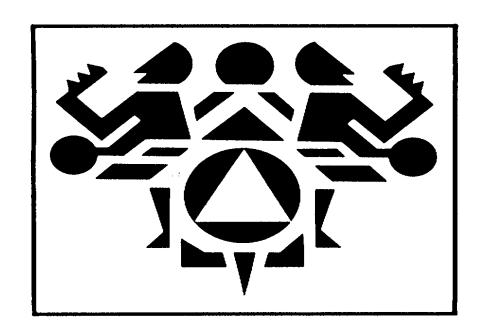
SUMMARY OF MINUTES



QUARTERLY BOARD MEETING

JANUARY 17-19, 2017 GREAT WOLF LODGE GRAND MOUND, WA



Great Wolf Lodge - Grand Mound, Washington 20500 Old Hwy 99 SW Centralia, WA 98531 January 17-19, 2017



<u>Issue</u>	<u>Summary</u> <u>Action</u>	Follow-
Tuesday January	17, 2017	<u>Up</u>
Tuesday January		
	Call to Order: Andy Joseph, Chairman,	
	Invocation: Dan Gleason, Chehalis Tribe	
	Welcome: Chehalis Chairman, Dan Secena	
	Posting of Flags: Chehalis Color Guard posted the flags.	
	Roll Call: Shawna Gavin, Secretary	
Executive Director	Personnel	
Report, Joe	New Hires:	
<u>Finkbonner</u>	- None	
	• Promotions:	
	- None	
	• Interns:	
	 Menolly Hart, Intern with HIV/HCV/STI Clinical Services Project 	
	• Anniversaries	
	Joe – 15 Years of Service	
	Eric Vinson – 15 Years of Service	
	Birdie Wermy – 10 Years of Service	
	Nancy Scott– Employee of the Year: Plaque was given	
	Meetings	
	November	
	Oregon Health Insurance Marketplace Advisory Committee, Portland, OR	
	Public Health Leader/Mentor Panel at the NWC Public Health Leadership Institute, UW	



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	December
	 WDSF Board Meeting & Alumni Lunch
	 PHAB Board of Directors, Washington, DC
	 NIHB Transition Meeting
	NPAIHB Annual Holiday Party
	 Quality Improvement training (Dec 15th)
	Upcoming Meetings
	<u>March</u>
	NWIC Foundation QBM (March 3 rd)
	WDSF Board meeting (March 17 th)
	PHAB Board meeting (March 29-30) Washington, Dc
1	<u>April</u>
	CMS I/T/U Training (April 4-5)
	<u>Business</u>
	Need a Representative for SAMHSA's Tribal Technical Advisory Committee (TTAC)
<u>LEGISLATIVE</u>	Status of FY 2017 IHS Budget
UPDATE, LAURA	Congress enacted a second continuing resolution (CR) for FY 2017 for the period of December 10,
<u>PLATERO,</u>	2016 to April 28, 2017.
GOVERNMENTAL	 Based on FY 2016 levels and under the authority and conditions of the FY 2016 appropriations.
AFFAIRS/POLICY	 Second CR provides an accelerated apportionment of funds for up-front needs, including IHS.
<u>DIRECTOR</u>	House and/or Senate Appropriations Committees' proposed budgets are not in effect during the CR
	period.
	 Appropriations bill must be negotiated for the remainder of FY 2017.



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Summary of Minutes

Status of FY 2017 IHS Budget

See graph on PowerPoint

Contract Support Costs

- . IHS has finally completed and published the new contract support cost (CSC) policy.
- Several beneficial provisions were negotiated by Tribal representatives.
- A major victory is that the policy will use the Office of Management and Budget (OMB) medical inflation rate for annual adjustments to direct CSC.
- CSC workgroup will continue to convene

Veteran's Administration

- On September 12, 2016, the Veteran's Administration issued a Dear Tribal Leader Letter (DTLL)
- In October, 2015, VA submitted a Plan to Congress to Consolidate Programs of the Department of Veterans Affairs and conducted Tribal Consultations.
- As part of implementation of this Plan, Tribal consultation is being sought on Tribal health programs participation in the core provider network and potentially transitioning from the current reimbursement agreement structure to a model under which Tribal health programs deliver care to all those eligible for services.
- In person consultation occurred on September 28, 2016 and written comments were due by November 5, 2016 and then re-opened and extended to November 30, 2016
- VA's position is still pending.

CHAP Expansion

- On June 1, 2016, IHS issued a DTLL to create a National Indian Health Service Community Health Aide (CHA) Program.
- The goal is to fully utilize CHAs within the Indian health system.
- Tribal consultations (telephonic and in person) took place in September and October, and written



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comments were due on October 27, 2016.

