topics:

- Recognition of Tribal Organizations for Representation of VA Claimants (Effective March 21, 2017)
- Consolidated Mail Order Pharmacy (CMOP) and Pharmacy Reimbursement
- Mental Health Care Services for Veterans

Tribal Endocrinology teleECHO Clinic Pilot 2018

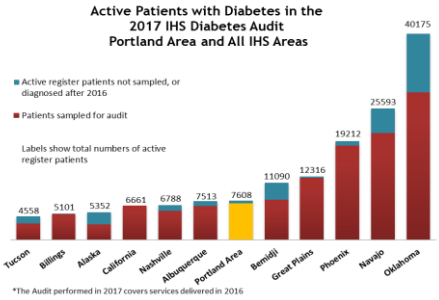
Project ECHO®
Northwest Portland Area Indian Health Board (NPAIHB)

Presented by
Nanette Star, MPH (Project Director WEAVE-NW NPAIHB)
Kathi Murray MS, RDN, CDE (Portland Area IHS Diabetes Consultant)

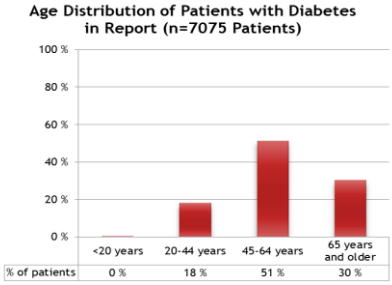
Tribal Endo ECHO Project

ECHO is…
Extension for **C**ommunity **H**ealthcare **O**utcomes

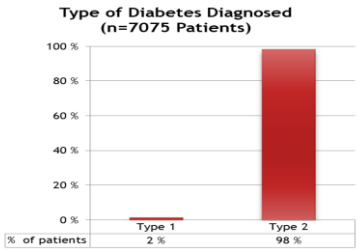
Purpose
- ✓ Improve quality of clinical services
- ✓ Enhance community-clinical relationships
- ✓ Increase experts in the field
- ✓ Adopt cultural practices



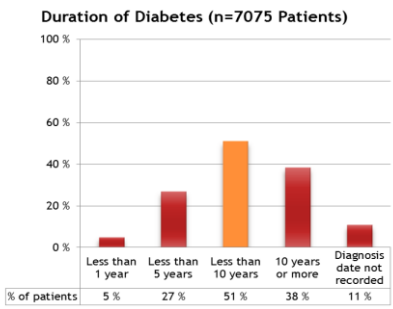
*Graphs generated by NPAIHB - Western Tribal Diabetes Project.

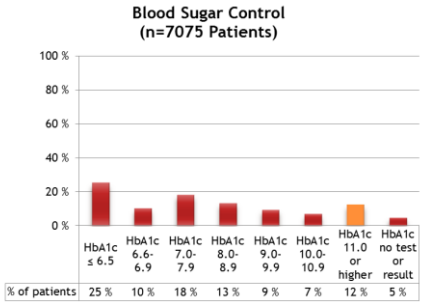


* Number of patients in 2017 diabetes audit report



Portland Area





Team Based Approach for Diabetes Care

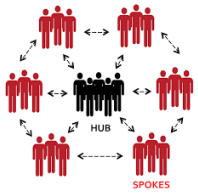
Why a Pilot Project?

- Request from tribes for increased specialists
- Established model in PNW Tribal Clinics
- Measure effectiveness of Tribal Endo Clinic
- Build best practices
- Launch with other Projects

Tribal Endo ECHO Pilot: Your Clinic's Role

1. Submit a case
2. Join our Endo ECHO as a participant or to learn more about ECHO
   2nd Thursday of every month April – October 2018

- **Physicians**
- **Physician Assistants (PAs)**
- **Nurse Practitioners**
- **Registered Dieticians**
- **Medical Assistants**
- **Community Health Workers**
- **Other Health Providers**
- **SDPI Grantees**
- **Medicine Person/Tribal Leaders**
- **Behavioral Health Specialist**



Tribal Endo ECHO Pilot

2nd Thursday of every month April – October

First Clinic:
- April 12, 2018 from 10-11am PST

Evaluation:
- April – October 2018
  Process Evaluation Results shared at each QBM

Final Report & Continuation Plan: November 2018

NPAIHB
Indian Leadership for Indian Health

For more information
or to submit a case please contact
weave@npaihb.org
503.416.3254

Maternal and Child Health Guiding Framework for the Northwest Portland Area Indian Health Board

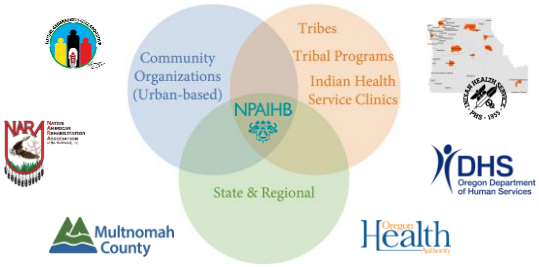
A SUMMARY OF QUALITATIVE DATA COLLECTED BY NPAIHB

Overview

- MCH Core inquiry
- Process
- Share Key themes
- Discussion
- Application to Framework and Strategic Plan
- Discussion

A start

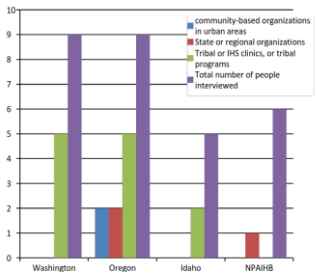
- We wanted to understand Maternal Child Health (MCH) efforts provided to NW Tribes both internally and externally
- We wanted to elicit MCH priorities for NW Tribes
- We wanted to understand how MCH fits into the NPAIHB overall strategic plan
- We wanted to elicit Tribal input in the direction of how we should approach improving MCH.
- Before developing a guiding frameworks or specific statement relating to MCH and the NPAIHB's mission or and goals, the MCH Core decided to employ a student intern to conduct interviews of those who work in MCH and serve Tribal people.



PROCESS

Who did we speak with?

- Conversational, open-ended interviews
- MCH definition, priorities, supporting wellness
- 23 interviews, 29 participants
- 17 organizations: NPAIHB, clinics (IHS, Tribal), tribal health and human services, community-based organizations in urban areas, state/regional level organizations
- Feedback from a tribal clinic and the Native American Rehabilitation Association of the Northwest



Questions

Tribal Leaders

- Background
- Population you serve
- What makes for healthy…
- What supports growth
- Outside Influence
- What you would do
- Resource available
- Challenges
- Key issues

Board Members

- Background
- MCH definition
- What make healthy…
- What does good health look like
- Strengths/assets
- Challenges
- Important Issues
- Available Resources

Urban Organizations

- Background
- MCH Definition
- Population you serve
- Priority Issues for NW
- Suggested Indicators to Measure Progress
- Key Issues

FINDINGS

What is MCH?

"The beginning [of MCH] is difficult because some things are important for a healthy pregnancy, before you are planning to become pregnant. I see the separation between adolescent health because that is such a huge beast of its own. I would say [MCH] goes up to maybe age 12, but the cutoff is not firm, or as important"

"I would like to see no age restraint on MCH—a child is a child until age 18; [I see it as] more of a continuum of support for whole wellness (beyond just clinical care) throughout life"

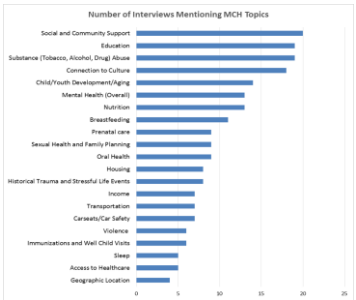
"We should be able to define what [MCH] means to us firstly; but…programs have specific funding for specific populations. We are reactive in that sense. We work in the areas that are funded"

"There are multiple generations involved in support; and the community and systems impact the mother and child. There are circles of involvement"

What is MCH?

- Mothers and children at the core
- Fathers, elders, communities play a role
- Distinct challenges at different ages and stages of life, but fluidity and overlap between stages
- Focus areas (often in response to funding priorities) but whole picture view is necessary

Common MCH Topics



Common MCH Topics

- Social community support
- Education
- Substance Abuse
- Connection to Culture
- Child Youth Development/Aging
- Mental Health
- Nutrition
- Breastfeeding
- Prenatal Care
- Sexual health and family planning
- Housing
- x
- Immunization/Well Child
- Sleep
- Access to Care
- Geographic location
- Historical Trauma Stressful Event
- Oral Health
- Income
- Transportation
- Car Safety
- Violence

Support

Support: Quotes

Focus on Specific Groups:

"There is a tendency for us to focus more on women…Indian mothers pass along cultural and traditional teachings to women and have high expectations…We sometimes tend to let men slide. We don't hold young men to the responsibility of being community leaders and fathers…In some ways we have let our men down"

Culturally Relevant Support:

"[We need] support systems for parents. [We] need support that is delivered in a culturally and socially appropriate way, respectful and non-judgmental. [We need to] serve people with open minds and open hearts"

Support: Topics

- Childcare
- Home visiting
  - Delivered in an integrated way
- Gatherings or support groups
  - Culturally relevant
  - In collaboration with medical providers (prenatal care, pediatricians)
- Breastfeeding support
  - Especially for young moms
- Need for reaching specific groups
  - Fathers, young mothers, connection between elders and younger generations

Education

Education: Quotes

"In the US there is not always support for parents, and that can be isolating. Many Native people are still reeling from a time when kids were taken away from parents and put in boarding schools. There was a break in parenting and it comes up today and is traumatic. ***People feel they do not know how to parent; so encouraging traditional ways in parenting is very important. There is a lot of focus on pregnancy and delivery, but less focus on parenting"***

"The hospitals have training for parents and support groups, but ***something more local or regional and culturally relevant would be better****. Parents may want to have support groups with people they have grown up with, and have something more meaningful and relevant to them"*

Education: Topics

- Education for parents that is culturally relevant and tribally specific
  - Understanding childhood and adolescent milestones
  - Education for mothers and fathers

Mental Health and Substance Use

Mental Health

.

*"Many problems in pregnancy, birth, and development are related to **addiction**. The health of the baby is connected to the health of the mother and the community. **Trauma, stress,** and **depression** are passed in utero, and trauma is ongoing, not just historical. Early intervention at the start of pregnancy and before pregnancy, and intervention after birth is critical"*

Topics Mentioned in Interviews Discussing Substance Abuse

- Drugs
- Alcohol
- Tobacco
- FASD
- Addiction Support

- Addiction support
- Mental health for families
- Postpartum depression
- Strong behavioral health programs
- Trauma, grief, and loss and a need for opportunities for healing
- Connection between reproductive health and mental health

Connection to Culture & Holistic Health

Holistic Health

"[I would like a] facility or wing with a full healthcare team, including a nurse, dietician, primary care provider. A comprehensive wellness and care team for mothers and their partners, and for children. It would offer the full spectrum of care: nutrition, fitness, healthy eating, parenting, healthy relationships, housing, case management. It would be a one-stop-shop for everyone"

"People don't come in pieces"

Holistice Health: Topics

Culture

- Not a "one size fits all" approach
- Making traditional practices an accessible option by supporting culture through health and social systems and education
- Traditional foods, language programs, spirituality, traditional medicine and healing

"Culture is Prevention"

Culture: Topics

- Not a "one size fits all" approach
- Making traditional practices an accessible option by supporting culture through health and social systems and education
- Traditional foods, language programs, spirituality, traditional medicine and healing

Data Collection

COMMON DATA COLLECTION ISSUES AND SUGGESTIONS

Suggestions

- Collecting local, tribal-specific baseline data for comparison across tribes or between communities within a reservation.
- Building community-level metrics, looking at connectedness and wellness.
- Measuring attendance at well-child, prenatal, and dental appointments

Issue: Statistical Significance

"There is also this idea of 'statistical significance' and populations with small sample sizes do not get reported because they are not 'significant'. [This] leads to exclusion of populations and 'statistical significance' drives funding"

NPAIHB

Indian Leadership for Indian H

Suggestions & Next Steps for NPAIHB

Suggestions

- Information sharing
- Advocacy
- Partnerships and creative thinking
- Regular needs assessment including community members

SPECIFIC DATA COLLECTION ISSUES AND SUGGESTIONS

CLINICS	NPAIHB	COMMUNITY
Care coordination and tracking of attendance at appointments	Indicators to measure connection to culture or tradition	Indicators to measure connection to culture or tradition
Better follow up after delivery	Qualitative data and story telling	Qualitative data and story telling
Lost data on patients when mothers referred out for OB care, or when children attending private pediatric appointments	Data linkage across sectors	Data linkage across sectors
Lack of data sharing between systems	Creating shared metrics	Creating shared metrics

Discussion

Do these themes resonate in the community(s) you serve?

Is there anything about these topics that surprises you?

Are topics we haven't heard that you think are important?

Are there other questions you think we should ask?

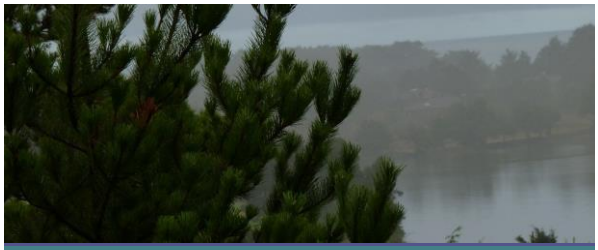
Next Steps

Facilitating opportunities for information sharing:

- Developed and publishing MCH Guiding Framework online
- Developing our Vision, Mission Statement, and Goals that blend with the NPAIHB Strategic Plan
- Determining How Board Delegates would like to be engaged in the process
- Deciding how NPAIHB, and other organizations should collaborate moving forward

Acknowledgement

Respondents
HRSA Maternal Child Health Board Graduate Student Epidemiology Program
Alyssa Bosold



Project Contact

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Monika Damron
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Policy & Legislative Update

NW Portland Area Indian Health Board
Quarterly Board Meeting
Embassy Suites – Portland, OR
January 17, 2018

Report Overview

1. Status of IHS Budgets
2. Current & Pending Policy Issues
3. Legislation in 115th Congress
4. National & Regional Meetings

Status of IHS Budgets

3

FY 2018 IHS Budget

- Congress passed another continuing resolution (CR) for FY 2018 budget which funds the government through January 19, 2018.
- President's budget proposes a 5.2% decrease below FY 2017 enacted level ($4.2B) for services and facilities.
- House bill proposes a $179m increase above FY 2017 enacted level for services and facilities.
- Senate bill proposes less than $1m increase above FY enacted level for services and facilities
- Hill visits advocacy per our FY 2018 analysis.
  - $246.5m for services & facilities
  - $140m for program increases

FY 2019/2020 IHS Budgets

- FY 2019 National Tribal Budget Formulation Workgroup's Recommendations
  - Available at: http://www.nihb.org/legislative/budget_formulation.php
- FY 2020
  - Portland Area Budget Formulation Meeting was November 30, 2017
  - National Budget Formulation Meeting is February 15-16, 2018 in Washington, D.C.

Current & Pending Policy Issues

6

CMS 4 Walls Limitation

- CMS determined that If a Tribal facility is enrolled in the state Medicaid program as a provider of clinical services under 42 CFR 440.90, the Tribal facility may not bill for services furnished by a non-Tribal provider or Tribal employee at the facility rate for services that are provided outside of the facility.
- Per CMS, under FQHC designation there is no requirement that the services be provided within the 4 walls.
- Section 1905 of the SSA recognizes outpatient Tribal clinics as FQHCs.
- CMS FAQ released January 18, 2017.
- *Deadlines*:
  - January 18, 2018: Tribe must notify state of intent to change provider status – clinical provider to FQHC.
  - January 30, 2021: Effective date

CMS Pharmacy Outpatient Rule Implementation

- Covered Outpatient Drug Final Rule (81 FR 517), dated 2/1/16; changes reimbursement methodology of covered outpatient drugs in Medicaid program.
- States may elect to reimburse I/T/U pharmacies through the OMB encounter rate.
- Oregon status:
  - SPA amendment approved 9/20/17 by CMS.
  - "The I/T pharmacy will receive one encounter per prescription filled or refilled and will not be limited to a certain number of prescriptions per day."
  - Tribes will receive AIR from October, 2017; systems need to be updated so reconciliation necessary initially.

CMS Medicare Diabetes Prevention Program (MDPP) Final Rule

- CMS publishes MDPP final rule on 11/15/17.
- MDPP Expanded Model start date is 1/1/18.
- MDPP Supplier enrollment begins in January 2018 and suppliers begin furnishing services and billing Medicare in April 2018.
- Unfortunately, tribal recommendations were not accepted in final rule.

CMS New Medicare Card Project

- CMS New Medicare Project Webinar on 1/23/18
- Removal of SSN-based Health Insurance Claim. Number (HICN) from Medicare cards.
- CMS will send out replacement Medicare cards with a new Medicare Beneficiary Identifier (MBI) by April 2019.
- CMS will begin mailing new Medicare cards to people with Medicare and all systems and processes will able to accept MBI in April 2018.
- Transition period runs from April 2018 through December 31, 2019.
- CMS is working to develop a look-up tool for providers to be able to access a patient's new MBI.

IHS Contract Support Costs Policy Update

- Dear Tribal Leader Letter on 12/21/2017
- Update to temporarily rescind Alternative Methods for Calculating Indirect Costs Associated with Recurring Service Unit Shares, referred to as the 97/3 split.
- 97/3 split is the alternative option to determine the amount in a tribe's indirect cost pool.
- IHS has found that in certain circumstances, the result is inconsistent with statutory authority.
- Next IHS CSC Workgroup meeting is March 6-7, 2018.

IHS Health Information Technology

- Issued a request for information (RFI) on 12/20/2017.
- Assess industry innovations and capabilities to address emerging healthcare delivery and modernization needs.
- Objective is to research clinical and technical approaches and to deliver next generation solutions with modularized software components.
- IHS ISAC workgroup recommended moving to a commercial off-the-shelf system.
- Responses accepted until 2/1/18

IHS Strategic Plan 2018-2022

- Dear Tribal Leader Letter on 11/28/17.
- Comments were due on 10/31/17; NPAIHB submitted comments. IHS received 137 comments.
- Established an IHS Strategic Planning workgroup to review comments and finalize a draft Strategic Plan, including, mission, vision, goals, objectives, strategies, and measures.
- IHS will initiate a 30-day public comment period for tribes to comment on the draft Strategic plan, which is anticipated to be finished by the end of January.
- IHS expects the final IHS Strategic Plan to be completed and published by April 2018.

IHS Indian Health Care Improvement Fund (IHCIF)

- Dear Tribal Leader Letter on 11/13/17
- Establishment of IHS/Tribal IHCIF workgroup.
- Workgroup will 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.

IHS CHEF

- Proposed rule issued on 1/26/16 (81 Fed. Reg. 4239–44).
  - Added "tribal" resources to the list of alternate resources.
- No Tribal consultation on this rule before it was issued.
- In 2016, several tribal consultations took place.
- Payer of last resort case of *Redding Rancheria v. Burwell*, No. 15-152 (DDC) has delayed IHS from issuing a final rule.

SAMHSA Confidentiality of Substance Use Disorder Patient Records

- Dear Tribal Leader Letter on 12/28/18.
- Virtual Tribal Consultation Session 1/22/18.
- Addresses prohibition on re-disclosure notice by including an option for an abbreviated notice.
- Addresses circumstances under which lawful holders and their legal representatives may use and disclose patient identifying information.
- Comments due 2/28/18.

Legislation in 115th Congress

17

Indian Legislative Bills in 115th Congress

- Important Dates
  - FY 2018 IHS Budget
    - CR ends on January 19
  - Children's Health Insurance Program
    - CR ends on January 19
  - Special Diabetes Program for Indians
    - Extended and expires on March 31

Legislation in 115th Congress

- Important Dates
- Affordable Care Act & Marketplace Stabilization
- Children's Health Insurance Program
- Special Diabetes Program for Indians Reauthorization Act of 2017 (S.747 & H.R. 2545)
- Native Health and Wellness Act of 2017 (H.R. 3706)
- Native Health Access Improvement Act of 2017 (H.R. 3704)
- Native American Suicide Prevention Act of 2017 (H.R. 3473)
- Drug Free Indian Health Service Act of 2017 (H.R. 3096)
- Restoring Accountability in the Indian Health Service Act of 2017 (S.1250)
- Independent Outside Audit of the Indian Health Service Act of 2017 (S.465)
- Tribal Veterans Health Care Enhancement Act (S.304)
- NEW: The Mitigating METH Act (S. 2270)
- IHS Advanced Appropriations Act of 2017 (H.R. 235) (no slide)

Indian Legislative Bills in 115th Congress

- Affordable Care Act & Marketplace Stabilization
  - Tax Cuts and Job Act
    - Repeals Individual mandate
    - 12/19/17: Passed House and Senate
  - Bipartisan Healthcare Stabilization Act of 2017
    - Sponsored by Sen. Lamar Alexander (R-TN) and Sen. Patty Murray (D-WA)
  - Lower Premiums Through Reinsurance Act of 2017 (S. 1835)
    - Introduced by Sen. Susan Collins (R-ME) and co-sponsored by Sen. Bill Nelson (D-FL) and Lisa Murkowski (R-AK)
    - 9/19/17: Referred to Senate Finance Committee.

Indian Legislative Bills in 115th Congress

- Children's Health Insurance Program – 5 year renewal bills
  - KIDS Act of 2017 (S.1827)
    - Introduced by Sen. Orrin Hatch (R-UT) on 9/18/2017
    - Referred to the Senate Finance Committee on 9/18/2017
    - 10/4/17: Committee hearing
    - 12/20/17: Placed on Senate Legislative Calendar
  - CHAMPION Act (H.R. 3922)
    - Introduced by Rep. Greg Walden (R-OR) on 10/3/17
    - 11/3/17: Passed House
    - 11/6/17: Referred to Senate Finance Committee
  - HEALTHY KIDS Act (H.R. 3921)
    - Introduced by Rep. Michael Burgess (R-TX) on 10/3/17
    - 10/23/17: Placed on Union Calendar

Indian Legislative Bills in 115th Congress

- Special Diabetes Program for Indians Reauthorization Act of 2017 (S.747 & H.R. 2545
  - Senate bill introduced by Sen. Tom Udall (D-NM) on 3/28/17; and House bill introduced by Rep. Norma Torres (D-CA) on 5/18/17 and has 13 co-sponsors.
  - Reauthorizes the Special Diabetes Program for Indians (SDPI) for FY 2018 at $150m; and
  - FY 2019-FY 2024 increases annually using medical inflation rate.
  - S. 747 - 3/28/17: Referred to Committee on Health, Education, Labor and Pensions.
  - H.R. 2545 - 5/19/17: Referred to House Energy and Commerce on Health.

Indian Legislative Bills in 115th Congress

- Native Health and Wellness Act of 2017 (H.R. 3706)
  - Introduced by Rep. Raul Ruiz (D-CA-36) and co-sponsored by Rep. Frank Pallone Jr. (D-NJ-6) on 9/07/2017
  - Creates a tribal health block grant.
  - Creates a grant program to recruit and mentor AI/AN youth and young adults.
  - Referred to the House Energy and Commerce Committee on 9/07/2017

Indian Legislative Bills in 115th Congress

- Native Health Access Improvement Act of 2017 (H.R. 3704)
  - Introduced by Rep. Frank Pallone, Jr. (D-NJ-6) and co-sponsored by Rep. Raul Ruiz (D-CA-36) on 9/7/17.
  - Establishes a grant program similar to the SDPI to increase access to substance abuse prevention and behavioral heath services for Tribes and Urban Indians.
  - 9/7/17: Referred to the Energy and Commerce Committee as well as to the Committee on Natural Resources and Ways and Means Committee.
  - 9/13/17: Referred to the Subcommittee on Indian, Insular and Alaska Native Affairs within the Committee on Natural Resources.

Indian Legislative Bills in 115th Congress

- Native American Suicide Prevention Act of 2017 (H.R. 3473)
  - Introduced by Rep. Raul Grijalva (D-AZ-3) on 7/27/17.
  - Requires States and their designees receiving grants for development and implementation of statewide suicide and early intervention and prevention strategies to collaborate with Tribes.
  - 7/17/17: Referred to the House Energy and Commerce Committee on 7/27/17.
  - 7/Referred to the Subcommittee on Health under the Energy and Commerce Committee on 7/28/2017.

Indian Legislative Bills in 115th Congress

- Drug-Free Indian Health Service Act of 2017 (H.R. 3096)
  - Introduced by Rep. Kristi Noem (R-SD) on 6/28/17; no other co-sponsors.
  - To implement a mandatory random drug testing program for certain employees of the Indian Health Service, and for other purposes.
  - 6/28/17: Referred to Committee on Natural Resources and Committee on Energy and Commerce.
  - 6/30/17: Referred to the Subcommittee on Health.
  - 7/13/17: Referred to the Subcommittee on Indian, Insular and Alaska Native Affairs.

Indian Legislative Bills in 115th Congress

- Restoring Accountability in the Indian Health Service Act of 2017 (S. 1250 & H.R. 2662)
  - Senate and House bills Introduced by Sen. John Barasso (R-WY) and Rep. Kristi Noem (R-SD) on 5/25/17, respectively.
  - This bill attempts to address quality of care issues occurring at some IHS-operated hospitals in the Great Plains Area and elsewhere.
  - 5/25/17: Referred to House Senate and House Committees.
  - S. 1250- 6/13/17: Senate hearings were held.
  - H.R. 2662- 6/21/17: House Subcommittee hearing was held; Chairman Andy Joseph, Jr. testified.

Indian Legislative Bills in 115th Congress

- Independent Outside Audit of the Indian Health Service Act of 2017 (S. 465)
  - Introduced by Sen. Mike Rounds (R-SD) on 2/28/17 with co-sponsors Sen. James Lankford (R-OK) and John McCain (R-AZ).
  - Requires an independent outside audit of the Indian Health Service with report to Congress.
  - 2/28/17: Referred to Committee on Indian Affairs
  - 11/8/17: Committee hearing

Indian Legislative Bills in 115th Congress

- Tribal Veterans Health Care Enhancement Act (S. 304)
  - Introduced by Sen. John Thune (R-SD) and Sen. Mike Rounds (R-SD) on 2/3/17.
  - 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.
  - 3/29/17: Referred to Committee on Indian Affairs.
  - 6/15/17: Committee recommended that bill pass.
  - 6/15/17: Committee created a report to accompany S.304.
- House Draft to Establish a Permanent Veterans Choice Program "CARE Act"
  - 10/24/17: Hearing on the draft bill.

Indian Legislative Bills in 115th Congress

- NEW: The Mitigating METH Act (S. 2270)
  - Introduced by Sen. Steve Daines (R-MT) on 12/21/17 with co-sponsors Sen. Jeff Merkley (D-OR) and others
  - Amends the 21st Century Act to include funding for tribes for opioid prevention and response.
  - Authorizes a tribe or state to use grants for prevention and treatment of substances, including methamphetamines, if use of substances is determined by a state or tribe to have a substantial public impact on the state or tribe.
  - 12/21/17: Referred to HELP Committee.

National & Regional Meetings

31

HHS Secretary's Tribal Advisory Committee (STAC)

- Last meeting was on September 20-21, 2017.
- Next meeting is January 17-18, 2018
- HHS Secretary Update:
  - Eric D. Hargan was sworn into office as Deputy Secretary on Oct. 6, 2017, and was appointed as Acting Secretary of the U.S. Department of Health and Human Services (HHS) on Oct. 10, 2017.
  - President Trump nominated Alex M. Azar II to be HHS Secretary on Nov. 13.
  - HHS nominee Alex Azar faced a Senate Health Education, Labor and Pensions Committee confirmation hearing on Nov. 29 and a Senate Finance Committee confirmation hearing on January 9, 2018.

MMPC & CMS TTAG Update

- Medicare, Medicaid and Health Reform Policy Committee's (MMPC) –last face-to-face meeting was on October 31, 2017.
  - Next conference call is TBD; next MMPC face-to-face is February 20, 2018.
- CMS TTAG – last face-to-face meeting was November 1-2, 2017.
  - Next conference call is on January 10, 2018 ; and the next TTAG face-to-face meeting is February 21-22, 2018.

MMPC/TTAG Issues

- CMS New Policy Guidance on Work Requirements
- New Waivers in Current Administration
- 100% FMAP/4 Walls Issue
- Future of RPMS

Discussion?

DEPARTMENT OF HEALTH & HUMAN SERVICES

10A
Public Health Service

Indian Health Service
Rockville MD 20852

DEC 21 2017

Dear Tribal Leader:

I am writing to notify you of an important policy update to the Indian Health Service (IHS) Indian Health Manual, Part 6 – *Services to Tribal Governments and Organizations*, Chapter 3 – *Contract Support Costs* (CSC) ("CSC policy"). Effective immediately, the IHS has decided to temporarily rescind § 6-3.2E(3) – *Alternative Methods for Calculating Indirect Costs Associated with Recurring Service Unit Shares* of the CSC policy.

The IHS has become aware that this section may not conform in all cases with the statutory authority of the Indian Self-Determination and Education Assistance Act (ISDEAA) at 25 U.S.C. § 5325(a). The IHS will initiate Tribal Consultation in the near future regarding this provision prior to making a final decision on how to amend the CSC policy.

This section of the CSC policy, often referred to by Federal and Tribal ISDEAA negotiators as the "97/3 Split" or "97/3 Method," permits a Tribe or Tribal organization to exercise the option for "Service Unit level shares" that is similar to the option that previously applied only to "Area" and "Headquarters" level shares. In sum, this option in the policy provides an alternative method for use in determining the amount in a Tribe's or Tribal organization's indirect cost pool that is associated with transferred programs, functions, services, or activities already funded by the Secretarial amount, as defined by the ISDEAA. After a year of implementing the revised CSC policy, the IHS has found that in certain circumstances, this option yields a result that is inconsistent with statutory authority.

One of the CSC policy's guiding principles, at § 6-3.1B(18), is that it will "be reassessed on a regular basis." In addition, the CSC policy, at § 6-3.1D, states that "IHS will continue to reassess the [CSC policy] on a regular basis, and further changes will only be implemented after Tribal consultation." As an initial step, the IHS will seek input on a final decision on how to amend this provision of the CSC policy through the CSC Workgroup (CSCWG) no later than mid-January 2018. The last IHS CSCWG meeting convened in Tulsa, Oklahoma, on August 16, 2017. During this meeting, the CSCWG discussed the manner in which the updated CSC policy has been implemented since October 26, 2016. The input from the CSCWG will be one of the next steps of Tribal Consultation on how to update the CSC policy.

I will provide an update with additional details on the Tribal Consultation in a separate letter and during the next All Tribal Leader and Urban Indian Organization Leader Call.

If you have any questions, please contact Ms. Roselyn Tso, Acting Director, Office of Direct Service and Contracting Tribes, IHS, by telephone at (301) 443-1104 or by e-mail at roselyn.tso@ihs.gov.

Sincerely,

/Michael D. Weahkee/

RADM Michael D. Weahkee, MBA, MHSA
Assistant Surgeon General, U.S. Public Health Service
Acting Director

B

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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Warm Springs Tribe
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2121 S.W. Broadway
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Portland, OR 97201
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Fax: (503) 228-8182
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SUBMITTED VIA EMAIL

January 12, 2018

RADM Michael D. Weahkee
Acting Director
Indian Health Service
5600 Fishers Lane
Rockville, MD 20857

RE: Invitation to Attend Contract Support Cost Workgroup Meeting; Request for Information on CSC Issues

Dear Acting Director Weahkee:

The Indian Health Service (IHS) Contract Support Cost (CSC) Workgroup, on which I serve as the Tribal Co-Chair, has scheduled an in-person meeting, at a location to be determined, on March 6-7, 2018. On behalf of the tribal leaders and technical experts on the Workgroup, I urge you to attend this important meeting. Among other topics, the meeting will address IHS's unilateral decision, announced in your letter to tribal leaders dated December 21, 2017, to immediately rescind a key provision of the agency's CSC Policy without notice to, let alone consultation with, tribes. This abrupt decision surprised and troubled tribal leaders, as it disregarded the agreement struck in lengthy and challenging negotiations. I hope you will take the opportunity provided by the Workgroup meeting to hear and respond personally to these concerns. Between now and then, I also hope the 97/3 option (Manual section 6-3.2E.3) will have been reinstated, as requested in my letter of January 3, 2018.

In my January 3rd letter, I requested that IHS provide the Workgroup all information on which the agency relied in concluding that the 97/3 option in § 6-3.2E(3) of the Policy may not "in all cases" conform to the Indian Self-Determination Act. Now that a Workgroup meeting has been scheduled and a preliminary agenda set, I would like to expand this information request accordingly. Please provide the Workgroup in advance with all relevant information and documentation on the following Workgroup agenda items:

- All data and other documentation underlying IHS's decision to rescind the 97/3 option;
- All data developed by IHS in 2016 at the time that IHS agreed to the 97/3 option;
- Delays in indirect cost rate negotiation in the Department of Health and Human Services;

- IHS's response to a tribal request that IHS reconsider its refusal to pay CSC on Catastrophic Health Emergency Fund (CHEF) funding;
- IHS's response to a tribal request that IHS reconsider its refusal to pay CSC on Domestic Violence Prevention Initiative and Substance Abuse and Suicide Prevention funding;
- CSC distribution data for FYs 2014 through 2017 (update of spreadsheet provided at the Workgroup's last meeting in Tulsa in August 2017);
- Establishment of a tribal-federal sub-workgroup to develop CSC budget projections; and
- Ongoing review of the CSC Negotiation Template.

In order to allow time for careful tribal review of this information and maximize the productivity of the meeting, we request that IHS provide the information above no later than **February 9, 2018**.

We look forward to meeting with you on March 6-7, and we remain committed to working with IHS to resolve these issues in accordance with the Policy's guiding principles of transparency and collaboration in the government-to-government relationship.

Sincerely,

Andy Joseph, Jr., NPAIHB Chairperson
Colville Tribal Council Member

cc: IHS CSC Workgroup members

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Confederated Tribes of Colville
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians
Confederated Tribes of Grand Ronde
Confederated Tribes of Siletz
Confederated Tribes of Umatilla
Confederated Tribes of Warm Springs
Coquille Tribe
Cow Creek Tribe
Cowlitz 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
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Upper Skagit Tribe
Yakama Nation

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January 3, 2018

Via Email

RADM Michael D. Weahkee, Acting Director
Indian Health Service
5600 Fishers Lane
Rockville, MD 20857

RE: Tribal CSC Workgroup Objections to IHS's Unilateral Rescission of "97/3" Option for Determining Indirect Costs Associated with Service Unit Shares

Dear RADM Weahkee:

As the Tribal Co-Chair of the Indian Health Service (IHS) Contract Support Cost (CSC) Workgroup, I write to express concern about your letter to tribal leaders, dated December 21, 2017, in which you announce IHS's decision to immediately rescind a key provision of the agency's CSC policy. The Workgroup objects to this unilateral decision, made without tribal consultation in violation of the policy's own requirements for adopting changes. Any amendments IHS wishes to propose should be implemented only after thorough discussion with the IHS CSC Workgroup and full tribal consultation. In preparation for this process, IHS should immediately distribute to the Workgroup the data that IHS believes support the proposed change.

The provision at issue arises from IHS's attempt to account for duplication between indirect CSC and indirect cost funding IHS believes is included in the Secretarial or program amount. When a tribe assumes a new or expanded program, function, service, or activity (PFSA), or adds staff associated with a joint venture, IHS requires a duplication review when determining the amount of CSC associated with the expansion. The rescinded provision gave tribes a choice between two methods: (1) a "case-by-case detailed analysis" of indirect costs transferred in the Secretarial amount; or (2) a 97/3 split, in which 97% of the expansion would be deemed part of the direct cost base (and thus generate indirect CSC), while 3% would be deemed indirect cost funding (and thus excluded from the direct cost base and offset against indirect CSC otherwise due).

The 97/3 option evolved from extensive and difficult negotiations between the tribal and federal representatives on the IHS CSC Workgroup in 2016. It was modeled on the longstanding 80/20 split for Area and Headquarters tribal shares. Like the 80/20 rule, the 97/3 split provides a reasonable approximation that saves much time and effort on both sides, replacing hours or days of potentially contentious negotiations with a simple computation. But now IHS proposes to unilaterally revoke, at least temporarily, this efficient option, which your letter says "may not conform in all cases with the statutory authority of the

Indian Self-Determination and Education Assistance Act (ISDEAA)."

For well over a year, Tribes worked with IHS on a government-to-government basis to reach difficult compromises on contested issues such as accounting for duplication on service unit shares. The parties agreed that the policy will "be reassessed on a regular basis,"[1] but specified that "changes will only be implemented **after** Tribal consultation."[2] Revoking the 97/3 option, even temporarily, fundamentally changes the agreement struck between the parties and should be implemented, if at all, only after informed discussion with the Workgroup and full tribal consultation—as IHS agreed in the policy itself.

As a first step, we respectfully request that IHS immediately distribute to the Workgroup the data which IHS relies for its conclusion that the 97/3 split may not "in all cases" conform to the ISDEAA. This should include the annual CSC Funding Report called for in the policy,[3] as well as data specific to the composition of service unit funding. To enable meaningful discussion, tribes need to conduct their own analysis of all information that, in IHS's view, mandates re-opening this issue. IHS should then convene the CSC Workgroup, comprised of tribal leaders and technical experts, to develop a shared interpretation of the data. Finally, any changes agreed to by the Workgroup must be vetted through full tribal consultation.

Throughout this process, and until a final decision is made, IHS should continue to carry out its CSC policy as written, including the 97/3 option. If, in some individual case, IHS can show that the 97/3 split clearly and demonstrably conflicts with the ISDEAA, the policy already recognizes that the statute supersedes it in the event of a conflict.[4] A complete revocation of the 97/3 option is not necessary. More importantly, it disregards the bargain struck in government-to-government negotiations and ignores the deliberative process for amendments set forth in the policy itself.

Thank you for your prompt attention to this matter. We look forward to working with IHS as the conversation on this issue develops.

Sincerely,

Andrew C. Joseph Jr.

Andrew C. Joseph Jr.
Tribal Co-Chair, IHS CSC Workgroup

cc: IHS CSC Workgroup members

[1] Indian Health Manual, § 6-3.1B(18).
[2] Indian Health Manual, § 6-3.1D (emphasis added).
[3] Indian Health Manual, § 6-3.5B.
[4] Indian Health Manual, § 6-3.1C.

DEPARTMENT OF HEALTH & HUMAN SERVICES

10C
Public Health Service

Indian Health Service
Rockville MD 20852

DEC 29 2017

Dear Tribal and Urban Indian Organization Leader:

I am writing to update you on the progress of the Indian Health Service (IHS) Strategic Planning Workgroup (Workgroup) activities and to inform you of changes to the timeline of the IHS draft Strategic Plan 2018-2022 (Strategic Plan).

Over the past two months, the Workgroup met several times to develop the objectives, strategies and measures for each goal in the Strategic Plan. They will resume their work in January 2018. You may view the progress and timeline of the Workgroup, including meeting minutes, on-line at the IHS Strategic Planning web page: https://www.ihs.gov/dper/planning/strategicplanning.

I accepted the recommendation and request from several Workgroup members for additional time for the Workgroup to thoroughly consider IHS-operated, tribally-operated, and Urban health care environments. Additional time and meetings have been added to the Workgroup schedule. With the changes to the timeline, we anticipate the Workgroup to complete a draft Strategic Plan by the end of January 2018.

As a next step, we will initiate a 30-day public comment period on the draft Strategic Plan. During the comment period, the IHS will hold a National All Tribal and Urban Leader Call to share updates and provide a forum for comment on the draft Strategic plan. We expect the final IHS Strategic Plan to be completed and published for use in April 2018.

As shared in previous updates, we will continue to accept comments throughout the Strategic Planning process. For additional Strategic Plan updates, including Workgroup progress and instructions on how to submit comments, please visit the IHS Strategic Planning web page.

Thank you for your continued support and contributions to this important activity. If you have any questions about the Strategic Planning process, please contact CAPT Francis Frazier, Director, Office of Public Health Support, IHS, by telephone at (301) 443-0222 or by e-mail at francis.frazier@ihs.gov.

Sincerely,

/RADM Michael D. Weahkee/

RADM Michael D. Weahkee, MBA, MHSA
Assistant Surgeon General, U.S. Public Health Service
Acting Director

Substance Abuse and Mental Health Services Administration
SAMHSA
5600 Fishers Lane • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

DEC 28 2017

Dear Tribal Leader:

On behalf of the Substance Abuse and Mental Health Services Administration (SAMHSA), I invite you to participate in a virtual Tribal Consultation session regarding implementation of the Confidentiality of Substance Use Disorder Patient Records regulations (42 CFR Part 2 or Part 2). The purpose of the consultation is to gain your input on the effect of Part 2 on patient care, health outcomes, and patient privacy.

The virtual Tribal Consultation session will be held on Monday, January 22 from 2:30 pm – 4:00 pm, Eastern Standard Time. You may register for the session at:

https://part2-tribal-consultation.eventbrite.com

In addition to the Tribal Consultation session, SAMSHA welcomes your written comments on the implementation of Part 2 no later than February 28. Comments may be sent to tribalconsultation@samhsa.hhs.gov or by mail to:

Sharece Tyer, MBA, MS
Public Health Analyst
Office of Tribal Affairs and Policy
Office of Policy, Planning and Innovation (OPPI)
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, 18E09C
Rockville, Maryland 20852

Enclosed for your reference is background information and resources on Part 2 in preparation for the Tribal Consultation session. My staff and I look forward to participating in this session and obtaining your input on the implementation of Part 2.

Sincerely,

Elinore F. McCance-Katz, M.D., Ph.D.
Assistant Secretary for Mental Health and Substance Use

cc: Kimberly Johnson, Director, Center for Substance Abuse Treatment
Mirtha Beadle, Director, Office of Tribal Affairs and Policy
Brian Altman, Director, Division of Policy Innovation, OPPI
Mitchell Berger, Public Health Advisor, OPPI, SAMHSA

mln call

A MEDICARE LEARNING NETWORK® (MLN) EVENT

Medicare Diabetes Prevention Program (MDPP) Expanded Model

December 5, 2017

Presenter(s):

Amanda Van Vleet
Arielle Zina

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

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Acronyms

Below is a list of acronyms used frequently throughout this presentation.

Acronym	Description
CDC	Centers for Disease Control and Prevention
CDC DPRP	Centers for Disease Control and Prevention Diabetes Prevention Recognition Program
National DPP	National Diabetes Prevention Program
CMS	Centers for Medicare and Medicaid Services
CMMI	Center for Medicare and Medicaid Innovation
MDPP	Medicare Diabetes Prevention Program
NPI	National Provider Identifier
PFS	Physician Fee Schedule

Agenda

Objectives

Our primary objectives for today's call are outlined below.

1. Enhance awareness of the MDPP expanded model set of services
2. Increase knowledge and understanding of the MDPP policies finalized in the CY18 Physician Fee Schedule final rule
3. Provide additional resources and address questions related to the MDPP expanded model

Context

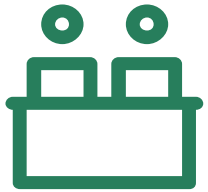
MDPP services respond to high rates of type II diabetes among older Americans.

Problem

25% of Americans 65 years and older are living with type II diabetes, which negatively impacts health outcomes

Care for older Americans (65+ years) with diabetes costs Medicare **$104 billion annually, and is growing**

MDPP Services

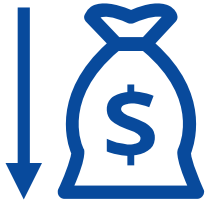


Health behavior change sessions furnished by coaches with the goal of **weight loss**

CDC-approved curriculum delivered in person to beneficiaries with an indication of prediabetes

Impact

Promotes healthier behaviors for eligible Medicare beneficiaries that could prevent or delay type II diabetes



Decreases healthcare costs associated with diabetes

Overview of MDPP Services

MDPP services are offered over a two year period and are intended to prevent the onset of type II diabetes.

Months 0-6
Core Sessions

- MDPP suppliers must offer a minimum of 16 sessions, offered at least a week apart, during the first 6 months
- Sessions are available to eligible beneficiaries regardless of weight loss and attendance
- MDPP suppliers must use a CDC-approved curriculum to guide sessions

Months 7-12
Core Maintenance Sessions

- MDPP suppliers must offer a minimum of 6 monthly sessions during the second 6 months
- Sessions are available to eligible beneficiaries regardless of weight loss and attendance
- MDPP suppliers must use a CDC-approved curriculum to guide sessions

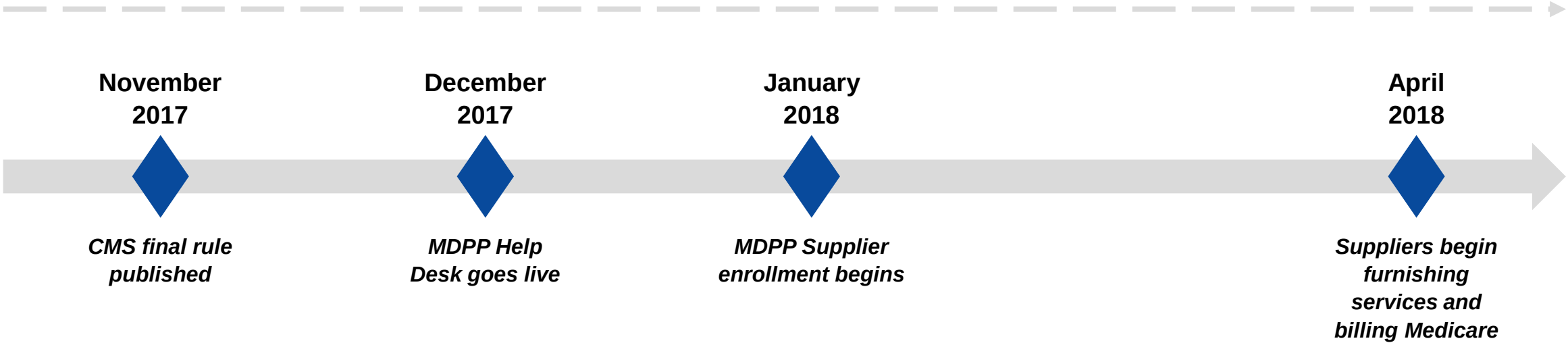
Months 13-24
Ongoing Maintenance Sessions

- MDPP suppliers must offer monthly maintenance sessions for an additional 12 months
- Eligible beneficiaries who achieve and maintain weight loss and attendance goals have coverage for 3 month intervals of monthly maintenance sessions for up to 1 year
- MDPP suppliers must use topics from a CDC-approved curriculum to guide sessions. Session topics may be repeated.

Key Upcoming Dates

Key upcoming dates related to the MDPP services rollout are highlighted below.

Prospective MDPP supplier applicants and coaches may obtain National Provider Identifiers (NPIs) at any time



MDPP Policies Finalized in the CY17 Physician Fee Schedule

The first cycle of MDPP rulemaking impacted the following policies in the CY17 PFS.

- MDPP Services and Description
- Expansion Authority and Timing
- Beneficiary Eligibility
- CDC Recognition
- Supplier Enrollment
- Coach NPI Requirements
- Supplier Revocation
- Evaluation Requirements

MDPP Policies Finalized in the CY18 Physician Fee Schedule

The second cycle of MDPP rulemaking impacted the following policies in the CY18 PFS.

- MDPP Services and Description
- Supplier Standards and Compliance
- Beneficiary Eligibility
- Payment Policy
- Supplier Enrollment
- Billing Codes
- Beneficiary Engagement Incentives

Key Policy Changes in the CY18 Physician Fee Schedule

MDPP Services and Description

New policy | Information added | Clarification

MDPP Policy	CY17	CY18	Change
MDPP start date	• Expanded Model start date January 1, 2018	• Supplier enrollment begins January 1, 2018 • Delivery and billing begin April 1, 2018	New start date
Terminology	The CY17 PFS established these terms: • "MDPP core benefit" • "MDPP eligible beneficiary" • "Maintenance session bundle"	The CY18 PFS removed the previous terms and established the following: • "MDPP services" • "Set of MDPP services" • "MDPP services period" • "Core session" • "Core maintenance session" • "Ongoing Maintenance session" • "MDPP session" • "MDPP beneficiary" • "Core maintenance session interval" • "Ongoing maintenance session interval" • "Make-up session" • "Virtual make-up session"	Terms added and removed

Key Policy Changes in the CY18 Physician Fee Schedule

MDPP Services and Description

New policy | Information added | Clarification

MDPP Policy	CY17	CY18	Change
Set of services	• 12 month core service period; unspecified number of ongoing maintenance sessions • Additional preventive service; no cost sharing requirements	• 12 months (not 24 months or unspecified) of ongoing maintenance sessions if beneficiaries meet weight loss and attendance goals, for a total MDPP services period of up to 2 years	New length
Make-up sessions	• No previous policy	• In-person o Must use same curriculum as session missed o Maximum of one per week; maximum of one per day of regularly scheduled sessions • Virtual o Same requirements as in-person make-up sessions o Only by beneficiary request o Compliant with DPRP virtual standards o Max of 4 during the core services period, of which no more than 2 are core maintenance sessions o Max of 3 that are ongoing maintenance sessions o Weight loss measurements taken cannot be used for payment or eligibility	New make-up session policy

Key Policy Changes in the CY18 Physician Fee Schedule

Beneficiary Eligibility

New policy | Information added | Clarification

MDPP Policy	CY17	CY18	Change
Eligibility criteria to begin MDPP services	• Enrolled in Medicare Part B • BMI of at least 25, 23 if self-identified as Asian • 1 of 3 pre-diabetic blood tests • No previous history of diabetes, except gestational diabetes • Must not have end-stage renal Disease (ESRD) • Once-per-lifetime limit: no previous receipt of MDPP core services • Provider referrals are not required	• Diabetes diagnosis during the MDPP Services Period does not disqualify beneficiaries • Once-per-lifetime limit: no previous receipt of <u>any</u> MDPP services (not just core services)	Criteria clarified
Eligibility criteria for ongoing maintenance sessions	• Beneficiary must have maintained 5% weight loss during the previous interval to be eligible for the next ongoing maintenance session interval	• Beneficiaries must attend at least one in-person core maintenance session in months 10-12 and achieve or maintain 5% weight loss in months 10-12 to be eligible for coverage of the first ongoing maintenance session interval • Beneficiaries must attend at least 2 sessions and maintain 5% weight loss within an ongoing maintenance session interval to be eligible for the next ongoing maintenance session interval	Addition of attendance-based eligibility criteria

Key Policy Changes in the CY18 Physician Fee Schedule

Payment Policy

New policy | Information added | Clarification

MDPP Policy	CY17	CY18	Change
Payment policy	• No previous policy	• Medicare payments to MDPP suppliers made if requirements met: o Beneficiary is eligible o Supplier meets all program requirements, including accepting mandatory assignment o Sessions furnished by an eligible coach o Weight loss measurement taken in person at an MDPP session o Beneficiary meets attendance or weight loss goal(s) o Includes at least 2 sessions per maintenance intervals o The supplier is eligible for a bridge payment	New requirements

Key Policy Changes in the CY18 Physician Fee Schedule

Payment Policy

MDPP Core Services			Ongoing Maintenance Sessions (12 months, 4 intervals)			
Core Sessions (6 months)	Core Maintenance Sessions (6 months, 2 intervals)					
(Months 0 – 6)	*Interval 1 (Months 7-9)*	*Interval 2 (Months 10-12)*	*Interval 1 (Months 13-15)*	*Interval 2 (Months 16-18)*	*Interval 3 (Months 19 – 21)*	*Interval 4 (Months 22-24)*
1 session: $25 4 sessions: $50 9 sessions: $90	2 sessions (with 5% WL*): $60	2 sessions (with 5% WL*): $60	2 sessions (with 5% WL*): $50	2 sessions (with 5% WL*): $50	2 sessions (with 5% WL*): $50	2 sessions (with 5% WL*): $50
NOTE: Core session payments are made regardless of achievement of weight loss	2 sessions (without 5% WL*): $15	2 sessions (without 5% WL*): $15	2 sessions (without 5% WL*): $0	2 sessions (without 5% WL*): $0	2 sessions (without 5% WL*): $0	2 sessions (without 5% WL*): $0
5 Percent weight loss achieved: $160						
9 percent weight loss achieved: $25						

* WL = weight loss from the beneficiary's baseline's weight

Key Policy Changes in the CY18 Physician Fee Schedule

Billing Codes

HCPCS G-Code for MDPP Services	Payment Amount	Description of MDPP Service	May be reported with Modifier VM (Virtual Make Up Session)
G9873	$25	1st core session attended	No
G9874	$50	4 total core sessions attended	Yes
G9875	$90	9 total core sessions attended	Yes
G9876	$15	2 core maintenance sessions attended in months 7-9 (weight loss goal not achieved or maintained)	Yes
G9877	$15	2 core maintenance sessions attended in months 10-12 (weight loss goal not achieved or maintained)	Yes
G9878	$60	2 core maintenance sessions attended in months 7-9 and weight loss goal achieved or maintained	Yes
G9879	$60	2 core maintenance sessions attended in months 10-12 and weight loss goal achieved or maintained	Yes
G9880	$160	5 percent weight loss from baseline achieved	No
G9881	$25	9 percent weight loss from baseline achieved	No
G9882	$50	2 ongoing maintenance sessions attended in months 13-15 and weight loss goal maintained	Yes
G9883	$50	2 ongoing maintenance sessions attended in months 16-18 and weight loss goal maintained	Yes
G9884	$50	2 ongoing maintenance sessions attended in months 19-21 and weight loss goal maintained	Yes
G9885	$50	2 ongoing maintenance sessions attended in months 22-24 and weight loss goal maintained	Yes
G9890	$25	Bridge payment – first session furnished by MDPP supplier to an MDPP beneficiary who has previously received MDPP services from a different MDPP supplier	Yes
G9891	$0	MDPP session reported as a line-item on a claim for a payable MDPP services HCPCS G-code for a session furnished by the billing supplier that counts toward achievement of the attendance performance goal for the payable MDPP services HCPCS G-code	Yes

Key Policy Changes in the CY18 Physician Fee Schedule

Supplier Enrollment

New policy | Information added | Clarification

MDPP Policy	CY17	CY18	Change
MDPP supplier eligibility: Recognition	• In order to enroll as an MDPP supplier, organizations require full CDC recognition • Preliminary recognition deferred to CY18	• Suppliers with MDPP preliminary recognition may enroll • MDPP preliminary includes MDPP interim preliminary and any preliminary recognition established by the CDC • Created MDPP interim preliminary recognition Standard. Criteria include at least 60% of participants attend at least 9 sessions in months 1-6 and at least 60% attend at least 3 sessions in months 7-12. An organization must continue to follow other CDC DPRP standards.	MDPP Preliminary recognition fully defined
Enrollment application and fee	• Established new MDPP supplier type • Re-enrollment requirement for current Medicare providers • High categorical risk screening • Collect coach NPI and identifying information	• New Medicare enrollment application specific to MDPP suppliers • Prospective MDPP suppliers must pay fee upon enrollment • Revalidate every 5 years, at moderate risk	Enrollment application clarified

Key Policy Changes in the CY18 Physician Fee Schedule

Supplier Standards and Compliance

New policy | Information added | Clarification

MDPP Policy	CY17	CY18	Change
Compliance with MDPP supplier standards	• Suppliers will be revoked if CDC recognition is lost	• Established MDPP supplier standards: o Excludes suppliers with for-cause Medicaid terminations o Prevents use of ineligible coaches o Ensures MDPP suppliers are operational o Enables appropriate beneficiary access o Ensure adequate beneficiary disclosures o Protect beneficiaries against complaints, o Supports compliance with the expanded model evaluation	Established and defined standards
Coach eligibility	• NPI requirement • Identifying information for vetting purposes	• Established eligibility criteria • Ineligible coaches would result in MDPP supplier enrollment denial or revocation, as appropriate. • In the case of administrative action based on an ineligible coach, MDPP suppliers have the opportunity to submit a corrective action plan to regain compliance	Use of coach information clarified

Key Policy Changes in the CY18 Physician Fee Schedule

Supplier Standards and Compliance

New policy | Information added | Clarification

MDPP Policy	CY17	CY18	Change
Crosswalk requirement	• Crosswalk policy described	• MDPP suppliers become eligible to submit crosswalk 6 months after furnishing MDPP services and must submit at the closest quarter • Must continue submitting quarterly thereafter.	Clarified frequency
Other record-keeping	• Suppliers are required to maintain and handle any beneficiary PII and PHI in compliance with HIPAA • Must maintain all documents for 7 years	• Clarified that beneficiary information related to MDPP, including PII and PHI, must be maintained and handled as appropriate under HIPAA, other applicable state and federal privacy laws, and CMS standards. • Upon first session, records must include: o Organizational and beneficiary information o Evidence of beneficiary eligibility • Upon every additional session, records must include: o Type of session o NPI of coach leading the session o Date and place of service o Beneficiaries' weights • Records must be kept for a 10-year period	Additional requirements added

Key Policy Changes in the CY18 Physician Fee Schedule

Beneficiary Engagement Incentives

New policy | Information added | Clarification

MDPP Policy	CY17	CY18	Change
Beneficiary engagement incentives	• No previous policy	• Incentives may be furnished by an MDPP supplier to a beneficiary to whom the supplier is furnishing MDPP services. The items or services furnished as incentives must meet the following conditions: o Furnished directly by an MDPP supplier or by an agent of the MDPP supplier, such as a coach, under the MDPP supplier's direction and control o Reasonably connected to the CDC-approved DPP curriculum o Preventive care item or service or an item or service that advances a clinical goal for an MDPP beneficiary by engaging him or her in better managing his or her health. ▪ *Clinical goals*: session attendance, weight loss, long-term dietary change, and adherence to long-term health behavior changes. o Not be tied to the receipt of services outside of the MDPP services. o Not be tied to the receipt of services from a particular provider, supplier, or coach. o Not be advertised or promoted; an MDPP beneficiary may be made aware during the engagement incentive period when they could reasonably benefit from the items/services o The cost must not be shifted to another federal health care program. o The cost must not be shifted to an MDPP beneficiary.	New policy

Key Policy Changes in the CY18 Physician Fee Schedule

Beneficiary Engagement Incentives

New policy | Information added | Clarification

MDPP Policy	CY17	CY18	Change
Beneficiary engagement incentives of technology	• No previous policy	Items or services involving technology furnished as incentives must meet the following conditions: • May not, in the aggregate, exceed $1,000 in retail value for any one MDPP beneficiary • Must be the minimum necessary to advance a clinical goal for an MDPP beneficiary. • Items exceeding $100 in retail value must: o Remain the property of the MDPP supplier; and o Be retrieved from the MDPP beneficiary at the end of the engagement incentive period. The MDPP supplier must document all retrieval attempts, including the ultimate date of retrieval. ▪ Documented diligent, good faith attempts to retrieve items of technology will be deemed to meet the retrieval requirement.	New policy

Key Policy Changes in the CY18 Physician Fee Schedule

Beneficiary Engagement Incentives

New policy | Information added | Clarification

MDPP Policy	CY17	CY18	Change
Beneficiary engagement incentives	• No previous policy	Suppliers must establish contemporaneous documentation of incentives that exceed $25 in retail value that includes at least: • The date the incentive was furnished. • The identity of the MDPP beneficiary to whom the item or service was furnished. • Documentation establishing that the item or service was furnished to the MDPP beneficiary during the engagement incentive period. • For items or services that are used on an ongoing basis during the engagement incentive period, including items involving technology exceeding $100 in retail value, documentation must establish that the MDPP beneficiary is in the engagement incentive period throughout while using the item or service • The agent of the supplier who furnished the item or service, if applicable. • A description of the item or service. • The retail value of the item or service. • The MDPP supplier must retain and provide access to the documentation.	New policy

Helpful Resources and Information

There are many resources available to support organizations interested in becoming an MDPP supplier.

About MDPP

- MDPP website
- CDC DPRP standards

Medicare Enrollment/NPIs

- Enrollment: PECOS
- NPIs: NPPES

Billing/Claims

- MAC jurisdictions

If you cannot find what you are looking for:

mdpp@cms.hhs.gov

Thank You – Please Evaluate Your Experience

Share your thoughts to help us improve – Evaluate today's event

Visit:

- MLN Events webpage for more information on our conference call and webcast presentations
- Medicare Learning Network homepage for other free educational materials for health care professionals.

Question and Answer Session

There will now be an opportunity for a live question and answer session.

If you have questions that are not addressed during today's call, please submit them to mdpp@cms.hhs.gov

The New Medicare Card Project: Indian Health Service Preparation

Presentation developed by Marni Land, CMS Federal Partners Liaison

Presented by Susy Postal DNP, RN-BC , Chief Health Informatics Officer

October 24, 2017

Disclaimer

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Important Note: This presentation was developed in collaboration with Centers for Medicare & Medicaid Services (CMS).

All slides are courtesy of Centers for Medicare & Medicaid Services (CMS) from CMS presentations about the New Medicare Card Project at the IHS Partnership Conference August 22, 2017 or from CMS Website https://www.cms.gov/Medicare/New-Medicare-Card/Open-Door-Forums.html (with the exception of slides 18 & 19).

Background

The Health Insurance Claim Number (HICN) is a Medicare beneficiary's identification number, used for processing claims and for determining eligibility for services across multiple entities (for example, Social Security Administration (SSA), Railroad Retirement Board (RRB), States, Medicare providers, and health plans).

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 mandates the removal of the Social Security Number (SSN)-based HICN from Medicare cards to address current risk of beneficiary medical identity theft.

The legislation requires that CMS mail out new Medicare cards with a new MBI (also referred to as Medicare Beneficiary Identifier – (MBI)) by April 2019.

The new MBIs won't change Medicare benefits. People with Medicare may start using their new Medicare cards as soon as they get them.

Operational Goals

Primary Operational Goal: To decrease Medicare Beneficiary vulnerability to identity theft by removing the SSN-based number from their Medicare identification cards and replace with a new unique MBI.

In achieving this goal, CMS seeks to:

- Minimize burdens for people with Medicare
- Minimize burdens for providers
- Minimize disruption to Medicare operations
- Provide a solution to our business partners that allows usage of HICN and/or new MBI for business critical data exchanges
- Manage the cost, scope, and schedule for the project

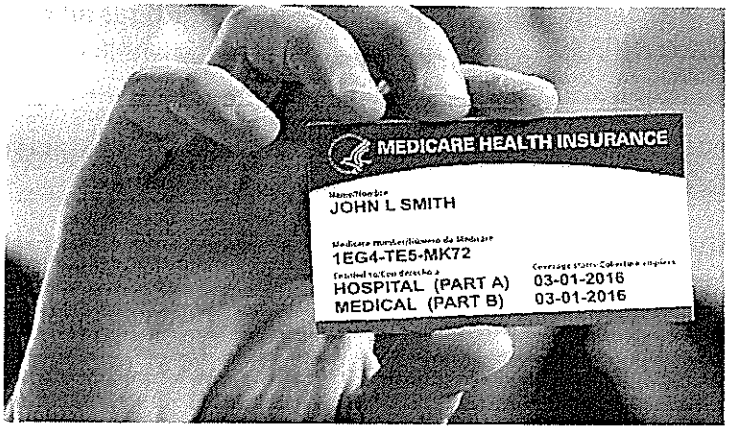
Operations: Three Steps to the New MBI

1. **Generate Medicare Beneficiary Identifiers (MBI) for all beneficiaries:** Includes existing (currently active, deceased, or archived) and people new to Medicare
2. **Issue new, redesigned Medicare cards:** New cards containing the new MBI to existing and new people with Medicare
3. **Modify systems and business processes:** Required updates to accommodate receipt, transmission, display, and processing of the new MBI

Comparison of Different Identifiers

KEY	Example
SSN	123-75-9812
CAN	123-75-9812-A
HICN	123-75-9812-A
RRB Post April 1964	A-123-75-9812 (prior years it is A-000000 – not based on SSN)
New MBI	1EG4-TE5-MK73

Example of New Card



New MBI Characteristics

The new MBI will have the following characteristics:

- The same number of characters as the current HICN (11), but will be visibly distinguishable from the HICN
- Contain uppercase alphabetic and numeric characters throughout the 11-digit identifier
- Occupy the same field as the HICN on transactions
- Be unique to each beneficiary (e.g., husband and wife will have their own MBI)
- Be easy to read and limit the possibility of letters being interpreted as numbers (e.g., alphabetic characters are upper case only and will exclude S, L, O, I, B, Z)
- Not contain any embedded intelligence or special characters
- Not contain inappropriate combinations of numbers or strings that may be offensive

CMS anticipates that the MBI will not be changed for an individual unless the MBI is compromised or other limited circumstances still undergoing review.

Using the New Medicare Number – During Transition

The transition period will run from April 2018 through December 31, 2019

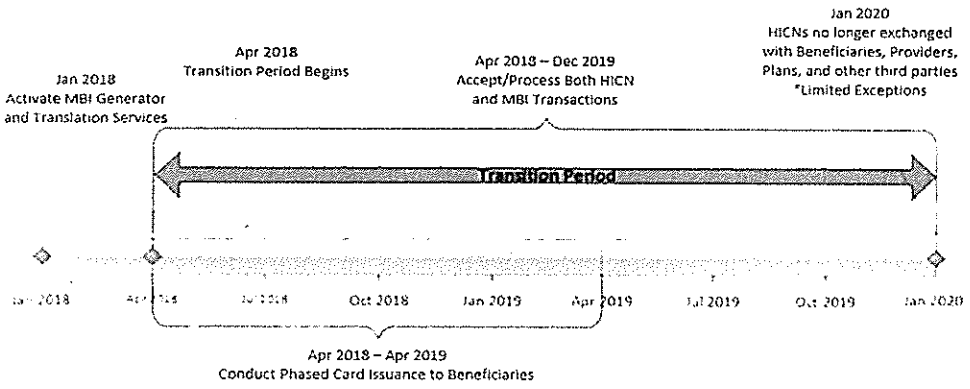
CMS will complete its system and process updates to be ready to accept and return the MBI on April 1, 2018

All stakeholders who submit or receive transactions containing the HICN must modify their processes and systems to be ready to submit or exchange the MBI by April 1, 2018. Stakeholders may submit either the MBI or HICN during the transition period

CMS will accept, use for processing, and return to stakeholders either the MBI or HICN, whichever is submitted on the claim, during the transition period

CMS will actively monitor use of HICNs and MBIs during the transition period to ensure that everyone is ready to use MBIs only by January 1, 2020

Operations: Transition Period



Operations: Transition Period

- In addition, CMS is working to develop capabilities where providers will be able to access a patient's new MBI through a secure look up tool at the point of service. Instructions for access will be distributed once the tool is released.
- CMS is making systems changes so that when a provider checks a patient's eligibility, the CMS HIPAA Eligibility Transaction System (HETS) will return a message on the response indicating that CMS mailed that particular patient's new Medicare card.

New Medicare Number Exceptions After the Transition Period

- Beneficiaries, providers, and plans will no longer use the HICN for internal and most external purposes.

However, once the transition period is over, you'll still be able to use the HICN in these situations:

Medicare plan exceptions:

- **Appeals** – You can use either the HICN or the MBI for claims appeals and related forms
- **Adjustments** – You can use the HICN indefinitely for some systems (Drug Data Processing, Risk Adjustment Processing, and Encounter Data) and for all records, not just adjustments
- **Reports** – We will use the HICN on these reports until further notice:
  - Incoming to us (quality reporting, Disproportionate Share Hospital data requests, etc.)
  - Outgoing from us (Provider Statistical & Reimbursement Report, Accountable Care Organization reports, etc.)

New MBI, New Card Issuance

- CMS will begin mailing new cards in April 2018 and will meet the congressional deadline for replacing all Medicare cards by April 2019.
- The gender and signature line will be removed from the new Medicare cards.
- The Railroad Retirement Board will issue their new cards to RRB beneficiaries.
- CMS will work with states that currently include the HICN on Medicaid cards to remove the Medicare ID or replace it with a new MBI.
- CMS will conduct intensive education and outreach to all people with Medicare, their families, caregivers, and advocates to help prepare for this change.

Outreach to CMS's Business Partners

CMS's Business partners are making system changes to support the new MBI.

How CMS is supporting this:

- Dedicated website at **https://www.cms.gov/newcard**
- Listening sessions
- Open door forums / calls
- Medicare Learning Network

Outreach to People with Medicare

September 2017: Setting Expectations

- General Messaging
  - Coming in 2018: New Medicare Cards!
  - Make sure your address on file with Medicare is correct or go to **ssa.gov/myaccount** to update
- Simple and responsive high-level messaging on **Medicare.gov** and 1-800-MEDICARE, Guard Your Card ad campaign
- Training to prepare partners ahead of broad-based outreach and education

September 2017: Card Awareness

- New Medicare card design is unveiled
- Beneficiaries get information about the new card in the 2018 "Medicare & You" Handbook: When you get your new card, safely and securely destroy the old Medicare card, keep the new number confidential
- Educational Materials and a more detailed training webinar will be available for Partners

Outreach to people with Medicare

October 2017 – December 2017: Open Enrollment

Continue "Card Awareness" outreach through messaging embedded in regular Open Enrollment events and earned media, steady drumbeat messaging via press, social media, speaking engagements, blogs, etc.

Card messaging should supplement, but not supersede "review and compare" actions for Open Enrollment

January 2018 – March 2018: New Cards are Coming!

Ramp up pre-mailing outreach and identify opportunities for sharing messages and materials with providers and people with Medicare

April 2018 – April 2019: Watch for your New Card

Cards are mailed!

Simple, direct instructions included with the new card mailing

Active, localized information sharing

Robust messaging on Medicare.gov, 1-800-MEDICARE, Medicare social media

Specialized communications for those with limited English proficiency and alternative format needs

Spotlight on Indian Health Service

Outreach and Education 2017

A few examples of outreach:

August

- IHS partnerships conference: August 22 & 23
- NIHB Tribal Technical Advisory Group (TTAG): August 23

September

- Outreach to IHS, Tribal and Urban Partners: September 2017
- Information System Advisory Council: September 19
- NIHB National Tribal Health Conference: September 25

October

- IHS National Business Office Committee Meeting: October 25

November

- TTAG: November 1

Slide prepared by IHS

IHS Preparation

- Office of Information Technology (OIT) addressing applications impacted
  - Resource Patient Management System (RPMS)
  - National Patient Information Reporting System (NPIRS)- National Data Warehouse
- OIT Project team formed
  - Meeting
  - Developed Project plan
  - Addressing communication
  - Addressing data flow of information
  - Addressing need for future patch to accept MBI number before April 1, 2018
  - Future initiatives proactive planning

Slide prepared by IHS

Impacted Applications

The current plan is to release the following updates in Feb 20, 2018 (FY18Q2 release):

- Third Party Billing (ABM) v2.6 p25
- Point of Sale (ABSP) v1.0 p50
- Contract Health Management System (ACHS) v3.1 p27
- Patient Registration (AG) v7.1 p13
- IHS Dictionaries (Patient) + IHS PCC Suite (AUPN) v99.1 p26
- Accounts Receivable (BAR) 1.8p27
- Practice Management Suite (BPRM) v3.0 p5

Note: Information is accurate pending there are no changes from CMS

What IHS Facilities Need to Know to Get Ready for the New MBI

1. **Get ready to use the new MBI format**
   - Ask your billing and office staff if your practice management system can accept the 11 digit alpha numeric MBI.
   - If you use vendors to bill Medicare, ask them about their new MBI practice management system changes and makes sure they are ready for the change.
   - Encourage practices and health care facilities to visit our website at **https://www.cms.gov/newcard.**
2. **Help your patients get ready**
   - If the address you have on file is different than the address you get in electronic eligibility transaction responses, encourage your patients to correct their address in Medicare's records at SSA using **ssa.gov/myaccount** (this may require coordination between your billing and office staff).
   - Remind people with Medicare that Medicare will never contact them and request personal information. They should protect their new MBI like a credit card and only share it those they trust.

CMS Resources

Additional technical information, detailed updates, training opportunities, and materials to share available at: https://www.cms.gov/newcard

CMS Open Forum Resource Materials at https://www.cms.gov/Medicare/New-Medicare-Card/Open-Door-Forums.html

CMS welcomes comments and questions! Please submit any additional comments or questions to the New Medicare Card team mailbox at: NewMedicareCardSSNRemoval@cms.hhs.gov

Questions

susy.postal@IHS.gov

IHS Office of Information Technology Update

October 2017

CAPT Mark Rives, DSc, CHCIO
Chief Information Officer

Indian Health Service
Office of Information Technology

Impact and guidance for IHS Health IT

- Information Systems Advisory Committee is heavily involved.
  - Working to increase communication
  - Updating ISAC Charter to be a broader, larger, and more inclusive group.
- ISAC generated recommendations for IHS
- Recap of current future for RPMS

Update from ISAC Meeting, September 19-20, 2017 - Recommendations

- The ISAC recommends the IHS Chief Information Officer (CIO) provide a standing report on the monthly All Tribes conference call for transparency in Information Technology (IT)/Health IT (HIT) programs, services, functions, and activities.
- The ISAC advocates for continued collaboration between IHS and the Veterans Affairs (VA) and the Department of Health and Human Services (HHS) on HIT modernization efforts, acknowledging the initiative is in early discovery right now.
- The ISAC recommends the IHS go forward with a budget request for HIT modernization as soon as feasibly possible.
- The ISAC recommends that the IHS and OIT strategic plans include reference to the OIT Human Capital Management Plan.

Indian Health Service
Office of Information Technology

Update from ISAC Meeting, September 19-20, 2017 - Actions

- The ISAC continues to work on updates to the ISAC Charter.
- The ISAC continues to work on updates to the OIT Human Capital Management Plan to place more emphasis on Informatics positions and updating IT position descriptions.
- The ISAC will continue work on revising the FY 2018-2019 IT Priorities to add HIT modernization, infrastructure, a phased approach for modernization, and process improvement.
  - The IT priorities will be shared with IHS management, Areas, Tribes, and other stakeholder groups.

Veteran Affairs Migration to Cerner and Impact on the Resource and Patient Management System (RPMS) Updates

- Held four listening sessions and gathered comments.
  - Plus, received 22 sets of comments via email and mail
- Engagement at all levels within HHS.
  - VA, HHS OCTO, HHS ONC, USCG, DoD MHS, tribal health programs, TSGAC, DSTAC, HHS ASFR, and numerous industry analysts.
- Developed Request for Information (RFI)
  - Goal: Ask industry what they would propose as a solution
  - Anticipated outcome: Good understanding of HIT as a foundation for a larger strategy
  - Status - Undergoing revision

Indian Health Service
Office of Information Technology

Future plans for RPMS

- IHS is taking an advanced posture to plan for Health Information Technology Systems modernization.
- RPMS and VISTA will continue to be supported in the near term.
- RPMS development to date has always been supported by and dependent upon the VISTA platform.
- IHS has unique needs for patient care, population health management, and referral management and many of those are different from the VA and DoD.
- RPMS Data must be available and accessible for delivery of care, reporting, etc.

Future plans for RPMS

- Must continue to develop interoperability functionality to ensure access to patient data.
- Continuing development for
  - EPCS
  - New Medicare Cards (NMC)
    - 8 RPMS applications that will require modifications
    - Expected to release in Feb 20, 2018 (FY18Q2 release)
    - Other minor application updates for reporting will occur throughout 2018 to address reports.
  - Routine Updates
    - Update schedule to be published on IHS.Gov
- All options are still in consideration.
  - Working towards a broader HIT Modernization initiative

Indian Health Service
Office of Information Technology

Questions?

Mark.Rives@ihs.gov
301-443-2019

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

NOV 13 2017

Dear Tribal Leader:

I am writing to share an update on Indian Health Service (IHS) actions relating to the Indian Health Care Improvement Fund (IHCIF), which is authorized by the Indian Health Care Improvement Act (25 U.S.C. § 1621). This includes our immediate plans to establish a new IHS/Tribal IHCIF workgroup to review the existing IHCIF formula and recommend changes for future use. The IHCIF formula was established to determine the overall level of need funded for health care facilities operated by the IHS, Tribes, or Tribal organizations.

With the beginning of the fiscal year (FY) and action by Congress on the FY 2018 budget, a possibility of receiving a funding increase for the IHCIF in FY 2018 makes our actions particularly timely.

After reauthorization of the Indian Health Care Improvement Act in 2010, the IHS initiated Tribal Consultation on the IHCIF and its formula on December 30, 2010. The IHS shared its decisions made after Tribal Consultation in a subsequent letter to Tribal Leaders dated November 25, 2011. The letters are available on the IHS website at: https://www.ihs.gov/newsroom/triballeaderletters/.

A review of the IHCIF formula at this time acknowledges the considerable changes in the health care environment since the 2010 Tribal Consultation on IHCIF. The IHS is currently updating the data used in the existing IHCIF formula by collecting and analyzing the FY 2016 user population numbers, recurring base budgets at IHS and Tribal sites, geographic cost differentials, and health status data. We anticipate having this data update completed in January 2018, at which time we plan to share our findings in a report to the IHS/Tribal IHCIF workgroup to assist them in conducting their work.

In the interim between now and January, we are looking to establish a new IHS/Tribal IHCIF workgroup. With regard to the IHCIF formula, the workgroup will assess a number of factors, which include, but are not limited to, the impact of past allocations in addressing funding inequities and the effects of the current health care environment on the formula. The IHS/Tribal IHCIF workgroup will also make recommendations regarding the IHCIF formula that will be sent out for Tribal Consultation prior to the IHS issuing a decision on any changes.

Throughout this month, IHS Area Directors will reach out to Tribal Leaders to identify individuals interested in serving as a primary or alternate Tribal representative to the workgroup. As with all workgroups chartered by the IHS, this body will operate under the intergovernmental exemption to the Federal Advisory Committee Act as authorized by the Unfunded Mandates Reform Act (2 U.S.C. § 1534(b)). An elected Tribal official (or a designated employee with authority to act on the behalf of a Tribal official), may contact your local Area Director for consideration (in writing), by no later than **Friday, December 1**.

We would also welcome your feedback and recommendations on topics for IHS/Tribal IHCIF workgroup consideration.

- Please send your comments electronically through December 15 to the following e-mail address: **IHCIFcomments@ihs.gov**.

We look forward to engaging with you in this important work. Thank you for your support. If you have any questions, please contact Ms. Ann Church, Acting Director, Office of Finance and Accounting, IHS, by telephone at (301) 443-1270 or by e-mail at ann.church@ihs.gov.

Sincerely,

/Michael D. Weahkee/

RADM Michael D. Weahkee, MBA, MHSA
Assistant Surgeon General, U.S. Public Health Service
Acting Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

SMD: 18-002

RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries

January 11, 2018

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) is announcing a new policy designed to assist states in their efforts to improve Medicaid enrollee health and well-being through incentivizing work and community engagement among non-elderly, non-pregnant adult Medicaid beneficiaries who are eligible for Medicaid on a basis other than disability.[1] Subject to the full federal review process, CMS will support state efforts to test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility or coverage for certain adult Medicaid beneficiaries in demonstration projects authorized under section 1115 of the Social Security Act (the Act). Such programs should be designed to promote better mental, physical, and emotional health in furtherance of Medicaid program objectives. Such programs may also, separately, be designed to help individuals and families rise out of poverty and attain independence, also in furtherance of Medicaid program objectives. [2]

This guidance describes considerations for states that may be interested in pursuing demonstration projects under section 1115(a) of the Act that have the goal of creating incentives for Medicaid beneficiaries to participate in work and community engagement activities. It addresses the application of CMS' monitoring and evaluation protocols for this type of demonstration and identifies other programmatic and policy considerations for states, to help them design programs that meet the objectives of the Medicaid program, consistent with federal statutory requirements.

[1] States will have the flexibility to identify activities, other than employment, which promote health and wellness, and which will meet the states' requirements for continued Medicaid eligibility. These activities include, but are not limited to, community service, caregiving, education, job training, and substance use disorder treatment.
[2] Section 1901 of the Social Security Act authorizes appropriations to support State Medicaid programs: "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care[.]"

Health Benefits of Community Engagement, including Work and Work Promotion

While high-quality health care is important for an individual's health and well-being, there are many other determinants of health. It is widely recognized that education, for example, can lead to improved health by increasing health knowledge and healthy behaviors.[3] CMS recognizes that a broad range of social, economic, and behavioral factors can have a major impact on an individual's health and wellness, and a growing body of evidence suggests that targeting certain health determinants, including productive work and community engagement, may improve health outcomes. For example, higher earnings are positively correlated with longer lifespan.[4] One comprehensive review of existing studies found strong evidence that unemployment is generally harmful to health, including higher mortality; poorer general health; poorer mental health; and higher medical consultation and hospital admission rates.[5] Another academic analysis found strong evidence for a protective effect of employment on depression and general mental health.[6] A 2013 Gallup poll found that unemployed Americans are more than twice as likely as those with full-time jobs to say they currently have or are being treated for depression.[7] Other community engagement activities such as volunteering are also associated with improved health outcomes[8,9], and it can lead to paid employment.

CMS, in accordance with principles supported by the Medicaid statute, has long assisted state efforts to promote work and community engagement and provide incentives to disabled beneficiaries to increase their sense of purpose, build a healthy lifestyle, and further the positive physical and mental health benefits associated with work. CMS supports state efforts to enable eligible individuals to gain and maintain employment. Optional Medicaid programs such as the Medicaid Buy-In, for example, allow workers with disabilities to have higher earnings and maintain their Medicaid coverage. For beneficiaries who are able to work but have been unable to find employment, some states encourage employment through concurrent enrollment in state-sponsored job training and work referral, either automatically or at the option of the Medicaid beneficiary. A number of states have also initiated programs to connect non-disabled Medicaid beneficiaries to existing state workforce programs.

States also provide a range of employment supports to individuals receiving home and community based services under section 1915(c) waivers or section 1915(i) state plan services. These include habilitation services designed to "assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in

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[3] Bartley, M and Plewis, I. (2002) Accumulated labor market disadvantage and limiting long term illness. International Journal of Epidemiology 31:336-41.

[4] Chetty R, Stepner M, Abraham S, et al. The association between income and life expectancy in the United States, 2001-2014. JAMA. 2016; 315(16):1750-1766.

[5] Waddell, G. and Burton, AK. Is Work Good For Your Health And Well-Being? (2006) EurErg Centre for Health and Social Care Research, University of Huddersfield, UK

[6] Van der Noordt, M, Jzelenberg, H, Droomers, M, and Proper,K. Health effects of employment: a systemic review of prospective studies. BMJournals. Occupational and Environmental Medicine. 2014: 71 (10).

[7] Crabtree, S. In U.S., Depression Rates Higher for Long-Term Unemployed. (2014). Gallup. http://news.gallup.com/poll/171044/depression-rates-higher-among-long-term-unemployed.aspx

[8] United Health Group. Doing good is good for you. 2013 Health and Volunteering Study.

[9] Jenkins, C. Dickens, A. Jones, K. Thompson-Coon, J. Taylor, R. and Rogers, M. Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteers BMC Public Health 2013. 13 (773)

home and community based settings."[10] These activities have been historically focused on services and programs for individuals with disabilities and receipt of these supports is not a condition of eligibility or coverage.
The successes of all these programs suggest that a spectrum of additional work incentives, including those discussed in this letter, could yield similar outcomes while promoting these same objectives.

New Opportunity for Promoting Work and Other Community Engagement for Non-Elderly, Non-Pregnant Adult Beneficiaries Who Are Eligible for Medicaid on a Basis Other than Disability

On March 14, 2017, the Department of Health and Human Services (HHS) and CMS issued a letter to the nation's governors affirming the continued commitment to partner with states in the administration of the Medicaid program. In the letter, we noted that CMS will empower states to develop innovative proposals to improve their Medicaid programs. Demonstration projects under section 1115 of the Act give states more freedom to test and evaluate approaches to improving quality, accessibility, and health outcomes in the most cost-effective manner. CMS is committed to allowing states to test their approaches, provided that the Secretary determines that the demonstrations are likely to assist in promoting the objectives of the Medicaid program.

Some states are interested in pursuing demonstration projects to test the hypothesis that requiring work or community engagement as a condition of eligibility, as a condition of coverage, as a condition of receiving additional or enhanced benefits, or as a condition of paying reduced premiums or cost sharing, will result in more beneficiaries being employed or engaging in other productive community engagement, thus producing improved health and well-being. To determine whether this approach works as expected, states will need to link these community engagement requirements to those outcomes and ultimately assess the effectiveness of the demonstration in furthering the health and wellness objectives of the Medicaid program.[11]

Today, CMS is committing to support state demonstrations that require eligible adult beneficiaries to engage in work or community engagement activities (e.g., skills training, education, job search, caregiving, volunteer service) in order to determine whether those requirements assist beneficiaries in obtaining sustainable employment or other productive community engagement and whether sustained employment or other productive community engagement leads to improved health outcomes. This is a shift from prior agency policy regarding work and other community engagement as a condition of Medicaid eligibility or coverage,[12] but it is anchored in historic CMS principles that emphasize work to promote health and well-being.

We look forward to working with states interested in testing innovative approaches to promote work and other community engagement, including approaches that make participation a condition of eligibility or coverage, among working-age, non-pregnant adult Medicaid beneficiaries who qualify for Medicaid on a basis other than a disability. Consistent with section

[10] Social Security Act, section 1915(c)(5)(A)
[11] https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html
[12] https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=29927

1115(a) of the Act, demonstration applications will be reviewed on a case-by-case basis to determine whether the proposed approach is likely to promote the objectives of Medicaid. CMS is also committed to ensuring state accountability for the health outcomes produced by the program, and demonstration projects approved consistent with this guidance will be required to conduct outcomes-based evaluations, based on evaluation designs subject to CMS approval. We note that approved demonstration projects that promote positive health outcomes may also achieve the additional goal of the Medicaid program to promote independence.

State Flexibility in Program Design

In its work with states, CMS has identified a number of issues for states to consider as they develop programs to promote work and other forms of community engagement among Medicaid beneficiaries. Each state is different, and states are in the best position to determine which approaches are most likely to succeed, based on their specific populations and resources. In drafting demonstration project applications, states should articulate the reasoning behind their proposal. While CMS will evaluate each demonstration project application on its own merits, we believe the following considerations will facilitate states' work to develop proposals and allow them to focus their resources on permissible areas of innovation while allowing CMS to maintain its oversight and fiduciary responsibilities.

Alignment with Other Programs

Many states already have systems in place for implementing employment and community engagement programs. For instance, beginning in 1996, welfare reform provided states with more flexibility to manage their state welfare programs under the Temporary Assistance for Needy Families (TANF) program consistent with the four statutory purposes of TANF. Supplemental Nutrition Assistance Program (SNAP) rules require all recipients to meet work requirements unless they are exempt. Exemptions may include, but are not limited to age, disability, responsibility for a dependent, participation in a drug addiction or alcohol treatment and rehabilitation program, or another state-specified reason.

CMS supports states' efforts to align SNAP or TANF work or work-related requirements with the Medicaid program as part of a demonstration authorized under section 1115 of the Act, where such alignment is appropriate and consistent with the ultimate objective of improving health and well-being for Medicaid beneficiaries. Based on states' experiences with their TANF or SNAP employment programs, they may wish to consider aligning Medicaid requirements with certain aspects of the TANF or SNAP programs, such as:

- Excepted populations (e.g., pregnant women, primary caregivers of dependents, individuals with disabilities or health-related barriers to employment, individuals participating in tribal work programs, victims of domestic violence, other populations with extenuating circumstances, full time students);
- Protections and supports for individuals with disabilities and others who may be unable to meet the requirements;
- Allowable activities (e.g., subsidized and unsubsidized employment, educational and vocational programs, job search and job readiness, job training, community service, caregiving, and other allowable activities under TANF or SNAP) and required hours of participation (e.g., hours/week, including hours completed under TANF or SNAP);

- Changes to requirements or allowable activities due to economic or environmental factors (e.g., unemployment rate in affected areas);
- Enrollee reporting requirements (e.g., frequency and method for reporting work activities); or
- The availability of work support programs (e.g., transportation or child care) for individuals subject to work and community engagement requirements.

CMS will consider the extent to which proposed Medicaid community engagement or work requirements align with features of the TANF or SNAP programs and whether that alignment is consistent with Medicaid objectives. For example, aligning certain requirements across these programs would streamline eligibility and could reduce the burden on both states and beneficiaries and maximize opportunities for beneficiaries to meet the requirements. Many states have already developed or are developing integrated eligibility systems, and have taken advantage of the waiver of OMB Circular A-87 cost allocation rules (available through CY 2018) to support the integration of eligibility systems between health and human services programs. These integrated systems may be poised to allow for alignment of eligibility requirements for a segment of the Medicaid population, and to facilitate implementation of streamlined application and verification processes. Where additional information technology systems enhancements are required to support Medicaid demonstration activities, costs will be expected to be reasonable and comply with Medicaid statute and regulations. Federal Medicaid funding will be limited to allowable activities directly linked to Medicaid beneficiaries.

Individuals enrolled in and compliant with a TANF or SNAP work requirement, as well as individuals exempt from a TANF or SNAP work requirement, must automatically be considered to be complying with the Medicaid work requirements. To the degree that specific good cause exemptions exist in a state TANF or SNAP program, the state should make a reasonable effort to incorporate similar exemptions within a framework for a Medicaid community engagement and work requirement. States should also describe how they will communicate to beneficiaries any differences in program requirements that individuals will need to meet in the event they transition off of SNAP or TANF but remain subject to a Medicaid community engagement or work requirement.

Populations Subject to Work Promotion/Community Engagement Requirements
States should clearly identify the eligibility groups subject to the work and community engagement requirements and included in the demonstration. States may consider submitting for CMS consideration a proposal to tailor such requirements to adults within specific eligibility groups or sub-populations within the eligibility group. CMS recognizes that adults who are eligible for Medicaid on a basis other than disability (i.e. classified for Medicaid purposes as "non-disabled") will be subject to the work/community engagement requirements as described in this guidance. These individuals, however, may have an illness or disability as defined by other federal statutes that may interfere with their ability to meet the requirements. States must comply with federal civil rights laws, ensure that individuals with disabilities are not denied Medicaid for inability to meet these requirements, and have mechanisms in place to ensure that reasonable modifications are provided to people who need them. States must also create exemptions for individuals determined by the state to be medically frail and should also exempt

from the requirements any individuals with acute medical conditions validated by a medical professional that would prevent them from complying with the requirements.

States are required, in the design and administration of Medicaid demonstration projects, to comply with all applicable federal civil rights laws, including the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act, the Age Discrimination Act, and other applicable statutes. The federal disability rights laws are of particular importance, given the broad scope of protection under these laws and the fact that disabilities can affect an individual's ability to participate in work and community engagement activities. States may not impose such requirements on individuals classified as "disabled" for Medicaid eligibility purposes.

CMS recognizes that individuals who are eligible for Medicaid on a basis other than disability (and are therefore classified for Medicaid purposes as "non-disabled") may have a disability under the definitions of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, or section 1557 of the Affordable Care Act. States should include, in their proposals, information regarding their plans for compliance with these requirements, including provision of reasonable modifications in work or community engagement requirements. The reasonable modifications must include exemptions from participation where an individual is unable to participate for disability-related reasons, modification in the number of hours of participation required where an individual is unable to participate for the required number of hours, and provision of support services necessary to participate, where participation is possible with supports. States may not receive Federal Medicaid match for such supportive services for individuals enrolled in these Medicaid demonstrations. In addition, States should evaluate individuals' ability to participate and the types of reasonable modifications and supports needed. CMS, in consultation and coordination with the HHS Office for Civil Rights, is available to assist states in designing projects that comply with the civil rights laws.

CMS also recognizes that many states currently face an epidemic of opioid addiction, which has been declared a national public health emergency by the Secretary. States will therefore be required to take certain steps to ensure that eligible individuals with opioid addiction and other substance use disorders (who may not be defined as disabled for Medicaid purposes but may be protected by disability laws) have access to appropriate Medicaid coverage and treatment services. States must make reasonable modifications for these individuals, consistent with states' obligations under civil rights laws described above, and specifically identify such modifications in their demonstration applications. Such modifications may include counting time spent in medical treatment towards an individual's work/community engagement requirements, or exempting individuals participating in intensive medical treatment (e.g. inpatient treatment or intensive outpatient treatment) for substance use disorder from the work/community engagements requirements. CMS will also consider other reasonable modifications that states may design and propose in furtherance of their obligations under disability laws. Finally, states should identify, in their demonstrations, other strategies to support such individuals in meeting the requirements, and in obtaining access to treatment when they are ready.

Range of community engagement activities
We encourage states to consider a range of activities that could satisfy work and community-engagement requirements. Career planning, job training, referral, and job support services offered should reflect each person's employability and potential contributions to the labor market. As many Medicaid beneficiaries live in areas of high unemployment, or are engaged as caregivers for young children or elderly family members, states should consider a variety of activities to meet the requirements for work and community engagement, including volunteer and tribal employment programs, in addition to the activities identified to meet the requirements under SNAP or TANF.

Beneficiary supports
States will be required to describe strategies to assist beneficiaries in meeting work and community engagement requirements and to link individuals to additional resources for job training or other employment services, child care assistance, transportation, or other work supports to help beneficiaries prepare for work or increase their earnings. However, this demonstration opportunity will not provide states with the authority to use Medicaid funding to finance these services for individuals. Nothing in this letter changes the types of services eligible for Federal match; states may only receive Federal Medicaid match for allowable services in accordance with statute.

CMS expects that states will design their programs consistent with statutory and regulatory procedural requirements, including through provisions to ensure Medicaid beneficiaries' due process rights are protected. States are encouraged to include procedures that allow for an assessment of individuals' disabilities, medical diagnosis, and other barriers to employment and self-sufficiency in order to identify appropriate work and community engagement activities and services, supports, and any reasonable modifications necessary for those individuals to participate in work and community engagement activities and attain long-term employment and self-sufficiency.

Attention to market forces and structural barriers
CMS recognizes that States will need flexibility to respond to the local employment market by phasing in and/or suspending program features, as necessary. A state may need time to establish supports for beneficiaries in regions with limited employment opportunities, for example, or localities facing particular economic stress or lack of viable transportation. The state should describe its plan for assessing and addressing these and related issues in its demonstration application. In addition, the state should consider whether other circumstances may arise that could prevent individuals from complying with a community engagement and work requirement. States should detail how they would support individuals in meeting program requirements during those periods, which may include incorporation of good cause exemptions similar to those used in SNAP and TANF.

Transparency
CMS remains committed to supporting reasonable public input processes that provide states an opportunity to consider the views of Medicaid beneficiaries, applicants, and other stakeholders and gather input that may support continuous improvement of the program. Demonstration projects under section 1115 of the Act intended to promote work and other community

engagement are subject to all relevant public notice and transparency requirements, including those described in 42 C.F.R. Part 431, subpart G. Where applicable, states will also be required to comply with tribal consultation requirements and describe how they are responding to comments received through the tribal consultation process.

Budget Neutrality

To promote long-term sustainability of the Medicaid program for states and the federal government, we will continue to require states to demonstrate that projects authorized under section 1115 of the Act are budget neutral. CMS will work with states to identify those components of the demonstration that will be included in budget neutrality calculations and provide technical assistance as needed in determining budget neutrality. States will not be permitted to accrue savings from a reduction in enrollment that may occur as a result of using this section 1115 authority. States will be required to document the financial performance of the demonstration and track expenditures to ensure the demonstration does not exceed established budget neutrality limits. States will provide updated budget neutrality workbooks with every required monitoring report, and the specific reporting requirements for monitoring budget neutrality will be set forth in the demonstration special terms and conditions (STCs).

Monitoring and Evaluation

CMS remains committed to ensuring state accountability for the health and well-being of Medicaid enrollees. Monitoring and evaluation are important for understanding these outcomes and the impacts of the state innovations being demonstrated. We are undertaking efforts to help states monitor the elements of their programs, while giving them the flexibility to adapt to changing conditions in their states. States will be required to develop monitoring plans and submit regular monitoring reports describing progress made in implementing their requirements for work and other community engagement activities. We will also undertake our own monitoring and technical assistance efforts through regular communications with states and will review written reports from states on a quarterly basis.

Monitoring

States approved to implement work and other community engagement requirements for Medicaid beneficiaries will submit to CMS a draft of proposed metrics for quarterly and annual monitoring reports, and CMS will work with the state to jointly identify metrics for these reports. Metrics will reflect the major elements of the demonstration, including but not limited to data that applies to the work and other community engagement initiatives. CMS will combine these programmatic metrics with general metrics aimed at monitoring beneficiary enrollment and termination for failure to meet program requirements, access to services for both beneficiaries and individuals terminated for failure to meet the requirements, and the overall functioning of the demonstration.

States will be subject to other monitoring and reporting requirements, consistent with regulations in 42 C.F.R. § 431.420 and § 431.428. State reports will be required to provide sufficient information to document key challenges, underlying causes of those challenges, and strategies for addressing those challenges, as well as key achievements and the conditions and efforts that lead to those successes. Specific details related to monitoring and reporting for each state's demonstration will be discussed with states and described in the demonstration STCs.

Evaluation

States will also be required to evaluate health and other outcomes of individuals that have been enrolled in and subject to the provisions of the demonstration, and will be required to conduct robust, independent program evaluations. Evaluations must be designed to determine whether the demonstration is meeting its objectives, as well as the impact of the demonstration on Medicaid beneficiaries and on individuals who experience a lapse in eligibility or coverage for failure to meet the program requirements or because they have gained employer-sponsored insurance. A draft evaluation design should be submitted with the application, and the final evaluation design will be submitted for CMS approval no more than 180 days after demonstration approval.

Evaluation designs will be expected to include a discussion of the evaluation questions and hypotheses that the state intends to test, including the hypothesis that requiring certain Medicaid beneficiaries to work or participate in other community engagement activities increases the likelihood that those Medicaid beneficiaries will achieve improved health, well-being, and (if the State designs its program to pursue this additional goal) independence as contemplated in the objectives of Medicaid. Evaluation designs will be expected to include analysis of how this requirement affects beneficiaries' ability to obtain sustainable employment, the extent to which individuals who transition from Medicaid obtain employer sponsored or other health insurance coverage, and how such transitions affect health and well-being.

The hypothesis testing should include, where possible, assessment of both process and outcome measures, and proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. The evaluation design should use both quantitative and qualitative methods, and will need to identify comparison groups and appropriate statistical analyses to evaluate the impact of the demonstration. Evaluation designs should also include descriptions of multiple data sources to be used, including but not limited to multiple stakeholder perspectives, surveys of beneficiaries (both enrolled and those no longer enrolled as a result of the implementation of program requirements), claims data, and survey data (such as Consumer Assessment of Healthcare Providers and Systems (CAHPS)).

To the extent permitted by federal and state privacy laws, states should be prepared to track and evaluate health and community engagement outcomes both for those who remain enrolled in Medicaid, and those who are subject to the requirements but lose or experience a lapse in eligibility or coverage during the course of the demonstration, and provide details on how they will track these outcomes in their demonstration evaluation designs. Ongoing monitoring and evaluation efforts will help CMS learn more about the challenges and successes states experience while implementing innovative policies to increase productive community engagement, which we will then be able to share with other states looking to achieve similar goals related to their residents' well-being.

We hope this information is helpful, and we look forward to continuing to work with states to implement innovative solutions to improve their Medicaid programs. Questions and comments regarding this policy may be directed to Judith Cash, Acting Director, State Demonstrations Group, CMCS, at 410-786-9686.

Sincerely,

/s/

Brian Neale
Director

Cc:
National Association of Medicaid Directors
National Academy for State Health Policy
National Governors Association
American Public Human Services Association
Association of State and Territorial Health Officials
Council of State Governments
National Conference of State Legislatures
Academy Health
National Association of State Alcohol and Drug Abuse Directors

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

July 7, 2017

Dear Tribal Leader:

On September 28, 2016, the Department of Veterans Affairs (VA) facilitated tribal consultation in Washington, D.C., with a comment period through November 30, 2016, on VA's community care consolidation effort. VA received many comments from tribes, and as a result, VA is renewing existing reimbursement agreements through June 30, 2019. As reflected in the renewal amendment language, VA and Tribal Health Programs (THPs) are agreeing to work together to ensure VA's community care program allows for continuation and growth of the unique relationship that THPs have with VA and the Veterans they serve.

I would like to invite Alaska tribal leaders (or their representative designees) along with Alaska THPs' leadership to a roundtable discussion on August 2, 2017, from 9:00 am to 11:00 am at the Alaska Native Health Board Mega Meeting, Alaska Native Tribal Health Consortium Conference Room 1 and 2, 4000 Ambassador Drive Anchorage, AK 99508, to discuss how VA and THPs can work together to update the reimbursement agreements in advance of the June 30, 2019 expiration date. VA suggests the following topics as points of discussion:

- Do Alaska THPs have any suggestions on how VA can move from the all-inclusive rate payment methodology to more recent industry standard payment methodology (e.g., value based rate structure)?
- Do Alaska THPs have quality related standards in place that can be shared with VA and utilized as the basis for developing a value based rate structure?
- Do Alaska THPs have any suggestions related to care coordination between VA and Alaska THPs?
- Do Alaska THPs have any established care coordination procedures that may be utilized as basis for enhancing care coordination between VA and Alaska THPs?

If you or a representative plans to attend the roundtable discussion, please RSVP to tribalgovernmentconsultation@va.gov.

For additional information regarding this effort please contact Majed Ibrahim at majed.ibrahim@va.gov.

I look forward to meeting with you and I appreciate your support as we move forward together to enhance and improve the experience for our Veterans.

Sincerely,

Baligh Yehia

Baligh Yehia, M.D., M.P.P., M.Sc
Deputy Under Secretary for Health
for Community Care

United States Government Accountability Office

GAO

Report to Congressional Requesters

April 2013

VA AND IHS

Further Action Needed to Collaborate on Providing Health Care to Native American Veterans

GAO-13-354

April 2013

VA AND IHS

Further Action Needed to Collaborate on Providing Health Care to Native American Veterans

GAO Accountability * Integrity * Reliability

Highlights

Highlights of GAO-13-354, a report to congressional requesters

Why GAO Did This Study

Native Americans who have served in the military may be eligible for health care services from both VA and IHS. To enhance health care access and the quality of care provided to Native American veterans, in 2010, these two agencies renewed and revised an MOU designed to improve their coordination and resource sharing related to serving these veterans. GAO was asked to examine how the agencies have implemented the MOU.

This report examines: (1) the extent to which the agencies have established mechanisms through which the MOU can be implemented and monitored; and (2) key challenges the agencies face in implementing the MOU and the progress made in overcoming them. To conduct this work, GAO interviewed VA and IHS officials and reviewed agency documents and reports. GAO also obtained perspectives of tribal communities through attendance at two tribal conferences; interviews with tribal leaders and other tribal members, including veterans; and interviews with other stakeholders, such as health policy experts and consultants.

What GAO Recommends

GAO recommends that the agencies take steps to improve the performance metrics used to assess MOU implementation and to develop better processes to consult with tribes. VA and the Department of Health and Human Services agreed with these recommendations.

View GAO-13-354. For more information, contact Randall Williamson at (202) 512-7114 or williamsonr@gao.gov.

What GAO Found

The Department of Veterans Affairs (VA) and the Indian Health Service (IHS) have developed mechanisms to implement and monitor their memorandum of understanding (MOU); however, the performance metrics developed to assess its implementation do not adequately measure progress made toward its goals. VA and IHS have defined common goals for implementing the MOU and developed strategies to achieve them. They have also created two mechanisms to implement the MOU—12 workgroups with members from both agencies to address the goals of the MOU, and a Joint Implementation Task Force, comprised of VA and IHS officials, to oversee the MOU's implementation. These steps are consistent with practices that GAO has found enhance and sustain agency collaboration. The agencies have also developed three metrics aimed at measuring progress toward the MOU's goals. However, two of the three metrics are inadequate because their connection to any specific MOU goal is not clear and, while they include quantitative measures that tally the number of programs and activities increased or enhanced as a result of the MOU, they lack qualitative measures that would allow the agencies to assess the degree to which the desired results are achieved. The weaknesses in these metrics could limit the ability of VA and IHS managers to gauge progress and make decisions about whether to expand or modify their programs and activities.

VA and IHS face unique challenges associated with consulting with a large number of diverse, sovereign tribes to implement the MOU, and lack fully effective processes to overcome these complexities. VA and IHS officials told us the large number (566 federally recognized tribes) and differing customs and policy-making structures present logistical challenges in widespread implementation of the MOU within tribal communities. They also told us that tribal sovereignty—tribes' inherent right to govern and protect the health, safety, and welfare of tribal members—adds further complexity because tribes may choose whether or not to participate in MOU-related activities. Consistent with internal controls, VA and IHS have processes in place to consult with tribes on MOU-related activities through written correspondence and in-person meetings. However, according to tribal stakeholders GAO spoke with, these processes are often ineffective and have not always met the needs of the tribes, and the agencies have acknowledged that effective consultation has been challenging. For example, one tribal community expressed concern that agency correspondence is not always timely because it is sent to tribal leaders who are sometimes not the tribal members designated to take action on health care matters. Similarly, some tribal stakeholders told GAO that the agencies have not been responsive to tribal input and that sometimes they simply inform tribes of steps they have taken without consulting them. VA and IHS have taken steps to improve consultation with tribes. For example, VA has established an Office of Tribal Government Relations, through which it is developing relationships with tribal leaders and other tribal stakeholders. Additionally, in Alaska, VA has been consulting with a tribal health organization for insight on reaching tribes. However, given the concerns raised by the tribal stakeholders GAO spoke with, further efforts may be needed to enhance tribal consultation to implement and achieve the goals of the MOU.

Contents

Abbreviations

CMOP	Consolidated Mail Outpatient Pharmacy
EHR	electronic health record
HBPC	home-based primary care
IHS	Indian Health Service
MOU	memorandum of understanding
NCAI	National Congress of American Indians
OTGR	Office of Tribal Government Relations
VA	Department of Veterans Affairs

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

April 26, 2013

Congressional Requesters:

Native Americans (American Indians and Alaska Natives) have historically served in the military at a higher rate than any other ethnic group, according to the Department of Defense. Once separated from the military, some Native American veterans are eligible to receive health care services from both the Department of Veterans Affairs (VA) and the Indian Health Service (IHS), an agency within the Department of Health and Human Services.[1]

To improve the health status of Native American veterans through coordination, collaboration, and sharing of resources among VA, IHS, and tribes, in 2010, VA and IHS expanded upon a 2003 memorandum of understanding (MOU). This 2010 MOU outlined mutual goals for the agencies' collaboration and coordination of resources and care in providing health care services to Native American veterans. For example, it included provisions for joint contracts and purchasing agreements, sharing staff, ensuring providers in VA and IHS could access the electronic health records of shared patients, and the development of payment and reimbursement policies and mechanisms to support care delivered to Native American veterans eligible for care in both systems.

In a May 2012 congressional hearing, both VA and IHS reported that they have taken steps to collaborate to improve access to and quality of health care services for Native American veterans.[2] However, questions have been raised by members of Congress about the extent of collaboration between the two agencies. For example, a 2012 Senate report noted that stronger partnerships among VA, IHS, and tribally operated health facilities are essential to ensuring Native American veterans have access to health care services.[3] We were asked to examine how the agencies

[1]According to the U.S. Census Bureau, in 2011 approximately 150,000 individuals identified themselves as Native American veterans. This includes only individuals who identified as American Indian or Alaska Native alone and not in combination with another racial group. Therefore, it likely underestimates the number of Native American veterans.

[2]*Oversight Hearing on Programs and Services for Native Veterans*: hearing before the Committee on Indian Affairs, United States Senate, 112th Cong (May 24, 2012).

[3]S. Rep. No. 112-168, at 45 (May 22, 2012).

have implemented the MOU. In this report, we address the (1) extent to which VA and IHS have established mechanisms through which the MOU can be effectively implemented and monitored; and (2) key challenges that VA and IHS face in implementing the MOU, and the progress they have made in overcoming them.

To address both of these objectives, we reviewed the MOU and documentation related to the MOU's implementation, including periodic updates and descriptions of sharing agreements. We also reviewed the signed reimbursement agreement between VA and IHS as well as signed reimbursement agreements between VA and tribes.[4] We interviewed VA and IHS officials, including VA's Director of the Office of Rural Health and Office of Tribal Government Relations, the IHS Chief Medical Officer, and leaders of 8 of 12 VA/IHS workgroups tasked with addressing and implementing the MOU to learn about the steps that have been taken to implement and monitor the MOU and any related challenges. We selected these eight workgroups because they were involved in addressing issues regarding agency coordination and sharing resources.[5]

To assess the MOU's implementation and related challenges, we took several actions to obtain the views of tribal communities. We attended a VA tribal consultation on MOU implementation at the National Indian Health Board Consumer Conference in Denver, Colorado, in September 2012, and attended the National Congress of American Indians (NCAI) Annual Conference in Sacramento, California, in October 2012. At the NCAI conference, we conducted listening sessions for tribal members to solicit their views on MOU implementation. We also interviewed various other tribal health representatives outside of the listening sessions and

[4]VA is required to reimburse federally and tribally operated facilities for health care services provided to beneficiaries who are eligible for such services from VA. 25 U.S.C. § 1645(c).

[5]The eight workgroups we interviewed were: (1) Coordination of Care; (2) Health Information Technology; (3) System Level; (4) Payment and Reimbursement; (5) Sharing of Care Process, Programs and Services; (6) Training and Recruitment; (7) Oversight; and (8) Alaska. VA and IHS count the Training and Recruitment Workgroup as two separate workgroups. However, because these two workgroups share similar goals, an IHS official told us they combined them into one workgroup, and for the purposes of this report we considered them as one workgroup. There are also four other workgroups covering: (1) Services and Benefits, (2) New Technologies; (3) Cultural Competency and Awareness; and (4) Emergency and Disaster Preparedness. We did not interview these workgroups because they did not directly relate to our objectives.

the conferences. In all, we interviewed 34 tribal members and other representatives (collectively referred to in this report as tribal stakeholders), including tribal leaders, tribal veterans, tribal health directors and administrators, and tribal health policy experts and consultants. The tribes represented in our interviews were geographically varied, including representation from 9 IHS Areas and 10 Veterans Integrated Service Networks and included representation from tribes that varied in size from approximately 500 members to 310,000 members. We cannot generalize findings from these interviews as representative of all tribal communities; however, we believe that patterns or issues identified in these interviews may illustrate issues that other tribes face as well.

To evaluate the extent to which VA and IHS have established mechanisms through which the MOU can be effectively implemented and monitored, we assessed this evidence against relevant criteria from our past work on interagency collaboration, practices from leading results-oriented public-sector organizations, and agency strategic planning.[6] To evaluate key challenges that VA and IHS face in implementing the MOU, and the progress they have made in overcoming them, we assessed this evidence against internal controls.[7]

We conducted this performance audit from July 2012 to April 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[6]GAO, *Results-Oriented Government: Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies*, GAO-06-15 (Washington, D.C.: Oct. 21, 2005); *Managing for Results: Key Considerations for Implementing Interagency Collaborative Mechanisms*, GAO-12-1022 (Washington, D.C.: Sept. 27, 2012); *Executive Guide: Effectively Implementing the Government Performance and Results Act*, GAO/GGD-96-118 (Washington, D.C.: June 1996); and *Agencies' Strategic Plans Under GPRA: Key Questions to Facilitate Congressional Review*, GAO/GGD-10.1.16 (Washington, D.C.: May 1997).

[7]GAO, *Internal Control Standards: Internal Control Management and Evaluation Tool*, GAO-01-1008G (Washington, D.C.: August 2001).

Background

Native American Veteran Demographics

While Native American veterans are geographically dispersed throughout the United States, the West and South regions contain the majority of the Native American veteran population, according to Census data. Some Native American veterans are members of the 566 federally recognized tribes that are distinct, independent political communities that possess certain powers of self-government, which we refer to as tribal sovereignty. Specifically, federally recognized tribes have government-to-government relationships with the United States, and are eligible for certain funding and services provided by the United States. In addition, some Native American veterans are members of the more than 400 Indian groups that are not recognized by the federal government (which we refer to in this report as non–federally recognized tribes).[8] Many—but not all—Native American veterans are dually eligible for health care services in VA and IHS. For example, a veteran who is a member of a non–federally recognized tribe may be eligible for VA health care services, but would not be eligible for IHS health care services.[9]

VA and IHS Structure and Benefits

VA is charged with providing health care services to the nation's veterans, and estimates that it will serve 6.3 million patients in fiscal year 2013. VA's fiscal year 2012 budget for medical care was approximately $54 billion. The department provides health care services at VA-operated facilities and through agreements with non-VA providers.[10] Veterans who served in the active military, naval or air service and who were discharged or released under conditions other than dishonorable are generally eligible for VA health care.

[8]For more information on federal funding for non–federally recognized tribes, see GAO, *Indian Issues: Federal Funding for Non-Federally Recognized Tribes*, GAO-12-348 (Washington, D.C.: Apr. 12, 2012).

[9]To be eligible for IHS health care services, an individual must be closely affiliated with a federally recognized tribe, as evidenced by such factors as membership; enrollment; residence on tax-exempt land; ownership of restricted property; active participation in tribal affairs; or other relevant factors indicative of Native American descent. See 42 C.F.R. § 136.12.

[10]To manage its provision of health care services for eligible veterans, VA operates a system of annual patient enrollment in accordance with eight listed priorities. See 38 U.S.C. § 1705.

IHS is charged with providing health care to the approximately 2.1 million eligible Native Americans. IHS's fiscal year 2012 budget for medical care was approximately $3.9 billion. Similarly to VA, IHS provides health care services at IHS-operated facilities through direct care and pays for services from external providers through contract health services. In addition to IHS-operated facilities, some federally recognized tribes choose to operate their own health care facilities, which receive funding from IHS.[11] Like their IHS-operated counterparts, tribally operated facilities provide direct care services and pay for contract health services. IHS also provides funding through grants and contracts to nonprofit urban Native American organizations through the Urban Indian Health program in order to provide health care services to Native Americans living in urban areas.

VA and IHS Collaboration through Memorandums of Understanding

In 2003, VA and IHS signed an MOU to facilitate collaborative efforts in serving Native American veterans eligible for health care in both systems. In 2010, the agencies developed a more detailed MOU to further these efforts. The 2010 MOU contains provisions related to several areas of collaboration, including actions related to the following:

- *Joint contracts and purchasing agreements*: Development of standard, preapproved language for inclusion of one agency into contracts and purchasing agreements developed by the other agency; and processes to share information about sharing opportunities in early planning stages.

- *Sharing staff*: Establishment of joint credentialing and privileging, sharing specialty services, and arranging for temporary assignment of IHS Public Health Service commissioned officers to VA.

[11]Under the Indian Self-Determination and Education Assistance Act, as amended, federally recognized tribes can enter into self-determination contracts or self-governance compacts with the Secretary of Health and Human Services to take over administration of IHS programs for Native Americans previously administered by IHS on their behalf because of their status as Indians. Self-governance compacts allow tribes to consolidate and assume administration of all programs, services, activities, and competitive grants administered throughout IHS, or portions thereof, that are carried out for the benefit of Native Americans because of their status as Indians. Self determination contracts allow tribes to assume administration of a program, programs, or portions thereof. See 25 U.S.C. §§ 450f(a) (self-determination contracts)and 458aaa-4(b)(1) (self-governance compacts).

- *Electronic Health Record (EHR) access*: Establishment of standard mechanisms for VA providers to access records in IHS and tribally operated facilities, and vice versa, for patients receiving care in both systems.

- *Reimbursement*: Development of payment and reimbursement policies and mechanisms to support care delivered to dually eligible Native American veterans.

VA and IHS Tribal Consultation Policies

Executive Order 13175, issued on November 6, 2000, required federal agencies to establish regular and meaningful consultation and collaboration with Indian tribe officials in the development of federal policies that have tribal implications.[12] IHS issued a tribal consultation policy in 2006 to formalize the requirement to seek consultation and participation by Indian tribes in policy development and program activities. According to the policy, IHS will consult with Indian tribes to the extent practicable and permitted by law before any action is taken that will significantly affect Indian tribes. In November 2009, a Presidential Memorandum directed federal agencies to develop plans, after consultation with Indian tribes and tribal officials, for implementing the policies and directives of Executive Order 13175.[13] VA's plan included development of a tribal consultation policy, which the agency released in February 2011. VA's tribal consultation policy asserts that VA will establish meaningful consultation to develop, improve, or maintain partnerships with tribal communities. The policy states that consultation should be conducted before actions are taken but acknowledges there may not always be "sufficient time or resources to fully consult" on an issue.[14]

[12]Federal agencies are required to consult with Alaska Native corporations on the same basis as Indian tribes under Executive Order 13175. Pub. L. No. 108-199, div. H, § 161, 118 Stat. 3, 452 (2004), as amended.

[13]See 74 Fed. Reg. 57,881 (Nov. 9, 2009).

[14]According to the policy, the principal focus of consultation is the tribally designated "tribal official" and that consultation will be initiated by means of written notification.

Best Practices and Internal Control Standards for Interagency Collaboration and Performance Monitoring

In past work we have reported on key practices to enhance and sustain interagency collaboration[15] including

- agreeing on roles and responsibilities;
- establishing compatible policies, procedures, and other means to operate across agency boundaries; and
- developing mechanisms to monitor, evaluate, and report on results.

Additionally, our past work has identified a range of mechanisms that the federal government uses to lead and implement interagency collaboration.[16] We found that regardless of the mechanisms used, there are key actions the government can take, including (1) having clear goals; (2) ensuring relevant participants are included in collaboration; and (3) specifying the resources—human, information, technology, physical, and financial—needed to initiate or sustain the collaboration. We have also found in past work on leading public-sector organizations and agency strategic planning that it is important to (1) define clear missions and desired outcomes; (2) use performance measures that are tangible, measurable, and clearly related to goals to gauge progress; and (3) use performance information as a basis for decision making.[17] Finally, internal control standards emphasize the importance of effective external communications that occur with groups that can have a serious effect on programs, projects, operations, and other activities, including budgeting and financing.[18]

[15]GAO-06-15 and GAO-12-1022.

[16]GAO-12-1022.

[17]GAO/GGD-10.1.16 and GAO/GGD-96-118 (for this report, GAO studied a number of leading public-sector organizations that were successfully becoming more results-oriented, including state governments such as in Florida, Texas, and Virginia; and foreign governments such as in Australia and the United Kingdom).

[18]GAO-01-1008G.

VA and IHS Have Developed Mechanisms to Implement and Monitor the MOU, but Metrics to Monitor Performance Do Not Adequately Measure Progress toward MOU Goals

VA and IHS have documented common goals in their MOU, created 12 workgroups that are tasked with developing strategies to address the goals of the MOU, and created a Joint Implementation Task Force to coordinate tasks, develop implementation policy, and develop performance metrics and timelines—actions that are consistent with those we have found enhance and sustain agency collaboration. However, most of the performance metrics developed by VA and IHS to monitor the implementation of the MOU need to be more clearly related to the goals of the MOU in order to allow the agencies to gauge progress toward MOU goals.

VA and IHS Have Defined Common Goals and Created Mechanisms to Implement the MOU

Consistent with our past work on practices that can enhance and sustain collaboration, VA and IHS have defined common goals for implementing the MOU and developed specific strategies the agencies plan to take to achieve them. Table 1 summarizes the five goals in the 2010 MOU and selected strategies for implementing them.

Table 1: Goals and Associated Strategies in the Department of Veterans Affairs (VA) / Indian Health Service (IHS) 2010 Memorandum of Understanding (MOU)

MOU goal	Selected strategies to achieve goal
1. Increase access to and improve quality of health care and services to the mutual benefit of both agencies. Effectively leverage the strengths of the VA and IHS at the national and local levels to afford the delivery of optimal clinical care.	• Share specialty services • Develop joint credentialing and privileging of staff • Develop joint training initiatives • Develop and implement new models of care using new technologies, including telehealth services
2. Promote patient-centered collaboration and facilitate communication among VA, IHS, Native American veterans, tribal facilities, and Urban Indian Clinics.	• Establish mechanism to share electronic health records for patients receiving care in both systems and from tribally operated facilities • Improve the delivery of care through sharing of care processes, programs, and services (for example, post-traumatic stress disorder and diabetes management)
3. In consultation with tribes at the regional and local levels, establish effective partnerships and sharing agreements among VA headquarters and facilities, IHS headquarters and IHS, tribal, and Urban Indian Health programs in support of Native American veterans.	• Develop standard preapproved language for inclusion of one agency into the other agency's existing contracts • Develop preapproved templates for agreements to facilitate local, regional, and national collaboration
4. Ensure that appropriate resources are identified and available to support programs for Native American veterans.	• Develop payment and reimbursement policies and mechanisms for veterans receiving care in both systems
5. Improve health promotion and disease prevention services to Native Americans to address community-based wellness.	• Improve the delivery of care through sharing of care processes, programs, and services (for example, post-traumatic stress disorder and diabetes management)

Source: GAO analysis of information provided by VA and IHS.

VA and IHS have created two mechanisms to implement the MOU—workgroups and a Joint Implementation Task Force. We have reported that MOUs are most effective when they are regularly updated and monitored, actions that can be achieved by workgroups and task forces.[19]

Workgroups

VA and IHS created 12 workgroups tasked with responsibility for implementing and developing strategies to address the goals of the MOU, such as interoperability of health information technology; developing payment and reimbursement agreements; and sharing of care processes, programs, and services.[20] Each workgroup includes members from VA

[19]GAO-12-1022.

[20]The 12 workgroups are: (1) Coordination of Care; (2) Health Information Technology; (3) System Level; (4) Payment and Reimbursement; (5) Sharing of Care Process, Programs and Services; (6) Training and Recruitment; (7) Oversight; (8) Alaska; (9) Services and Benefits; (10) New Technologies; (11) Cultural Competency and Awareness; and (12) Emergency and Disaster Preparedness.

and IHS, a step that can foster mutual trust across diverse agency cultures and facilitate frequent communication across agencies to enhance shared understanding of collaboration goals, according to our previous work on interagency collaboration. According to VA and IHS officials, most of the workgroup members volunteered to serve on the workgroups and were self-selected, and VA officials told us that they have consulted with tribes on how to increase tribal participation in the workgroups. The agencies also told us that some workgroup members were asked to participate because of their subject-matter expertise.[21]

Goals established by each workgroup appear to be aligned with MOU goals. Specifically, all eight of the workgroups we interviewed described goals that were consistent with the MOU goals.[22] Table 2 lists each workgroup we interviewed and provides a crosswalk between workgroup goals and the corresponding MOU goal or strategy.

[21]The officials told us that in cases where a workgroup lacks authority to implement an MOU task, workgroup members would notify MOU coordinators designated by each agency, who would then notify the appropriate agency officials about the issue.

[22]We did not interview 4 workgroups because they did not directly relate to our objectives: (1) Services and Benefits; (2) New Technologies; (3) Cultural Competency and Awareness; and (4) Emergency and Disaster Preparedness.

Table 2: Goals of Eight Workgroups Interviewed and Corresponding Department of Veterans Affairs (VA) / Indian Health Service (IHS) Memorandum of Understanding (MOU) Goals

Workgroup	Goals	Crosswalk to MOU goals
Coordination of Care	• Increase access to and quality of care. • Promote patient-centered collaboration and increase coordination of care, including comanagement of dual- eligible veterans. Work with tribal urban organizations.	Goal 1: Increase access to and improve quality of health care and services to the mutual benefit of both agencies. Goal 2: Promote patient- centered collaboration and facilitate communication.
Health Information Technology	• Improve care through the development of health information technology. • Establish system to share electronic health records.	Goal 1: Increase access to and improve quality of health care and services to the mutual benefit of both agencies. Goal 2: Promote patient-centered collaboration and facilitate communication.
System Level	• Plan and implement system-level resources to share information about contracts and purchasing arrangements.	Goal 3: Establish effective partnerships and sharing agreements. Goal 4: Ensure that appropriate resources are identified and available to support programs.
Payment and Reimbursement	• Design system to ensure VA and IHS systems are compatible for the billing and collecting process under contracts or agreements.	Goal 4: Ensure that appropriate resources are identified and available to support programs.
Sharing of Care Process, Programs and Services	• Several MOU goals, including improving access to and quality of care for post-traumatic stress disorder among Native American veterans. • Conduct outreach to tribal areas in areas such as public health and suicide prevention. • Develop and update suicide prevention training. • Provide IHS pharmacists access to VA programs to streamline pharmacy dispensing activities. • Coordinate and collaborate to improve the lives of elderly and frail Native Americans, and increase access to VA's home-based primary care program.	Goal 1: Increase access to and improve quality of health care and services to the mutual benefit of both agencies. Goal 2: Promote patient- centered collaboration and facilitate communication. Goal 3: Establish effective partnerships and sharing agreements. Goal 5: Improve health-promotion and disease-prevention services to Native Americans to address community-based wellness.
Training and Recruitment	• Increase capability and improve quality through training and workforce development, sharing of educational and training opportunities, and the development of joint training initiatives. • Increase access to care through sharing of staff and enhanced recruitment and retention of professional staff.	Goal 1: Increase access to and improve quality of health care and services to the mutual benefit of both agencies.

Workgroup	Goals	Crosswalk to MOU goals
Alaska	• Increase access to services and benefits of IHS and VA. • Improve coordination of care, including comanagement, for Native American veterans served by both VA and tribal organizations. • Increase availability of services, in accordance with law, by the development of payment and reimbursement policies and mechanisms.	Goal 1: Increase access to and improve quality of health care and services to the mutual benefit of both agencies. Goal 2: Promote patient- centered collaboration and facilitate communication. Goal 3: Establish effective partnerships and sharing agreements Goal 4: Ensure that appropriate resources are identified and available to support programs. Goal 5: Improve health-promotion and disease-prevention services to Native Americans to address community-based wellness.
Oversight	• Set priorities for the Joint Implementation Task Force to identify the strategies and plans for accomplishing the tasks and aims of the MOU, and help the task force follow the strategy and plans of the MOU. • Meet with and receive updates from other workgroups and elevate issues identified by the workgroups. • Develop reports on progress in implementing the MOU.	Goal 1: Increase access to and improve quality of health care and services to the mutual benefit of both agencies. Goal 2: Promote patient- centered collaboration and facilitate communication. Goal 3: Establish effective partnerships and sharing agreements. Goal 4: Ensure that appropriate resources are identified and available to support programs. Goal 5: Improve health-promotion and disease-prevention services to Native Americans to address community-based wellness.

Source: GAO evaluation of interviews with workgroups and agency officials and the MOU.

Joint Implementation Task Force

VA and IHS created the Joint Implementation Task Force to oversee the overall implementation of the MOU. This task force comprises officials from both agencies including from the Office of the Secretary of Veterans Affairs, the IHS Chief Medical Officer, and the director of VA's Office of Tribal Government Relations, and is scheduled to meet quarterly. It develops implementation policy and procedures for policy-related issues identified by the workgroups; creates performance metrics and timelines, evaluates progress; and compiles an annual report on progress in MOU implementation. Creating a mechanism, such as a task force, intended not only to address issues arising from potential incompatibility of standards and policies across agencies but also to monitor, evaluate, and report on MOU results, can help to facilitate collaboration, according to our previous work on interagency collaboration.

VA and IHS Performance Metrics Do Not Adequately Measure Progress on the MOU Goals

The process developed by the Joint Implementation Task Force to monitor the implementation of the MOU includes obtaining data on three performance metrics; however, two of the three metrics do not allow the agencies to measure progress toward the MOU's goals. Our previous work has found that successful performance metrics should be tangible and measureable, clearly aligned with specific goals, and demonstrate the degree to which desired results are achieved.[23] Although all three of the performance metrics are tangible and measurable, only one is also clearly aligned with a specific goal and defined in a manner that would allow the agencies to adequately measure the degree to which desired results are achieved. The other two metrics are inadequate because their connection to a specific goal is not clear and they lack qualitative measures that would allow the agencies to measure the degree to which desired results are achieved. For example, one MOU goal is to increase access to and improve quality of health care services, but none of the metrics mention any targets specifically linked to increased access or improved quality of care. Another goal is to establish effective partnerships and sharing agreements among the agencies and the tribes in support of Native American veterans. Although one of the metrics appears to be related to this goal, in that it is focused on measuring the number of outreach activities that are a result of partnerships, it lacks measures to determine how well the outreach activities are meeting the goal of establishing effective partnerships or other potential goals to which the outreach may contribute, such as facilitating communication among VA, IHS, veterans, and tribally operated facilities. The metrics would therefore not enable VA and IHS to determine how well these specific goals are being achieved. Table 3 describes the performance metrics and performance measures and our evaluation of them.

[23] GAO/GGD-96-118 and GAO/GGD-10.1.16.

Table 3: GAO Evaluation of Performance Metrics and Measures Developed to Monitor Progress toward Department of Veterans Affairs (VA) / Indian Health Service (IHS) Memorandum of Understanding (MOU) Goals

Metric	Measures	GAO evaluation
Metric 1: Programs increased or enhanced as a result of the VA-IHS MOU	1. Number of programs enhanced and increased 2. Number of events and activities to increase or enhance the programs 3. Number of veterans impacted 4. Met purposes of MOU (yes or no) 5. Met intent of MOU (yes or no) 6. Level of VA-IHS-Tribal participation (poor, fair, good, excellent)	Inadequate Tangible and measurable, but not clearly aligned with an MOU goal and would not allow agencies to determine how well MOU goals are achieved.
Metric 2: Outreach activities that are the result of MOU partnerships	1. Types of outreach events held 2. Number of outreach events held 3. Number of veterans and others (families, caregivers) impacted 4. Met purposes of MOU (yes or no) 5. Met intent of MOU (yes or no) 6. Level of VA-IHS-Tribal participation (poor, fair, good, excellent)	Inadequate Tangible and measurable but not clearly aligned with an MOU goal, and would not allow agencies to determine how well MOU goals are achieved.
Metric 3: Development of reimbursement agreements and sharing agreements as a result of the MOU	1. Number of sharing agreements developed 2. Number of tribes impacted 3. Number of reimbursement agreements developed 4. Number of tribes impacted 5. Met purposes of MOU (yes or no) 6. Met intent of MOU (yes or no) 7. Level of VA-IHS-Tribal participation (poor, fair, good, excellent)	Adequate Tangible and measureable, aligned with an MOU goal, and allows the agencies to measure progress toward goals three and four.

Source: GAO analysis of information provided by VA and IHS.

Note: The five MOU goals are:

(1) Increase access to and improve quality of health care and services to the mutual benefit of both agencies. Effectively leverage the strengths of the VA and IHS at the national and local levels to afford the delivery of optimal clinical care.

(2) Promote patient-centered collaboration and facilitate communication among VA, IHS, Native American veterans, tribal facilities, and Urban Indian Clinics.

(3) In consultation with tribes at the regional and local levels, establish effective partnerships and sharing agreements among VA headquarters and facilities, IHS headquarters and IHS, tribal, and Urban Indian Health programs in support of Native American veterans.

(4) Ensure that appropriate resources are identified and available to support programs for Native American veterans.

(5) Improve health promotion and disease prevention services to Native Americans to address community-based wellness.

Using these metrics, the agencies have issued MOU progress reports, but the metrics included in the reports generally are not clearly tied specifically to the goals of the MOU, nor do they allow the agencies to

determine how well MOU goals have been achieved. Leading public-sector organizations have found that metrics that are clearly linked to goals and allow determination of how well goals are achieved are key steps to becoming more results-oriented. For example:

- According to the agencies' fiscal year 2011-2012 metrics report,[24] for Metric 1 (programs increased or enhanced as a result of the MOU), more than 15 programs were enhanced or increased as the result of the MOU, and 440 events and activities occurred that increased or enhanced the programs. The report then provides examples of programs that have been enhanced, such as a care coordination program in which a registered nurse "works with Indian Health, Tribal Programs, and other agencies and hospitals through direct meetings at various facilities to ensure communication and improved care." However, the report does not always describe information that would allow the agencies to determine how well each activity contributes to meeting MOU goals. For instance, in the description of an enhanced care coordination program noted above, the report does not indicate how the agencies determined that communication has improved among participants. Absent this information, it is not clear how the agencies could draw conclusions about whether improved communication has actually been facilitated and therefore how well the activity contributed to meeting the MOU goal of promoting patient-centered collaboration and facilitating communication.

- According to the metrics report, for Metric 2 (outreach activities increased or enhanced as a result of MOU partnerships), eight types of activities were increased or enhanced. However, the report lists only seven types of outreach and does not include enough information to determine how well the outreach contributes to meeting MOU goals. For example, one outreach activity cited in the report, "Outreach to promote implementation of new technologies," includes the activity "VA Office of Telehealth Services (OTS) Coordinator participated in Web-ex sessions with IHS on use of technology to improve patient care." Although not stated in the report, this activity appears to help implement the MOU strategy of enhancing access through the development and implementation of new models of care using new technologies, including telehealth, related to the MOU

[24]Department of Veterans Affairs and Indian Health Service, *Department of Veterans Affairs (VA) Indian Health Service (IHS) Memorandum of Understanding (MOU) Metrics Report—Fiscal Year (FY) 2011/2012.*

goals of promoting patient-centered care and increasing access to care. However, while outreach activities are measurable and tangible, and might help to achieve goals of the MOU, the report does not state how the agencies will determine whether the sessions actually were effective in improving patient care or increasing access, information that is necessary to allow the agencies to tell how well the activity helps achieve the MOU goals.

- For each metric, the agencies report whether the activities "met the purpose of the MOU," "met the intent of the MOU," and whether the "level of VA-IHS-Tribal participation" was poor, fair, good, or excellent. While determining whether the agencies' activities meet the purpose and intent of the MOU is a critical step, and obtaining tribal participation is consistent with MOU goals, the report does not describe how these determinations were made. Agency officials told us that these determinations were made subjectively by each workgroup while keeping in mind the goals and strategies in the MOU.

The weaknesses we found in these performance metrics could limit the ability of VA and IHS managers to gauge progress and make decisions about whether to expand or modify programs or activities, because the agencies will not have information on how well programs are supporting MOU goals. VA and IHS officials told us that they developed these performance metrics because the initial performance metrics, drafted by the workgroups themselves and other VA and IHS staff, varied in quality. The three metrics and measures were intended to provide some simple, measurable ways for workgroups to report on their progress. However, they also acknowledged that there were weaknesses in the measures and told us that refining these performance metrics is a priority. According to the officials, they plan to revise workgroup metrics by April 2013 and on a continuous basis going forward. In doing so, they plan to consult subject-matter experts and existing VA and IHS performance metrics, for example, prevention of hospital admissions in home-based primary care programs.

VA and IHS Lack Effective Processes to Overcome the Challenges of Consulting with a Large Number of Diverse, Sovereign Tribes

Mainly because of the large number of diverse tribal communities and tribal sovereignty, VA and IHS face unique challenges associated with coordinating and communicating to implement the MOU. VA and IHS have processes in place for consulting with tribes, but these measures fall short in several respects and do not ensure such consultation is effective.

VA and IHS Face Challenges Implementing the MOU Related to the Large Number of Diverse, Sovereign Tribes

VA and IHS officials told us the large number (566) of federally recognized tribes and differing customs and policy-making structures present logistical challenges in widespread implementation of the MOU within tribal communities.[25] For instance, according to some VA officials, in some tribes as a matter of protocol, an agency must be invited on tribal lands or be sponsored by a council member in order to address a tribal council. Such a policy could add administrative processes that might delay implementation and require greater sensitivity from agency officials, adding to the challenge of consulting with tribes. As another example, the title or position of the tribal person designated to make decisions regarding health care may differ from tribe to tribe, complicating the decision-making process among VA, IHS, and tribes. VA officials told us in some tribes, for example, a tribal leader may have several roles, only one of which is making decisions on health care, whereas in other tribes there may be a tribal health director whom the tribal leader has designated to manage health care in the tribal community. Potentially, these differences can affect the speed and degree at which collective decisions can be made.

In addition, VA and IHS officials noted that tribal sovereignty further adds to the logistical complexity of the efforts of the agencies to implement the MOU. Tribal sovereignty includes the inherent right to govern and protect the health, safety, and welfare of tribal members. Indian tribes have a

[25]In addition to the federally recognized tribes, there are more than 400 non–federally recognized tribes. Although these non–federally recognized tribes may not receive IHS funding and members may not be eligible for IHS services, VA has an obligation to serve their members who are eligible for VA services.

legal and political government-to-government relationship with the federal government, meaning federal agencies interact with tribes as governments, not as special interest groups or individuals. VA and IHS officials told us that because of tribal sovereignty, tribally operated facilities may choose whether or not to participate in a particular opportunity for collaboration related to the MOU, which makes it challenging to achieve some of the goals of the MOU. VA and IHS can inform tribes of an opportunity but cannot require them to participate. For example:

- In order to meet the MOU goal to establish standard mechanisms for access to electronic health record (EHR) information for shared patients, VA and IHS have coordinated to adapt their information technology systems to allow them both to participate in the eHealth Exchange, a national effort led by the Department of Health and Human Services for sharing EHR information.[26] However, EHR workgroup members told us that some tribally operated facilities have opted to use an off-the-shelf product in place of the IHS system, which the workgroup members do not have the resources to support.

- In another instance, as a part of their efforts to meet the MOU goal to establish effective partnerships and sharing agreements, VA and IHS are working to implement VA's Consolidated Mail Outpatient Pharmacy (CMOP) throughout IHS. Workgroup members assigned to these activities said they plan to implement the program in all IHS-operated facilities by spring 2013 but cannot require tribally operated facilities to participate. Some smaller tribal communities with more limited postal access are not interested in using the CMOP program, according to the workgroup members.

[26]The eHealth Exchange is a set of standards, services, and policies that enable the secure exchange of health information over the Internet.

VA and IHS Processes in Place to Overcome the Complexities Associated with Consulting with Tribes Do Not Always Ensure Effective Consultation

VA and IHS communicate MOU-related information with the tribes through written correspondence, in-person meetings, and other steps, as is consistent with internal controls calling for effective external communications with groups that can have a serious effect on programs and other activities; however, according to tribal stakeholders we interviewed, these methods for consultation have not always met the needs of the tribal communities, and the agencies have acknowledged that effective consultation has been challenging.

Written Correspondence

VA and IHS send written correspondence (known as "Dear Tribal Leader" letters) regarding the MOU to tribal communities. However, the agencies have acknowledged that because of the large and diverse nature of the tribes, they have struggled to reach the tribal member designated to make health care decisions with information about the MOU. Both VA officials and members of tribal communities told us that, because tribal leaders are not always the tribal person designated to make decisions regarding health care, the "Dear Tribal Leader" letters may not always make their way to tribal members designated to take action on health care matters. VA officials told us that their formal consultation is conducted with tribal leaders. However, these officials also noted that, in addition to the letters sent to tribal leaders, they have a network of contacts within each tribe that includes, among others, tribal health directors, and this network receives concurrent notice of communication with tribal leaders via conference calls, listservs, and newsletters. IHS officials said sometimes, in addition to the tribal leader, they may also send letters to, or otherwise communicate directly with, tribal health program directors if they know of them. However, they also noted they do not maintain a specific record—such as a listserv—of tribal health program directors. Without reaching the tribal members responsible for decision-making on healthcare matters, VA and IHS may not always be effectively communicating with tribes about the status of the MOU and its related activities nor be obtaining tribal feedback that is critical with respect to implementation of the MOU.

Likewise, seven tribal stakeholders we spoke with noted similar concerns regarding the "Dear Tribal Leader" letters as VA and IHS. For example, one tribal stakeholder said letters should go to a specific person, such as a tribal health director, to ensure that the information is seen by the right people in a timely manner. It may take the tribes time to pass along letters sent only to tribal leaders to the tribal health director or other appropriate people, by which point any deadlines included in the correspondence could be missed. Once the information has reached the tribal leader,

tribes bear the responsibility to ensure it is passed on to the appropriate audience in a timely manner.

Another specific concern tribal stakeholders that we spoke with expressed relating to written correspondence was that the agencies sometimes use the letters to simply inform them of steps the agencies have taken without consulting the tribes, as called for by the agencies' tribal consultation policies. For example, some tribal stakeholders said VA and IHS did not include them in the original development of the 2010 MOU, even though the goals and activities in the MOU could directly affect them. According to 10 of the tribal stakeholders we spoke with, tribes should have been included in developing the MOU, which addresses proposed plans, policies, and programmatic actions that may affect tribes. For example, the MOU seeks to improve delivery of health care by developing and implementing new models of care using new technologies, including telehealth services such as telepsychiatry. Instead, the agencies solicited tribal comments after the agencies had signed the MOU. According to two tribal stakeholders, the agencies were not responsive to the comments provided on the MOU. One stakeholder said their comments were not acknowledged upon receipt nor did IHS ever follow up on the issues raised by their comments. The stakeholder suggested IHS designate a point person to track feedback and ensure follow-up. VA and IHS officials told us that they did not hold tribal consultation meetings before the signing of the MOU because they viewed the MOU as an agency-to-agency agreement rather than as an agreement between the agencies and the various tribes.

In-person Meetings

VA and IHS officials said they hold quarterly meetings with tribal communities and also attend events, such as conferences held by Native American interest organizations. Three tribal stakeholders told us that when the agencies have held consultation meetings, the meetings are not interactive enough—stating that agency officials speak for the majority of the time—and that VA does not provide enough information prior to these meetings. These tribal stakeholders said providing information ahead of time could allow tribes to better prepare for meetings, discuss issues as a tribe beforehand, and determine which tribal members should attend. If tribal officials with the authority and desire to work with VA and IHS do not receive needed information on opportunities because of an ineffective consultation process, local facility leadership may not have readily available access to information necessary to examine which collaborative opportunities are present, and thus VA and IHS may be hindered in their efforts to coordinate health care for Native American veterans.

VA and IHS are undertaking other efforts designed to enhance consultation with tribes. These include the following steps:

- In January 2011, VA established the Office of Tribal Government Relations (OTGR) to serve as the point of contact for tribes. According to VA officials, this office conducted four consultation meetings in 2012 and employed five field staff to help manage communication with tribal communities and to work with IHS on local MOU implementation efforts.

- In February 2011, VA released the agency's tribal consultation policy. VA officials said they are developing a report that will explain the process for evaluating comments from tribes and making decisions based on them. The officials expect the report to be released to the public in the spring of 2013.

- The agencies have made more local efforts to communicate with tribes, which have led to some success. For example, agency officials and tribal stakeholders noted that the workgroup assigned to implement MOU activities in Alaska used successful methods for working with tribes. The Alaska workgroup told us they cultivated a relationship with an Alaskan tribal health organization in order to get advice on the appropriate customs for consulting with individual tribes there. In addition, the workgroup said they scheduled consultation meetings in conjunction with other meetings, which would limit the amount of travel tribal community members would need to undertake. VA employees also took cultural awareness training, and VA officials visited Alaska to demonstrate the agency's dedication to providing care to Native American veterans, which, according to the workgroup, led to buy-in from tribal communities. VA and Alaskan tribes have signed 26 reimbursement agreements.

Some tribal stakeholders that we spoke with have acknowledged the steps taken by the agencies thus far as positive but in some cases expressed concerns regarding tribal consultation. In the case of the tribes working with the Alaska workgroup, one stakeholder praised VA's efforts to work with tribal health organizations to communicate with tribes. In another example, two tribal stakeholders said they approved of OTGR's establishment as an office dedicated to Native American veterans' issues. However, four tribal stakeholders expressed concerns that, despite the creation of OTGR, VA still has not always been effective in its efforts to consult with tribes or be responsive to tribal input provided during consultation. For example, one stakeholder questioned whether

consultation was done with every tribe and described VA's consultation process as sporadic. This stakeholder's concern implies that VA's outreach efforts may not be systematically reaching all tribal communities. However, VA officials told us that, in addition to issuing notices in the Federal Register and Dear Tribal Leader letters, they have a systematic process of hosting training summits for tribes and scheduling regular conference calls and presentations to tribal leadership. In another instance, one tribal community member said OTGR lacks—and thus cannot disperse to tribes—the technical knowledge necessary for tribes to partner with VA on activities such as negotiating reimbursement agreements. VA officials noted that OTGR staff may not always be technical experts on a given topic but said they are able to identify those experts and play a key role in linking tribes with them.

Conclusions

Coordination between VA and IHS is essential to ensuring that high-quality health care is provided to dually eligible Native American veterans. While the 2010 MOU includes common goals that should facilitate agency coordination, and the agencies have created workgroups tasked to implement the MOU, we found that a critical mechanism for monitoring the implementation of the MOU, the agreement's performance metrics, has weaknesses. Specifically, the inadequacies we found in performance metrics could limit the agencies' ability to measure progress towards MOU goals and ultimately make decisions about programs or activities.

Overcoming the challenges related to working with a large number of diverse, sovereign tribes is also essential to successfully achieving the goals of the MOU. Although steps have been taken to consult with tribes regarding the MOU and related activities, consultation has not always been effective in assuring that the people designated to make health care decisions in each tribe are reached and tribes are included in planning and implementation efforts. Ineffective consultation with tribal communities could delay or limit potential VA, IHS, and tribal community partnerships to achieve the goals of the MOU and could hinder agency efforts to gain support for MOU activities and address the health care needs of Native American veterans.

Recommendations for Executive Action

To ensure the health care needs of Native American veterans are addressed most efficiently and effectively, we recommend that the Secretary of Veterans Affairs and Secretary of Health and Human Services take the following two actions:

- As the agencies move forward with revising the MOU's performance metrics and measures, ensure that the revised metrics and measures allow decision makers to gauge whether achievement of the metrics and measures supports attainment of MOU goals.

- Develop processes to better ensure that consultation with tribes is effective, including the following:

  - A process to identify the appropriate tribal members with whom to communicate MOU-related information, which should include methods for keeping such identification up-to-date.

  - A process to clearly outline and communicate to tribal communities the agencies' response to tribal input, including any changes in policies and programs or other effects that result from incorporating tribal input.

  - A process to establish timelines for releasing information to tribal communities to ensure they have enough time to review and provide input or, in the case of meetings, determine the appropriate tribal member to attend the event.

Agency Comments

We provided draft copies of this report to VA and the Department of Health and Human Services for review. Both agencies concurred with our recommendations. In addition, VA provided us with comments on the draft report, which we have reprinted in appendix I, as well as general and technical comments, which were incorporated in the draft as appropriate.

We are sending copies of this report to appropriate congressional committees; the Secretary of Veterans Affairs; the Secretary of Health and Human Services; and other interested parties. In addition, the report is available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs are on the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.

Randall Williamson
Director, Health Care

List of Requesters

The Honorable Patty Murray
Chairman
Committee on the Budget
United States Senate

The Honorable Bernie Sanders
Chairman
Committee on Veterans' Affairs
United States Senate

The Honorable Mark Begich
United States Senate

The Honorable Jon Tester
United States Senate

Appendix I: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

April 5, 2013

Mr. Randall Williamson
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Williamson:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***"VA AND IHS: Further Action Needed to Collaborate on Providing Health Care to Native American Veterans"*** (GAO-13-354). VA concurs with GAO's two recommendations to the Department.

VA's Office of Rural Health (ORH) is the VA point of contact with oversight of the VA/Indian Health Service (IHS) Memorandum of Understanding (MOU) (VA/HIS MOU) and associated Workgroups. VA's Office of Tribal Government Relations (OTGR), established two years ago, supports the agency (Veterans Health Administration, Veterans Benefits Administration and National Cemetery Administration) in expanding its relationships and collaborative activities with tribes in order to effectively serve Veterans residing in tribal communities; members of 566 Federally recognized tribes. OTGR supports the agency's efforts by using its employees' knowledge of tribal leaders, governance structures, geography, political structure, cultural distinctions, tribal priorities, and through demographic data. During the past two years, VA has made significant strides in relationship building, being responsive to the needs of Veterans in tribal communities, and establishing positive communications, through the establishment of the OTGR.

In 2012, VA hosted 7 regional training summits inviting Veterans, tribal leaders, and tribal service providers (including tribal health directors), as well as colleagues from other government and private organizations that serve Veterans. VA senior leadership attended high profile tribal conferences, sponsoring outreach booths (the IHS Tribal Self-Governance Conference, the National Congress of American Indians and the National Indian Health Board Annual Consumer Conference) and Veterans training tracks, and, in partnership with ORH and the VA Medical Center in Alaska, trained over 300 tribal Veteran representatives who serve communities throughout the State. The level of engagement with tribal communities has been unprecedented for the agency the past two years and it is important that although we concur with some of the specific recommendations contained within this report, the report does not acknowledge the substantial strides made by VA.

Tribal Consultation has not been initiated on the entire MOU in the past two years or on all of its associated Workgroups. Tribal Consultation was initiated on the reimbursement agreement (associated with Workgroup 6) and in 2012 on the question of how to engage tribes in the activities and Workgroups relative to the VA/IHS MOU. Moving forward, VA plans to establish an aggressive communications plan specific to the VA/IHS MOU with a strong emphasis on increasing knowledge and awareness of all opportunities that exist pursuant to the MOU for tribal communities.

The enclosure specifically addresses GAO's two recommendations, provides an action plan for each, and includes general and technical comments. VA appreciates the opportunity to comment on your draft report.

Sincerely,

Jose D. Riojas
Interim Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
"VA AND IHS: Further Action Needed to Collaborate on Providing Health Care to Native American Veterans"
(GAO-13-354)

GAO Recommendation: To help ensure the health care needs of Native American veterans are addressed most efficiently and effectively, we recommend that the Secretary of VA and Secretary of Health and Human Services take the following two actions:

Recommendation 1: As the agencies move forward with revising the MOU's performance metrics and measures, ensure that the revised metrics and measures allow decision makers to gauge whether achievement of the metrics and measures supports attainment of MOU goals.

VA Response: Concur. As part of the Department of Veterans Affairs (VA)/Indian Health Services (IHS) Memorandum of Understanding (MOU) (VA/IHS MOU) continuous quality improvement process, the Veterans Health Administration (VHA) is implementing improved measures that will increase the ability of the collaborating agencies to gauge progress toward the MOU goals. Each of the VA/IHS MOU workgroups will be assigned to report "how" they determined that the reported activities met the purposes and intents of one or more of the five MOU goals. Specifically, metrics one and two will have this new reporting strategy, as suggested in the draft report. VHA is implementing this strategy now and intends to use the MOU workgroup responses to inform participating agencies about "how" specific activities address the five MOU goals. Anticipated completion date is October 31, 2013.

Recommendation 2: Develop processes to better ensure that consultation with tribes is effective, including:

> **A process to identify the appropriate tribal members with whom to communicate MOU-related information, which should include methods for keeping such identification up-to-date.**

VA Response: Concur. In 2012, VA formally consulted with tribes on how to engage tribes in workgroups and activities related to the VA/IHS MOU. Information obtained through the series of consultations informed VA as to specific actions to take moving forward that will enhance and increase awareness amongst tribes of collaborative activities the two agencies are engaged in pursuant to the MOU. The Director, Office of Tribal Government Relations (OTGR) participates in Workgroup 12. Workgroup 12 will be tasked with reviewing and applying specific communications recommendations obtained from the tribes during the 2012 tribal consultation process in developing the communications plan for the MOU. The primary point of contact to formally convey MOU information will be the 566 tribal leaders – VA uses the United States Department of Interior, Bureau of Indian Affairs Tribal Leaders Directory published annually for an up to date listing of the Federally recognized tribes to send correspondence. Additionally,

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Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
"VA AND IHS: Further Action Needed to Collaborate on Providing Health Care to Native American Veterans"
(GAO-13-354)

VA will use social media, the internet, conference calls, Federal, state, national advocacy and inter-tribal organizations to communicate to tribal service providers and tribal program points of contact updated information regarding MOU workgroup activities, opportunities, and accomplishments.

A process to clearly outline and communicate to tribal communities the agencies' response to tribal input, including any changes in policies and programs or other effects that result from incorporating tribal input.

VA Response: Concur. On August 24, 2012, VA moved forward with issuing a Dear Tribal Leader letter providing updates and responses to the two joint VA/IHS Dear Tribal Leader letters released March 5, 2012, and April 5, 2012, initiating consultation with tribes on the topic of VA reimbursement for services provided by the IHS and Tribal Health facilities to eligible American Indian and Alaska Native (AI/AN) Veterans; and on April 5, 2012, providing the actual draft agreement. Transmitted in the August 24, 2012, letter were the following documents for tribes' review and consideration: VA Tribal Consultation response document (FAQs), Highlights of VA and Tribal Health Program Agreements, Tribal Health Program Claim Processing Site Readiness, in addition to a specific email address for tribes to submit a letter of interest to VA through their tribal leadership or governing body. The transmitted documents detailed how VA incorporated tribal feedback from the March and April 2012 consultations and the process by which tribes could move forward with establishing reimbursement sharing agreements with VA.

VA's 2012 Tribal Consultation Report (which does not include information from joint consultation sessions with the IHS held in 2012) is scheduled to be published late Spring of 2013 which will outline and communicate the agency's response to tribal input. As in the August 2012 VA correspondence to tribes, the agency will continue to work to communicate to tribes through a process that includes Dear Tribal Leader Letter updates, listserv notices, Web site postings, All Tribes conference calls, Webinars, social media, and how the input received from tribes during consultation will affect changes in policies and programs resulting from tribal input.

A process to establish timelines for releasing information to tribal communities to ensure they have enough time to review and provide input or, in the case of meetings, determine the appropriate tribal member to attend the event.

VA Response: Concur. VA agrees it is important to provide tribes with sufficient advance notice and time to provide input and prepare for attendance at scheduled meetings. On March 19, 2012, VA posted notice in the Federal Register/Vol. 77,

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Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
"VA AND IHS: Further Action Needed to Collaborate on Providing Health Care to Native American Veterans"
(GAO-13-354)

No. 53 of the VA Tribal Consultation scheduled for April 5, 2012. On March 12, 2012, VA released a Dear Tribal Leader letter notifying tribes of upcoming tribal consultations scheduled for May 25, 2012, at the Dean'ina Center in Anchorage, Alaska, June 2012 in Lincoln, Nebraska, and September 2012 in Denver, Colorado. The letter specified the consultation topics being presented by all three VA administrations. On May 1, 2012, VA released a subsequent Dear Tribal Leader letter which provided the consultation topics and the location, dates, and times of each consultation session. Tribes were also notified in the Federal Register notice and Dear Tribal Leader Letters that the record for each tribal consultation would remain open for 30 days following the in-person sessions. This would allow additional time for tribes to submit comments and recommendations that would be submitted for consideration by VA leadership in making determinations regarding any changes to policy or programming as a result of the feedback received from tribes.

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Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Randall Williamson, (202) 512-7114 or williamsonr@gao.gov

Staff Acknowledgments

In addition to the contact named above, Gerardine Brennan, Assistant Director; Jennie Apter; Lori Fritz; Hannah Marston Minter; and Lisa Motley made key contributions to this report.

Nation to Nation: Treaties Between the United States and American Indian Nations

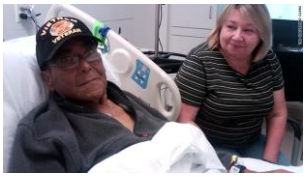
National Congress of American Indians (NCAI) president Walter Wetzel, Senator Lee Metcalf, and Senator Mike Mansfield, 1963 – meeting with President John F. Kennedy

We need to all work together as a nation of one tribe, the tribe of Human Kind, to make this world a good place for all.

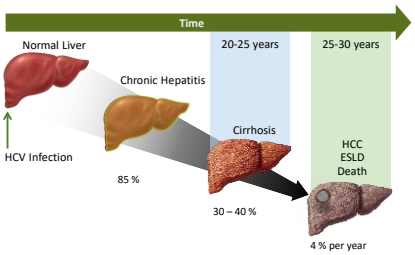
– Howard Lyons, Mohawk

What are we trying to prevent?

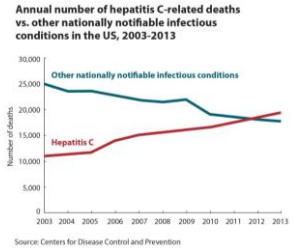
- Ascites
- Esophageal varices
- End stage liver disease
- Liver Cancer
- Death



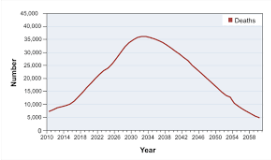
Hepatitis C – Progression of Disease



Increasing Deaths Due to Hepatitis C



The peak of deaths from Hepatitis C will be from 2030-2035 with around 35,000 per year.



HCV Burden in American Indians/Alaska Natives

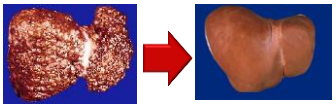
- Highest incidence rate of acute HCV
- Highest HCV related mortality, nearly 3x national average
- Highest rates hepatocellular cancer
- Estimated 40,000 persons infected with the hepatitis C virus

HCV new treatments

- Highly effective: up to 95% cure rate
- Short course: most treatments only require 12 weeks, 1-2 pills per day
- During treatment, visit clinic 1/month, plus final follow up
- Minimal side effects

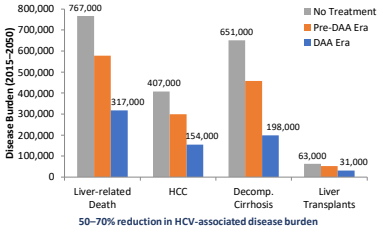
Why do we need to treat Hepatitis C?

- SVR (cure) of HCV is associated with:
  - 90% Reduction in Liver Failure
  - 70% Reduction of Liver Cancer
  - 50% Reduction in All-cause Mortality



Lok A. NEJM 2012; Ghany M. Hepatol 2009; Van der Meer AJ. JAMA 2012

HCV-Associated Disease Burden (2015–2050)



Chhatwal et al. AASLD 2015 Abstract 104

Current IHS Treatment

- Most I/T/U clinics are not currently treating systematically
- About 1% of total positives were treated last year
- What can IHS do to treat patients?

Breakdown of Hepatitis C Medication Regimens

- The most common medications are $15,000 – 37,000
- These have the potential to decrease in 2018

What about effectiveness? Savings?

Cost-effectiveness (ICER≤$100,000/QALY)
Cost-saving (ICER<$0)

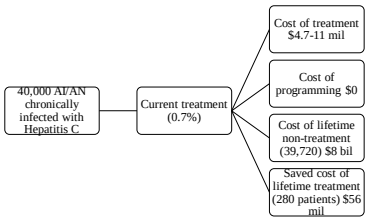
- The median threshold prices at which first-generation and second-generation DAAs became cost-effective were estimated as $120,000 and $277,200.
- At a discounted price of $60,000, a total of 71% of the analysis found second generation DAAs to be cost-saving and 22% to be cost-effective.

Based on a Meta-Analysis by Chhatwal et al., 2017

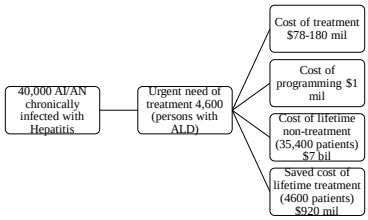
Cost of Treatment – and Benefits

Item	Estimated Current Value
Direct cost of HCV treatment [28]	$15,000 - $37,000
Indirect cost of treatment[2]	$2,000
Averted medical costs [26]	$200,000

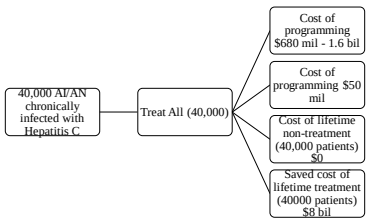
Policy Option A – No Change



Policy Option B – Treat Urgent Cases

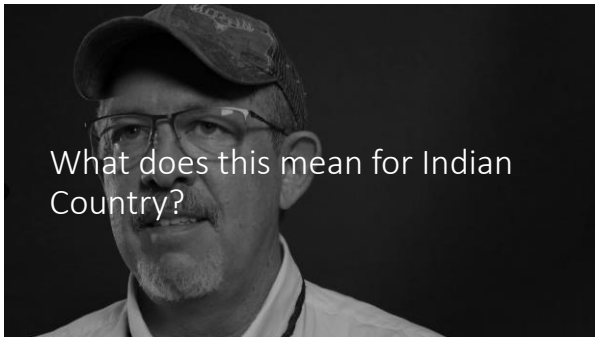


Policy Option C – New "Treat All"



Comparison of Options

	Current Treatment – 0.7%	Urgent Need of Treatment – 12%	Treat All – 100%
Direct and Indirect Cost	4.7 mil – 10.9 mil	78 mil – 180 mil	680 mil – 1.6 bil
Programming Costs	0	1,000,000	50,000,000
Lifetime Cost of non-Treatment	7.9 bil	7 bil	0
Lifetime Costs Saved	56 mil	920 mil	8 bil
Total Net	-8 bil	-6.2mil – -6.3 mil	7.3 – 6.4 bil



Financial Disparities in Indian Country

Per patient annual health care spending:

Medicare	$12,042
National	$7,713
Veterans Affairs	$6,980
Bureau of Prisons	$5,010
IHS	$2,849

FY 2019 National Tribal Budget Formulation Workgroup's recommendation is $32B to fully fund IHS

A HCV Success Story – Department of Veterans Affairs

- The VA has treated more than 92,000 HCV-infected veterans since all-oral DAAs became available in January 2014, with cure rates exceeding 90%*
- At current treatment rate, VA will have treated all its HCV patients in approximately 3 more years*

* Annals of Internal Medicine, **Medicine and Public Issues |3 October 2017** ***Curing Hepatitis C Virus Infection: Best Practices From the U.S. Department of Veterans Affairs*** Pamela S. Belperio, PharmD; Maggie Chartier, PsyD, MPH; David B. Ross, MD, PhD, MBI; Poonam Alaigh, MD; David Shulkin, MD

A HCV Success Story – Department of Veterans Affairs

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- At current treatment rate, VA will have treated all its HCV patients in approximately 3 more years*
- The VA has had special allocation of funding of over 3 billion dollars

* Annals of Internal Medicine, **Medicine and Public Issues |3 October 2017** ***Curing Hepatitis C Virus Infection: Best Practices From the U.S. Department of Veterans Affairs*** Pamela S. Belperio, PharmD; Maggie Chartier, PsyD, MPH; David B. Ross, MD, PhD, MBI; Poonam Alaigh, MD; David Shulkin, MD

What needs to be done?

- Leadership support
- Policy
- Strategy
- Collaborative work
- A careful analysis and decision to move forward with one of the policy options.
  - If coming from an evidence and practice-based best practice – the "treat all" policy would be the best for the system and the patients.

Nt’oyaxsn

“We are responsible for ourselves and each other” – Kodiak Aluttiiq Traditional Value



METHAMPHETAMINE CONTAMINATION

- INTRODUCTION
- ACCEPTABLE LEVELS OF CONTAMINATION
- COST AND INDUSTRY REQUIREMENTS
- TRAINING
- CLEANUP PROCESS
- POLICY EVOLUTION

- TENANT REACTION AND RESPONSE

  TESTING AND CLEANUP ACCURACY AND EFFICIENCY

  WHAT WE SEE TODAY

  EVOLUTION OF THE METH LAB

  MOVING FORWARD

- INTRODUCTION

  THOMAS DICKERSON
  TULALIP TRIBES HOUSING MAINTENANCE MANAGER

  OFFICE 360-716-4473
  CELL 425-622-4855
  FAX 360-716-0211
  EMAIL TDICKERSON@TULALIPTRIBES-NSN.GOV

ACCEPTABLE LEVELS OF CONTAMINATION

- WHAT WE CAN DETECT
- WHAT BECOMES A HEALTH HAZARD
- DEFINING THE HAZARD

COST AND INDUSTRY REQUIREMENTS

- COST AT DIFFERENT CONTAMINATION LEVELS
- SUBCONTRACTOR VERSUS IN HOUSE

METH CLEANUP BECAME BIG BUCKS

https://www.npr.org/templates/story/story.php?storyId=5059893

TRAINING

HAZWOPER

CDL REMEDIATION WORKER

CDL REMEDIATION SUPERVISOR

CLEANUP PROCESS

TESTING

CLEANING

DEMOLITION

DISPOSAL

POLICY EVOLUTION

WASHINGTON STATE LAW IN 1999

WASHINGTON STATE LAW IN 2014

POLICY TODAY

TENANT REACTION AND RESPONSE

DENIAL

ATTEMPTED CLEANUPS

TESTING AND CLEANUP ACCURACY AND EFFICIENCY

IT ISN'T…

UNIVERSITY OF WASHINGTON STUDY

CONTRACTOR CONFLICT OF INTEREST

POSSIBLE MANIPULATION

WHAT WE SEE TODAY

METHAMPHETAMINE

HEROIN

PILLS

FENTANYL

EVOLUTION OF THE METH LAB

BREAKING BAD

SHAKE AND BAKE

'Shake and bake' meth lab explodes in man's pants during scuffle with state trooper

By Daily Mail Reporter
Published: 14:56 EST, 27 April 2012 | Updated: 15:33 EST, 27 April 2012

Read more: http://www.dailymail.co.uk/news/article-2136304/Shake-bake-meth-lab-explodes-mans-pants-scuffle-state-trooper.html#ixzz53zdqtBjw
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'Shake and bake' meth lab explodes in man's pants during scuffle with state trooper

By Daily Mail Reporter
Published: 14:56 EST, 27 April 2012 | Updated: 15:33 EST, 27 April 2012

MOVING FORWARD

FENTANYL CRISIS: OHIO COP ACCIDENTALLY OVERDOSES DURING DRUG CALL

https://www.nbcnews.com/storyline/americas-heroin-epidemic/fentanyl-crisis-ohio-cop-accidentally-overdoses-during-drug-call-n759741

Tribal Policy Guide: An Indigenous Perspective on Policy Development

Adam Becenti, Diné Nation
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NICWA
National Indian Child Welfare Association
Protecting Our Children • Preserving Our Culture

January 17th, 2018

NPAIHB
Indian Leadership for Indian Health

Presentation Objectives

- Preview of the policy toolkit content, resources and tools
- Discuss:
  - Purpose and use of the guide
  - Theory and methodologies used
  - Policy phases
  - Discussion Questions

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Tribal Customary Policy

- Natural and customary law established by traditional beliefs & values
- Tribal perspective:
  - Guided tribal people in maintaining traditions, surviving inconceivable events, and thriving

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Purpose

- Support tribal community driven policy
- Provide a guide for tribal nations/communities in the policy making process
- Offer ideas, concepts, and structure relating to how tribal communities may approach policy
- Highlight and honor tribal perspective for policy development

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Utilization of Guide

- Practical step-by-step guide
- Course of action
- Address community need
- Advocacy/education for non-native partnership
- Tribal framework
- Tribal Sovereignty

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Traditional Forms of Policy

- Customary law, tribal protocol, community norm
- Philosophy/belief systems
- Traditional roles
- Application to modern day context

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Theoretical Framework

- Relational World View
- Benefits
- Application

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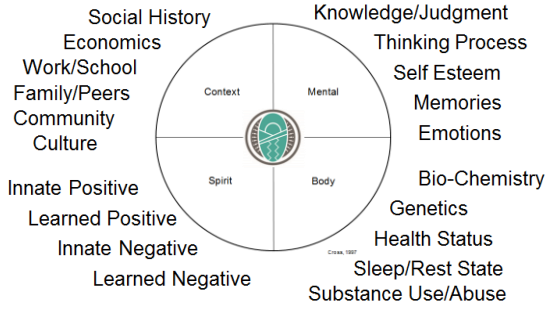
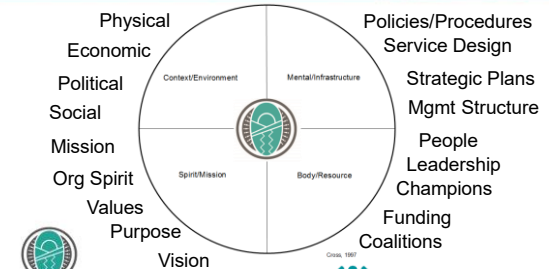
Relational Worldview Model Individual/Family Level



Relational Worldview Model Organizational Level



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Community Quadrants

Community Environment/Context: Social, political, economic, cultural, spiritual, community dynamics, relationships of community members to systems, institutions/organizations, or agencies. History of the community (e.g.. boarding schools, BIA, & federal Indian policy).

Community Infrastructure/Mind: System/services in community, formal/informal governing bodies, capacity of community organizing, community protocol/taboos, and community policies/procedures.

Community Resources/Physical: Formal/informal leaders within the community, expertise, education, & experience of community members, community readiness/capacity, identity of the community, elders, youth, medicine men/woman, cultural practices/traditions, community partnerships, and community space.

Community Mission/Spirit: Culture of community, tradition of community, community norms, roles of men/women in community, community practice, values of community, philosophy of the community, influences include both positive/negative learned teachings and practices, as well as positive/negative metaphysical or innate forces.

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Balance/Harmony

- How will your policy holistically incorporate the community level quadrants (e.g. environment, infrastructure, mission, and resource)?
- How does your policy consider the variables (e.g. quadrants) that may disturb the balance within the community?
- What factors can come into harmony and allow the community to achieve its goals and perform with excellence?

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Tribal Example

Policy: Traditional Tobacco Program & Policy
Re-introduce the use of traditional tobacco through education on the difference between Traditional and Commercial Tobacco. In addition, this policy is aimed to reduce and prevent the use of commercial tobacco to improve the health of the community.

Environment: policy helps to balance the use of tobacco by the community

Infrastructure: policy balances the relationship between community protocol and the health standards

Resources: policy is community driven with the voice and experience of the people

Mission: policy honors cultural traditions and community norms

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Tribal Example

Policy: Incorporation of tribal customary, natural, and common law within tribal justice system.

Environment: Integrating tribal customary law into justice system strengthens tribal sovereignty.

Infrastructure: Utilizing natural and customary law informs protocol for justice system.

Resources: Elders can serve as cultural advisors to justice system while youth can learn traditions of justice system protocol.

Mission: Adherence to traditional customs and/or practice respects the spiritual realm.

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Policy Process

- Thought behind our approach
- Structure
- Policy phases

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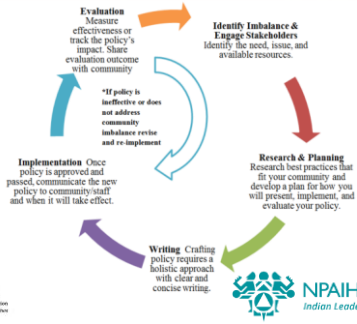
Phases of Policy



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Tools for the Community

- Environmental scan
- Community readiness
- Writing considerations
- Policy templates/Resolutions
- Policy checklist
- Evaluation & research
- Stakeholder engagement
- Roles within the community

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Discussion

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Thank You!

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IHS Health Information Technology Update

CAPT Mark Rives, DSc, CHCIO, Chief Information Officer
Indian Health Service
January 2018

Recent Cybersecurity Events

Cybersecurity events
- Ransomware outbreaks
  - WannaCry
  - Petya
  - Not-Petya
  - Impacted many organizations around the globe
  - IHS and Tribal IT organizations worked together to address vulnerabilities
- Meltdown and Spectre
  - 10 year old vulnerability
  - All Devices with processors
  - DHS reporting
  - Impacted cloud-service providers most

Recent Health IT Events

VA announcement to leave VistA
- VA Sec Shulkin announced in June 2017
  - 18 months before first implementation
  - 8-9 years transition

IHS response
- Already planning a Health IT modernization effort
- Working closely with stakeholders
- Working closely with HHS

RPMS EHR History

The Indian Health Service has long been a pioneer in using computer technology to capture clinical and public health data.

The IHS clinical information system is called the Resource and Patient Management System (RPMS).

RPMS development began nearly 30 years ago, and many facilities have access to decades of personal health information and epidemiological data on local populations.

The primary clinical component of RPMS, Patient Care Component (PCC), was launched in 1984.

The RPMS EHR graphical user interface represents the next phase of clinical software development for the IHS and was launched in 2004.

RPMS EHR and MU

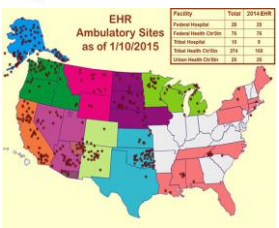
In April 2011, the IHS Resource and Patient Management System (RPMS) was certified according to standards established by the Office of the National Coordinator for Health Information Technology (ONC).

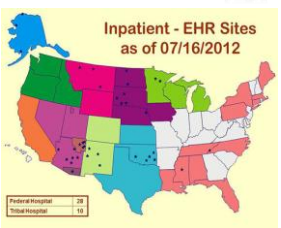
This accomplishment allowed Eligible Professionals (EPs) and Eligible Hospitals (EHs) to participate in the Centers for Medicare and Medicaid Services (CMS) EHR Incentive Program.

With the release of the 2014 ONC Rule and the 2014 CMS Stage 2 Rule, the scope of requirements for demonstrating Meaningful Use were greatly increased, and new certified electronic health technology (CEHRT) became necessary.

As of August 22, 2014, the 2014 RPMS EHR was certified according to the 2014 ONC standards

RPMS Deployments in IHS





Veterans Administration & VistA

IHS RPMS and VA VistA had shared start

RPMS and VistA are "open source" software

IHS relies on VA for some software development

IHS adapts VA software code then adds additional code for additional capabilities

VA Announcement to leave VistA means that IHS loses a source of software code development that we did not have to fund

Impact on the Resource and Patient Management System (RPMS) and IHS stakeholder engagement

Held four listening sessions and gathered comments.
- Plus, received 22 sets of comments via email and mail

Engagement at all levels within HHS.
- VA, HHS OCTO, HHS ONC, USCG, DoD MHS, tribal health programs, TSGAC, DSTAC, HHS ASFR, and numerous industry analysts.

Developed Request for Information (RFI)
- Goal: Ask industry what they would propose as a solution
- Anticipated outcome: Good understanding of HIT as a foundation for a larger strategy
- Status – Published in FedBizOps / Response due date: Feb 1

RPMS

Pros

Historically focused on Population Health and improving clinical outcomes

Designed by and for use in AI/AN healthcare delivery

Designed to meet specific functionality (i.e. PRC)

Multiple SureScripts White Coat of Quality awards, two Davies awards, two ComputerWorld awards, and an HHSInovates Award.

Mega-suite EHR platform – "Does it all"

Cons

Increased functionality demands/requirements outpacing development capabilities

Source of software development limited to IHS/OIT

Limited sources of training and support

Heavy reliance on local system administration and configuration

Heavy reliance on contracted development

Doing it all strains priorities for update/development

Information Systems Advisory Committee (ISAC)

Purpose: Established to guide the development of a co-owned and co-managed Indian health information infrastructure and information systems.

Goal: assure the creation of flexible and dynamic information systems that assist in the management and delivery of health care and contribute to the elevation of the health status of Indian people.

Charter: Located on IHS.GOV/ISAC

- Note: Being revised to simplify membership nomination and expand tribal participation

Meetings & Calls

- Last: Oklahoma City – Sept 2017
- Next call: December 8, 2017
- Next meeting: Phoenix Area – March 2018

Update from ISAC Meeting, September 19-20, 2017 Recommendations

The ISAC recommends the IHS Chief Information Officer (CIO) provide a standing report on the monthly All Tribes conference call for transparency in Information Technology (IT)/Health IT (HIT) programs, services, functions, and activities.

The ISAC advocates for continued collaboration between IHS and the Veterans Affairs (VA) and the Department of Health and Human Services (HHS) on HIT modernization efforts, acknowledging the initiative is in early discovery right now.

The ISAC recommends the IHS go forward with a budget request for HIT modernization as soon as feasibly possible.

The ISAC recommends that the IHS and OIT strategic plans include reference to the OIT Human Capital Management Plan.

Update from ISAC Meeting, September 19-20, 2017 - Actions

The ISAC continues to work on updates to the ISAC Charter.

The ISAC continues to work on updates to the OIT Human Capital Management Plan to place more emphasis on Informatics positions and updating IT position descriptions.

The ISAC will continue work on revising the FY 2018-2019 IT Priorities to add HIT modernization, infrastructure, a phased approach for modernization, and process improvement.

- The IT priorities will be shared with IHS management, Areas, Tribes, and other stakeholder groups.

Factors to consider

IHS is taking an advanced posture to plan for Health Information Technology Systems modernization.

RPMS and VISTA will continue to be supported in the near term only.

RPMS development to date has always been supported by and dependent upon the VISTA platform.

There is the potential for significant cost savings and efficiencies by moving to a common Federal EHR platform.

IHS has unique needs for patient care, population health management, and referral management and many of those are different from the VA and DoD- but a common federal platform may allow for the type of local flexibility many areas may desire.

Factors to consider, concl.

IHS clinicians, administrators, tribes and tribal organizations and other stakeholders will be very involved in how the process moves forward and in the implementation of the system.

In many ways IHS is well ahead of peers in clinical IT innovations and we will not discard our past work. And our work will help other partners in turn.

Furthermore IHS must obtain interoperability with VA, DoD, tribal and urban programs, academic affiliates, and community partners, many of whom are on different IT platforms.

We must consider an integrated product that will require a meaningful integration with other vendors to create a system that serves IHS, tribal, and urban beneficiaries in the best possible way.

Vision

We need technology to support the IHS mission… to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

This includes (but is not limited to) support for:

- Patient and family centered medical home
- Patient access to the medical record
- Interoperability
- Behavioral health / integrated care / traditional approaches
- Specialty care coordination / referrals
- Population health approaches
- Creative and innovative solutions with a look to the future
- Data analytics
- Data reporting
- Billing / revenue generation…

Near term Plans for IHS HIT Platform

Must continue to develop interoperability functionality to ensure access to patient data.

Continuing development for
- EPCS
- New Medicare Cards (NMC)
  - 8 RPMS applications that will require modifications
  - Expected to release in Feb 20, 2018 (FY18Q2 release)
  - Other minor application updates for reporting will occur throughout 2018 to address reports.
- Routine Updates
  - Update schedule to be published on IHS.Gov

All options are still in consideration.
- Working towards a broader HIT Modernization initiative

Questions?

Mark.Rives@ihs.gov

NPAIHB
Indian Leadership for Indian Health

Northwest Portland Area Indian Health Board

To:	Tribal Delegates, Tribal Health Directors, and Tribal Clinic Directors
From:	Northwest Portland Area Indian Health Board
Date:	January 16, 2018
Re:	RPMS/EHR Briefing for IHS Presentation/Discussion at NPAIHB Quarterly Board Meeting January 16-18,2018

I. Resource and Patient Management System (RPMS) Electronic Health Record (EHR) Consultation - Dear Tribal Leader Letter on 6/26/2017

REQUEST: NPAIHB requests that IHS conduct a consultation with the Northwest tribes prior to making a final decision on whether to modernize the current RPMS EHR or move to a new EHR system. Additionally, we request that IHS provide an ample transition period, training, and technical assistance to tribes once IHS makes a decision on whether to improve RPMS or contract with a new EHR system.

- Since 1984, the IHS has relied on RPMS as the health information solution. The RPMS is a government-developed health information system comprised of over 80 integrated software applications. The RPMS hardware, software, network, and database allows both large and small health facilities to work independently as well as within the larger network of the Indian Health system.
- VA has announced plans to modernize their EHR, the Veterans Information System and Technical Architecture (VistA). RPMS has a similar infrastructure and clinical applications to VistA. The VA has selected to single source contract with Cerner as to be on the same platform as Department of Defense (DOD).
- Thank you to IHS for including tribal consultation early in the process.
- Where is IHS is the process of communicating with VA on the new EHR system and impacts to operability to the RPMS system?
- Has the IHS ISAC workgroup made any recommendations?

II. Tribal Recommendations

- The Northwest tribes recommend that the RPMS improvements or the new EHR system focus on the benefits to patient care that improve the involvement and utilization of providers in the health IT system.

- We also recommend that IHS take into consideration the various EHR systems that tribes utilize instead of RPMS.
- There is a need for a more comprehensive configurable system to be pushed out nationally versus individual systems operating at each site.
- Many small health facilities in Indian Country do not have the capacity to fully optimize the existing RPMS EHR and would benefit from a system that has the capability to share more components such as drug files containing all available drugs or customized menus that users may use to place orders.
- There needs to be additional training and technical support, especially for smaller tribal health clinics because small clinics often only have a part-timer person who has not received as much training and experience with the system.
- It is crucial that IHS make the RPMS EHR more user-friendly. The EHR should include a friendlier format for health care providers to highlight certain patient information and reporting for data collection purposes.
- IHS must make operability more of a focus in the modernization of the RPMS or a new EHR system, so that the system is more streamlined and aligned with other EHR systems.

III. Tribal Health IT Issues

- There is not enough robust timely health IT support from IHS to each tribal health clinic. When needed changes are identified, too much time passes before they are delivered to the user.
- IHS must take into consideration that workforce training is a huge problem. Training currently does not occur often enough; for example, the basic training may not be offered for up to six months. The electronic learning courses also fill up too quickly compared to the in-person classroom style trainings. The training manuals and procedures need to be updated.
- It is challenging to identify and stay current with all of the most up-to-date patches and other updates to the software system.
- Interoperability is a problem especially with patients who are referred out in a different system. When two different health care systems are not able to communicate to one another then the patient's medical history is incomplete, which leaves a gap in care coordination.
- There is a responsiveness issue with software problems. When the issue is identified, too much time lapses between the problem being reported to when the users obtain the information on a work around or a fix is delivered.
- The billing package for RPMS is a barrier because it is not robust enough to handle sites that see non-tribal members.

IV. IHS ISAC Workgroup Meeting 9/17/2017

- IHS declared during the September ISAC meeting that they have not made a decision yet on whether they are going to modernize RPMS or transition to a commercial off-the-shelf system.
- HHS is engaged in the RPMS meetings and process.
- It was decided that IHS would do a phased approach for the budget process with the initial dollar request going forward for 2020.

American Indian Health Commission for Washington State

Cross Jurisdictional Collaboration Project

Distributing Medical Countermeasures Across Tribal and Non-Tribal Jurisdictions

January 17, 2018
NPAIHB Quarterly Board Meeting

Presenter:
Lou Schmitz, Consultant

Today's Presentation

PART 1: Understanding Medical Countermeasures and Medical Materiel

PART 2: Protecting Your Community through Cross-Jurisdictional Collaboration

PART 3: Overview of 2017-2018 Cross-Jurisdictional Collaboration Project

PART 4: The Asks

American Indian Health Commission for Washington State

2

American Indian Health Commission for Washington State

About Us

Pulling Together for Wellness
We are a Tribally-driven, non-profit organization providing a forum for the twenty-nine tribal governments and two urban Indian health programs in Washington State to work together to improve health outcomes for American Indians and Alaska Natives.

Part 1

UNDERSTANDING MEDICAL COUNTERMEASURES AND MEDICAL MATERIEL

American Indian Health Commission for Washington State

Public Health Threats

Chemical
Biological
Radiological
Nuclear

Pandemic Influenza

Emerging Diseases

5

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Medical Countermeasures

Medical treatments or prophylaxes for public health threats

6

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Medical Materiel

Supplies, equipment and other items needed to treat or protect against public health threats

7

American Indian Health Commission for Washington State

Our Mission

We must assure that Tribes receive appropriate and sufficient medical countermeasures and materiel in a timely manner during public health emergencies

8

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Part 2

PROTECTING YOUR COMMUNITY THROUGH CROSS-JURISDICTIONAL COLLABORATION

9

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Why is collaboration between Tribes, Local Governments, and the State **vital** to community health and safety?

10

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Every emergency and public health incident is experienced first and is responded to first by local, tribal, and state personnel.

See Homeland Security and Emergency Management, Abbott and Hetzel, p. 5

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American Indian Health Commission for Washington State

Public health issues, emergencies and disasters know no boundaries

American Indian Health Commission for Washington State

capacity

No federal, state, local, or tribal government has the capacity to respond to every public health incident or emergency that may occur within its jurisdiction without assistance

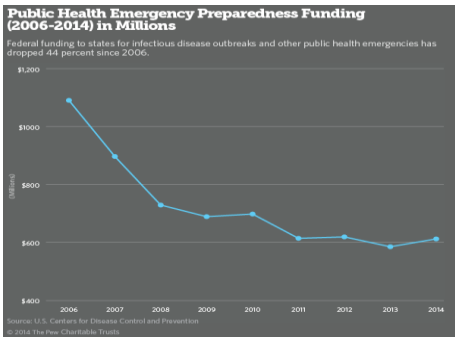
Cascadia Rising Exercise 2016

During a catastrophic event, some areas of Washington State may have to wait up to 7 days for state and/or federal assistance

Collaboration + preparedness

The unfolding of a catastrophic event is a poor time to begin learning how to collaborate with neighboring jurisdictions and knowing their capabilities and available resources

Diminishing Federal Funding



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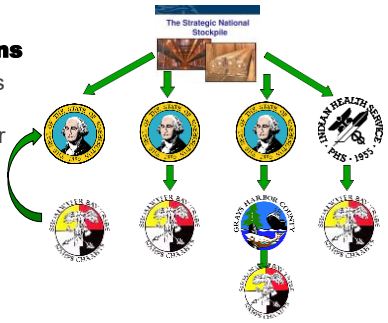
Options

What is best for your Tribe?



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Part 3

OVERVIEW OF 2017-2018 AIHC CROSS-JURISDICTIONAL COLLABORATION PROJECT

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American Indian Health Commission for Washington State

Project Goal

Assure the appropriate amount and type of medical countermeasures and materiel reach every Tribe quickly during public health emergencies

Project Objectives

- Strengthen collaboration and mutual aid between Tribes and non-Tribal partners
- Enhance each region's ability to manage and distribute medical countermeasures and materiel
- ***Prevent problems like those experienced during 2009-2010 H1N1 response***

Important

Regional Meeting Dates

Mark Your Calendar

Meeting 1 – Desired Outcomes

- Increase partners' understanding of each others' capacity, organization, resources, etc.
- Plan a tabletop exercise

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Meeting 2 – Desired Outcomes

- Test each region's ability to effectively distribute medical countermeasures and materiel across Tribal and non-Tribal jurisdictions
- Identify potential legal issues/challenges
- Document and provide actionable insight on strengths and areas for improvement
- Test and compare performance in partners who are signatories to Mutual Aid Agreements versus partners who are not

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Project Products

- Partner profile template
- Partner profiles
- Tabletop exercise scenario
- After-Action Reports
- Final project report
- Recommendations to address Tribal issues in the 2019 statewide full-scale exercise

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Part 4

THE ASKS

American Indian Health Commission for Washington State

The Asks

1. Please send tribal representatives to the two CJC meetings: (Tribal Leaders, Tribal Health Directors, Medical Directors, CHRs, Clinic Managers, Emergency Managers, YOU)
2. If your jurisdiction has not yet signed the *"Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State,"* **please consult with your legal counsel to finalize the agreement for your tribe**

http://www.aihc-wa.com/aihc-health-projects/emergency-preparedness/mutual-aid-project/

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American Indian Health Commission for Washington State

Questions?

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American Indian Health Commission for Washington State

Growing the Native
Public Health Workforce

I-LEAD

JANUARY 2018
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

I-LEAD

- 3-year project
- Partnerships with:
  - OHSU
  - We Are Healers
  - EngenderHealth

I-LEAD **AIMS**

- Improve resilience and life skills among AI/AN youth (14 to 24 years-old)
- Increase AI/AN youth participation and success in leadership positions
- Prepare AI/AN youth to join the public health workforce

I-LEAD **Goals**

- Improve **resilience** and **life skills** among AI/AN youth by increasing their participation and success in leadership positions and by preparing them to join the public health workforce.
  1. Create a year-long **training** program for We R Native's Youth Ambassadors and a newly-formed NPAIHB Youth Council
  2. Build an interactive **text mentorship** platform for AI/AN youth interested in the health professions.

TRAINING PROGRAM

Youth Ambassador & Youth Council Training Program

- NPAIHB will partner with EngenderHealth to create and launch a year-long training program for We R Native's Youth Ambassadors and a newly-formed NPAIHB Youth Council.
- The trainings will be delivered using Facebook, text messaging, and Zoom video-conferencing. Throughout the year, participants will use We R Native's communication channels to amplify their voice, promoting healthy social norms in their local communities and beyond.

TEXT MENTORING

Text Mentoring

- Enhance workforce readiness among 100 AI/AN youth by partnering with Oregon Health and Sciences University and We Are Healers to build an interactive text message-based mentorship platform for AI/AN youth interested in the health professions.
- Participants will be matched to paid internships and professional mentorship opportunities, and will receive training in research and evaluation methods, community-based participatory research strategies, and data literacy.

CREATING THE NPAIHB YOUTH COUNCIL

NPAIHB Youth Council Creation

- Recruitment
  - Ages
  - Recommendations (referrals) from Delegates?
  - From current Tribal Youth Councils
  - Other ideas?

NPAIHB Youth Council Creation

- Meetings
  - Virtual
  - At Summer QBM?
  - At THRIVE Conference?
  - Based on host location?

NPAIHB Youth Council Creation

- Involvement with the Board
  - Interact with Delegates?
  - Just at QBMs?
- Skills/experience you would like them to have?
  - Write and pass a resolution
  - Others?

Northwest Portland Area Indian Health Board

Indian Leadership for Indian Health

2121 SW Broadway, Suite 300
Portland, Oregon 97201
Phone: (503) 228-4185
Fax: (503) 228-8182

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Director – Project Red Talon & THRIVE
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Tana Atchley
I-LEAD Project Coordinator
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PLEASE JOIN US FOR THE 2018 CONTEMPORARY NORTHWEST TRIBAL HEALTH CONFERENCE APRIL 27-28, 2018

- Highlighting various health research efforts in American Indian/Alaskan Native (AI/AN) communities through oral and poster presentations, sharing best practices and lessons learned, and providing time for networking.

- All day Friday the 27th & the morning of Saturday the 28th

- Location: Native American Student & Community Center, Portland State University

FOR MORE DETAILS:

Please check NPAIHB's website at www.npaihb.org for more information. Additional questions can be addressed to Nancy Bennett at nbennett@npaihb.org

NPAIHB
Indian Leadership for Indian Health

PRC
Prevention Research Centers

SUMMER RESEARCH TRAINING INSTITUTE 2018

For American Indian & Alaska Native Health Professionals

Save the Dates

June 11-29, 2018

Location

Northwest Portland Area Indian Health Board
Portland, Oregon

Sponsored by

Northwest Portland Area Indian Health Board, Native American Research Centers for Health, Oregon Health & Science University - Center for Healthy Communities, & Indian Health Service.

For more information

Visit: www.npaihb.org/training/narch_training
Email: summerinstitute@npaihb.org

Previous courses included:

- Adolescent sexual health
- Cancer prevention and control
- Community-based participatory research
- Environmental epidemiology
- EpiData, STATA, and SAS
- Epidemiology methods
- Health literacy
- Human subjects protection
- Indian health policy
- Indigenous ways of knowing
- Introduction to epidemiology
- Maternal and child health
- Measuring quality improvement
- Program evaluation
- Qualitative research design
- Questionnaire design
- Research design & grant development
- Substance abuse epidemiology

For more information, visit our website:
www.npaihb.org/summer_institute
or email us: summerinstitute@npaihb.org

We welcome participation from other Native groups, including Native Hawaiians, Pacific Islanders, and First Nations/Inuit/Metis.

Postage

If you would like to be added to our mailing list, please fill in your name and email, place a stamp on the upper right hand corner of this card, and mail back to us.

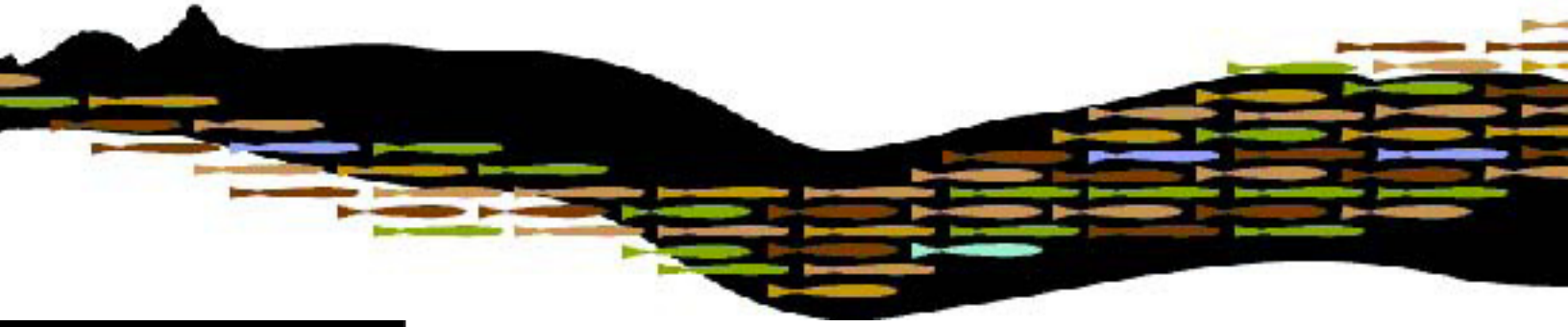
Name:_____

Email:_____

Mail To: Summer Institute
2121 SW Broadway #300
Portland, OR 97201

PRC
Prevention Research Centers

Tribal Researchers' Cancer Control Fellowship Program



Dates:
June 17-29th, 2018

Location:
Northwest Portland Area Indian Health Board, Portland, Oregon

Contact:
Ashley Thomas
Phone: 503-494-2907
Fax: 503-494-7536
E-mail: thomaas@ohsu.edu

Application Period:
Available: January 31st
Deadline: March 31st

Sponsored by the National Cancer Institute, Native American Research Centers for Health (NARCH), OHSU Prevention Research Center, & Northwest Portland Area Indian Health Board

SEEKING APPLICATIONS FROM QUALIFIED TRIBAL HEALTH RESEARCHERS TO JOIN CANCER CONTROL RESEARCH TRAINING PROGRAM

Building upon 15 years of experience in this area, we are excited to offer a new set of training activities and opportunities for qualified applicants.

Accepted Fellows will:

- Attend a two-week training in June 2018
- Attend one-week training in Fall 2018
- Receive peer and career mentorship to develop and implement cancer control projects
- Receive financial support to present research findings
- Be connected to a network of experts in cancer control and prevention in Indian Country

WHO SHOULD APPLY

Applications are encouraged from American Indians and Alaska Natives with a demonstrated interest in cancer prevention and control.

For application forms and more information, please visit the NPAIHB website at: http://www.npaihb.org/narch-training/

Elders Health Committee

Tuesday January 16, 2018
Embassy Suites By Hilton Portland Airport, Portland, OR

	Name and Title	Organization	Phone/FAX/E-mail
1	Ron Charlson	CTUIR 215	360-273-5911
2	Patty Kinswa-Cain	Colville	360 520-25[illegible]
3	Andy Joseph	Colville	
4	Janice Clements	Warm Springs Hlth+Wlns	
5	[illegible]	[illegible]	
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8	Clarice Changing	NPAIHB staff	
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Elder Committee Meeting Minutes

January 16, 2018

Embassy Suites by Hilton Airport

Portland, OR

Members: Patty Kinswa – Gaiser, Cowlitz Tribe, Janice Clements-Warm Springs Tribe, Twila Teeman – Burns Paiute Tribe, Louella Azule – Confederated Tribes of The Umatilla Indian Reservation/NPAIHB staff, Andy Joseph – Colville Tribe, Dan Gleason, Chair – Chehalis Tribe

NPAIHB Staff: Clarice Charging

Dan asked Andy for the opening prayer.

Dan asked for a motion to approve October 2017 minutes. Twila motioned. Andy seconded. Motion approved.

Updates:

Burns Paiute: Elders and youth are meeting at the tribal community center and continuing their work with their language project.

Colville: Tribal elders are updating their tribal code and have requested from Washington state their elder code guidelines.

Cowlitz: Elders are working on community gardens at Saint Mary's mission. They are taking trips and working together to build their community.

Chehalis: Classes have been provided to elders on plants, herbal medicines etc. Tribe held a grand opening of their second hotel, Fair Child Marriott. Elders were invited to stay overnight.

Warm Springs: Tribal council are working with elders, several have water and well problems at their residences. Wilson Wewa, Tribal Elder Program Director is applying for grants to secure additional funding for elders.

Behavioral Health Committee

Tuesday January 16, 2018
Embassy Suites By Hilton Portland Airport, Portland, OR

	Name and Title	Organization	Phone/FAX/E-mail
1	Tribal Affairs Director Julie Johnson	Oregon Health Auth.	julie.a.johnson@State.or.us
2	Alah Ham Health Committee Grand Ronde	Grand Ronde Tribe	503-449-2721 alahham1951@hotmail.com
3	Darryl Scott	Conf Tribes of Warm Springs	darryl.scott@wstribes.org
4	Leta Campbell	Coeur d'Alene tribe	LCampbell@CDAtribe-NSN.gov
5	Stephanie Craig Rushing	NPAIHB	scraig@npaihb.org
6	Celena McCray	NPAIHB	cmccray@npaihb.org
7	Colbie Caughlan	NPAIHB	ccaughlan@npaihb.org
8	Joshua Smith	NPaihb	JSmith@npaihb.org
9	Aliza Brown	Quinault Nation	ABROWN@Quinault.org
10	Julie Hargraves	Cow Creek	Jhargraves@cowcreek.co
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NPAIHB Behavioral Health Committee – Meeting Minutes

Portland, OR – January 2018

Participants: Julie Johnson, Alan Ham, Darryl Scott, Leta Campbell, Stephanie Craig Rushing, Colbie Caugnlan, Celena McCray, Joshua Smith, Aliza Brown, Julie Hargraves

- **Introductions**
- **eMAR: Activity Reports and Quarterly Reports**
    - Stephanie Asked: What would you like to know about our project activities that will be included in our quarterly reports to you?
    - Attendees reported: We haven't seen the Quarterly Reports.
- **Tele-behavioral Health**
    - Tribes have reported: We need more psychiatrists and behavioral health providers...
    - Including Traditional Healers, who can receive reimbursement for traditional practices. Traditional healers include the entire family in the treatment process.
        - One approach might be to get them recognized as Peer Support Specialists. They can be licensed in OR, WA and ID. Tribes can be reimbursed for their services.
        - Tribes can also write Traditional Healers into their treatment plan.
        - THRIVE's GLS grant can cover traditional treatment, for their grantees.
        - Challenges remain, covering traditional treatment supplies and incentives.
    - For-Profit Vendors:
        - Antonio Rodriguez – works with Tribes in the SW
        - Regroup Therapy – Will be at ATNI if you'd like to talk to them in person
    - Behavioral Health Apps might be another avenue to persue/explore.
- **Has anyone heard of kraton?**
    - Apparently is Highly Addictive, and is being sold at the Grand Ronde's grocery story.
    - **To-Do: Stephanie** will look up information/resources.

- **Suicide Prevention Training**
    - In WA State (which mandates training for medical personnel) – THRIVE can help your staff acquire the required 3- or 6 –hours of training that is now required in Suicide prevention. Contact Colbie (ccaughlan@npaihb.org) or Celena for assistance. THRIVE can also cover the cost to bring a trainer to you, if appropriate.
- **The group discussed trainings for youth, to build suicide peer intervention skills:**
    - Healing of the Canoe Curriculum – www.HealthyNativeYouth.org
    - Hope Squad
    - SOS – Signs of Suicide
    - Kognito – Friend 2 Friend – Is free for Tribal youth. Download in the App store.
- **The group also discussed "CANS" Training, which is a required assessment tool (by OR DHS) for staff within CPS and foster care systems.**
    - It's a screening you do with the child. The training is for providers, who need it to assess youth.
    - Online trainings exist. Warm Springs would prefer something in-person.
    - Cow Creek uses the County's training/screening resources to get those trainings.
    - **To-Do: Julie Johnson** is going to look into the resources that are available through DHS.
- **Question: We have a young community member, who doesn't have health insurance, who is recovering from an accident...**
    - Purchased and referred care doesn't cover skilled nursing care or rehabilitation services for them. And it takes time to sign up for and receive disability... Some facilities won't take Medicaid patients.
    - **Question**: What are other tribes doing for young people in this situation?
        - We do have a few younger adults in our elder/nursing facilities.
- **The DVPI Response Circles Project has returned to the Board**
    - The funds will be used to cover training and training scholarships for DV trainings or conferences, like SART and SANE trainings.
    - There are forms on the back table if you'd like to request training., or contact Colbie (ccaughlan@npaihb.org) or Ethan for assistance.
- **Committee Report on Thursday:** Leta Campbell, Coeur d'Alene

Veterans Health Committee

Tuesday January 16, 2018
Embassy Suites By Hilton Portland Airport, Portland, OR

	Name and Title	Organization	Phone/FAX/E-mail
1	Don Heal	NRAHB	dheal@nrpi.org
2	Cindy Harris	Sauk-Suiattle	CHarris@SaukSuiattle.com 360 436 0131 ext 223
3	Harvey Moses Jr.	Colville Tribes	509-634-[illegible]32 [illegible]
4	Terry Bentley	VA OTGR	541-440-1271 terry.bentley@va.gov
5	Bill Murray	VA VISN 20	360-567-4684 william.murray3@va.gov
6	Nate Tyler	Malech	nate.tyler@malech.com [illegible]
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Veteran's Committee Meeting, Portland, OR, January 16, 2018

In attendance:
Nate Tyler, Makah Tribe
Cindy Harris, Sauk-Suiattle Tribe
Harvey Moses, Jr, Colville Tribes
Terry Bentley, VA Office of Tribal Government Relations
Bill Murray, VA VISN 20
Don Head, NPAIHB, staff

The minutes of the October, 2017 meeting were read.

Terry Bentley pointed out that if the Northwest Tribes wanted to request a roundtable for tribal consultation of the reimbursement restructuring, she has the contact information for the new person in that position. She'll send that contact information.

She also mentioned that the Umatilla Tribe is going through the application process to become a recognized VA claims representative for the purposes of assisting tribal veterans to access VA services. The VA is working with the Umatilla Tribe to strengthen the application so that it has the best chance to be approved.

Bill Murray talked about the Veteran's Choice program, which received supplemental funding in December, 2017 in the amount of $2.1 billion. The VA estimates that this will keep the Veteran's Choice program funded through the end of May, 2018, and that by then the Veterans Coordinated Access & Rewarding Experiences (CARE) Act may be passed. The CARE legislation is intended to replace the Veteran's Choice program as a permanent program. If the CARE Act isn't passed by the time the funds for the Veteran's Choice program are exhausted, Bill said that there would be another allocation, so that veterans will not be left without health care until the CARE Act is passed.

Harvey Moses, Jr. asked if the CARE Act had gone through tribal consultation, and Bill and Terry both indicated that it had been, and also that the CARE Act had been discussed and consulted on from a number of veterans groups in addition to the tribal consultation. Those groups included AMVETS, a veteran's advocacy group, the American Legion, and Paralyzed Veterans of America.

Bill Murray brought up one of the priorities outlined by the current director of VA, that of transparency. The VA is pushing towards complete transparency, and to that end, they publish a Sales Report for every VA hospital and clinic and gives them a grading based on wait times and workloads. The VA also publishes the opioid prescription rates for each of its clinics and hospitals.

Bill Murray also mentioned that the President signed an Executive Order that allows everyone exiting military service to receive one year of mental health services, no matter what the character of discharge was, up to and even including dishonorable discharges.

Points on the CARE Act were discussed, and then the meeting was adjourned.

Public Health Committee

Tuesday January 16, 2018
Embassy Suites By Hilton Portland Airport, Portland, OR

	Name and Title	Organization	Phone/FAX/E-mail
1	Victoria Warren-Means	NWTEC	
2	Danna Drum Strategic Partnerships Lead	OHA	503-957-8869 danna.k.drum@state.or.us
3	Andrew Shogren	Suquamish	
4	Kelle Little	Coquille Indian Tribe	kelle.little@coquilletribe.org
5	CELESTE DAVIS	SELF (NPAIHB CONSULTANT)	celestedavis3323@gmail.com
6	Taylor Ellis	NPAIHB	
7	Nancy Bennett	NPAIHB	
8	Bridget Canniff	NPAIHB	
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Public Health Committee Meeting Minutes

January 16, 2018

Portland OR

Attending: Kelle Little – Coquille Indian Tribe; Andrew Shogren, Suquamish

Danna Drum – Oregon Health Authority

Celeste Davis – Consultant NPAIHB

Taylor Ellis - NWTEC

Nancy Bennett - NWTEC

Bridget Canniff -NWTEC

Victoria Warren-Mears - NWTEC

Introductions

Taylor Ellis joined our staff as a Public Health Associate though September 30th 2019. She will be working with Bridget Canniff on a variety of Public Health Projects.

Save the Date:

April 27th and April 28th will be the dates of the Northwest Contemporary Tribal Research Conference sponsored by the NW NARCH. It will be held in Portland OR. Save the date cards are on the tables and in packets. More details will follow.

The week of May 14th will be the annual Public Health Emergency Preparedness. The conference will be held in Suquamish at the Clearwater Casino. The Oregon Health Authority has doubled their contribution to the conference. Our primary sponsors are Washington State Department of Health, Oregon Health Authority and the Board. Many other partners are included in planning.

A discussion was held about the quarterly report formatting.

Primary interests include:

- Programs that could be applicable
- Ideas for potential TA
- Brief descriptions of projects
    - Tool kits available
    - Resources available
    - Mini-grants

- How do projects assist in meeting the strategic plan
- Ability to search on line by Tribe

Suquamish Update:

Suquamish has hired their first health director. Andrew is tasked with exploration of the needs of the tribe with regard to the clinic. Generally people do not travel to Seattle for care. The tribe is looking at integration of health care.

Coquille Update:

Coquille opened a pharmacy and is exploring additional specialty services. The pharmacy is primarily for mail orders of maintenance medications and acute prescription needs of those residing within 20 miles of the pharmacy. Eventually the pharmacy will also be looking at giving immunizations in addition to the clinic.

DHATs will start their preceptorship during the summer,

The recent tribal BRFSS results were presented in a two hour workshop to tribal council. A comparison of those within the CHISDA and out of the CHISDA was provided with interesting results.

Youth Committee

Tuesday January 16, 2018
Embassy Suites By Hilton Portland Airport, Portland, OR

	Name and Title	Organization	Phone/FAX/E-mail
1	Tommy, PR Assistant Ghost Dog	NPAIHB	
2	David Stephens RN	NPAIHB	
3	Shawn Stanphill DVM	Star Creek Tribe	541-580-5517 SStanphill@cowaucle.com
4	Subido Hodges, Charity	Cowlitz Tribal Health Board	Charity.Subido@gmail.com
5	Kim Thompson	Shoalwater Bay	
6	Ethan Newcomb	NPAIHB	
7	Nanette Star	NPAIHB	
8	Tana Atchley	NPAIHB	
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Youth Committee- January QBM
Tuesday January 16, 2018
Portland, OR

Attendees (8)
Cowcreek Tribe: Sharon Stanphill
Cowlitz Tribal Health: Charity SabidoHodges
Shoalwater Bay: Kim Thompson
NPAIHB: David Stephens, Tommy Ghost Dog, Ethan Newcomb, Tana Atchley, Nanette Star

Youth Council Learning Objective Ideas:
-tribal sovereignty
-financial literacy
-council foundation
-policy
-Advocacy

-NPAIHB delegates act as mentors
-youth attend 1x per year in person (Board Pay; Summer time), and report back to communities
    -youth sitting in on some portions of the QBM, but having own track, and sharing with the delegates
    -summary of what youth have done at your tribe (Tribal Update) and what you plan to do,
    -Create network of youth who can call each other and connect
-First year cohort to help plan and lead the agenda for yr 2 youth track
-Require 1 yr commitment from youth
-create stand-alone content that youth can go through outside of in-person meetings
-Overall: Create a youth version of the QBM/delegates and a network for youth to connect outside of the QBM platform

Ambassador objectives
-employment readiness
-act as peer mentors
-skill building

Application Criteria
-Delegates nominate youth?
-Put together application criteria and send to delegates to share/nominate individual
-1 youth per tribe, but allow multiple to attend
-include in application: what would you like to get out of this

-How would the Youth Committee like to stay involved: send draft plans, provide updates, committee to provide guidance and ensure fulfilling mission, youth to give update using video/recorded video

-youth committee to send Tana, and Nanette info to relay to youth; get youth feedback on how they want youth committee to be involved.

Legislative/Resolution Committee

Tuesday January 16, 2018
Embassy Suites By Hilton Portland Airport, Portland, OR

	Name and Title	Organization	Phone/FAX/E-mail
1	Council member Nicholas Lewis	Lummi Nation	360 303 6084
2	CHERYL RASAR	SWINOMISH	360-391-4755
3	Cheryle Kennedy	CTGR	503-879-5211
4	Greg Abrahamson	Spokane	509-458-6507
5	Julie Reed	Snoqualmie	425-888-6551
6	Gerald Hill	Klamath Tribes	541 627-7009
7	Brent Simcosky	Jamestown	
8	Joe Finkbonner	NPAIHB	
9	Laura Platero	NPAIHB	
10	Andy Joseph J.	Colville Tribes	(509) 631 4406
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Legislative Committee Report
January 16, 2018

Attendees: Andy Joseph, Jr. (Colville), Greg Abrahamson (Spokane), Karol Dixon (Port Gamble S'klallam), Gerald Hill (Klamath Tribe), Julie Reed (Snoqualmie), Nickolaus Lewis (Lummi), Cheryl Rasar (Swinomish), Cheryle Kennedy (Grande Ronde), Brent Simosky (Jamestown)

Staff/Other: Joe Finkbonner, Laura Platero

Three resolutions were considered and one was requested by the Legislative Committee:

1. **Employee Recognition Policy**

   Under this resolution, the Board recommends that the Employee Recognition Policy be incorporated into the Program Operations Manual of the NPAIHB.

   Action: A motion was made (Spokane) and second (Lummi) to pass the resolution with edit of title to "Employee Recognition Policy" to the full board for consideration, then unanimous vote occurred approving same.

   Concurrent to resolution discussion in Legislative/Resolution Committee, Personnel Committee also discussed the policy and asked that it be tabled until a new proposal is presented as to award amounts/gifts for years of service.

2. **Tribal Practices for Wellness in Indian Country**

   This resolution endorses and supports the efforts by staff of the EpiCenter, under the guidance of the Executive Director, to pursue funding through the CDC PPHF Tribal Practices for Wellness in Indian Country Funding Opportunity.

   Action: A motion was made (Swinomish) and second (Spokane) to pass the resolution with edits to the full board for consideration, then unanimous vote occurred approving same.

3. **Request that U.S. Department of Health and Human Services and Its Agencies Make Hepatitis C Medications a Clinical Priority and Request for Congressional Appropriation of Funding to Indian Health Service for Hepatitis C Medications in Parity with U.S. Department of Veterans Affairs Funding**

   Under this resolution, the Board requests that all Health and Human Services programs and services (CMS, IHS) make HCV treatment a clinical priority and ensure access to medications to all persons with medical need as determined per American Association for the Study of Liver Diseases (AASLD) guidelines; and also requests that Congress appropriate funding to the Indian Health Service to Assure Access to Hepatitis C Medications for all AI/AN people with HCV as part of the initiative to Eliminate HCV among AI/ANs.

Request that a whereas clause be added stating that treatment of HCV on an individual level is a treatment of the community. In addition, language stating that Congressional funding request is to achieve parity with the U.S. Department of Veteran's Affairs.

Action: A motion was made (Spokane) and second (Swinomish) to pass the resolution with edits to the full board for consideration, then unanimous vote occurred approving same.

4. **Request that State Medicaid Agencies Make Hepatitis C Medications a Clinical Priority**

Staff was directed to develop a second HCV medications resolution directed to State Medicaid Agencies. The ask is for State Medicaid Agencies to make HCV treatment a clinical priority and ensure access to medications to all persons with medical need as determined per American Association for the Study of Liver Diseases (AASLD) guidelines.

Personnel Committee

Tuesday January 16, 2018
Embassy Suites By Hilton Portland Airport, Portland, OR

	Name and Title	Organization	Phone/FAX/E-mail
1	Andra Wagner HR Coordinator	NPAIHB	awagner@npaihb.org
2	Cassandra Steele	Coquille Indian Tribe	
3	Shawna Gauin	CTUIR	—
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Northwest Portland Area Indian Health Board
Quarterly Board Meeting
Personnel Committee Meeting Notes

January 16, 2018

Start Time: 12:00 pm

Members Present: Cassandra Sellards-Reck, Shawna Gavin

Staff Present: Andra Wagner

- Personnel update was reviewed.
    - _4___ new hires
    - _2___ promotions/transfers
    - _0___ temp
    - _0___ resignations
- 1 open position for Health Policy Analyst
- David Stephens won the Employee of the Year award
- Kerri Lopez has been employed by the NPAIHB for 15 years
- Background checks were conducted for all new staff and the temp.
- There was discussion about adding an Employee Recognition section to the Program Operations manual. It was decided that the proposed policy will be reworded and brought to next QBM for review.

Adjourned at 12:35 p.m.