- On January 5, 2016, IHS issued a DTLL and Report on the Tribal Consultation and comments received.
- IHS will move forward with nationalization of the CHAP program.

Tribal Premium Sponsorship

- On July 18, 2016, IHS issued a DTLL on a new draft circular to address the purchase of health insurance by Tribes, Tribal organizations and urban Indian organizations under Section 402 of IHCIA.
- Provides guidance on when T/TO can purchase health insurance coverage for IHS beneficiaries using in part or in whole ISDEAA funding or other IHS appropriated funding.
- Tribal consultations (telephonic and in person) took place in October and September; and written comments were due on October 31, 2016.
- IHS has not issued a response to the comments received on the draft circular.

Catastrophic Health Emergency Fund (CHEF)

- Proposed rule issued on January 26, 2016 (81 Fed. Reg. 4239-44).
 - Adds "Tribal" resources to the list of alternate resources.
- No Tribal consultation on this rule before it was issued.
- DTLL issued on June 1, 2016 stating that IHS would engage in additional Tribal consultation.
- Tribal consultations (telephonic and in person) took place from August through September; and written comments were due on October 31, 2016.
- IHS's response is pending.

Other Policies

- CMS Medicare Expansion of Diabetes Prevention Program Final Rule Issued on November 2, 2016.
 - Sub-regulatory guidance will be issued.
- CMS Managed Care Final Rules
 - CMS issued an informational bulletin on the Indian provisions of the final Medicaid and CHIP



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managed care rule with a managed care Indian addendum.

- CMS 100% FMAP -- CMS issued a letter to State Health Officials on February 26, 2016 re-interpreting the scope of services to be considered "received through" an I/T to qualify for 100% FMAP:
 - CMS to issue a FAQ on new policy still pending.
- CMS All Tribes Call on December 15, 2016 on 4 walls limitation:
 - If 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.
 - If the Tribal facility is enrolled in the state Medicaid program as an FQHC, the Tribal facility may properly claim payment for services furnished by the non-Tribal provider at the facility rate.
- DHHS issued a DTLL and proposed rule to add new regulatory requirements to agreements under ISDEAA on November 10, 2016.
 - Telephonic Tribal consultation on December 9, 2016.
- IHS Re-alignment of IHS Headquarters
 - All Tribes Call on September 29, 2016 and in person discussion at NCAI on October 9, 2016.
 - Comments were due on January 13, 2016 (extended from November 5, 2016).
- SAMHSA's Draft Tribal Behavioral Health Agenda (TBHA)
 - Sets forth a framework, priorities and strategies to address behavioral health issues in Indian country.
 - Final version is available at:http://store.samhsa.gov/product/PEP16-NTBH-AGENDA

STAC Meeting Update

• Last meeting was December 7-8, 2016.



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	 Tribal leaders requested that STAC continue with the new administration. 	
	 2017 proposed meeting dates remain to be confirmed by the new administration: 	
	 March 7-8, 2017 	
	 May 31-June 1, 2017 	
	 September 19-20, 2017 	
	December 5-6, 2017	
	MMPC & CMS TTAG Update	
	 Medicare, Medicaid and Health Reform Policy Committee's (MMPC) last call was on January 9; next 	
	face-to-face meeting is on February 28, 2017.	
	 Priority List 	
	 CMS TTAG last conference call was on January 12; next face-to-face meeting is March 1-2, 2017. 	
1	Indian Legislative Issues 115 th Congress	
	Repeal of ACA/IHCIA through budget reconciliation process	
	Possible replacement provisions	
	Medicaid reform	
ELECTION OF	Vice-Chair: Nomination Cheryle Kennedy, second Brent Simcosky, Jamestown; motion to close second by	MOTION
<u>OFFICERS</u>	Bonnie Sanchez, Squaxin Island. Elected by acclamation	CARRIED
	Treasure: Nomination Shawna Gavin, second by Tino Batt, Shoshone-Bannock; motion to close by Dan	MOTION
	Gleason, Chehalis, second by Leland Bill, Yakama Nation. Elected by acclamation	CARRIED
	Sergeant- at-Arms: nomination, Kim Thompson, 2 nd by Shawna Gavin, Umatilla; motion to close by Dan	MOTION
	Gleason, Chehalis, second by Leland Bill, Yakama. Elected by acclamation	CARRIED
THRIVE PROJECT	See Attached PowerPoint	



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AND PROJECT RED	
TALON UPDATES,	
COLBIE	
CAUGHLAN,	
THRIVE SUICIDE	
PREVENTION	
PROJECT	
MANAGER	
	Committee Meetings (working lunch)
NATIVE DENTAL	See Attached PowerPoint
THERAPY	
<u>IMITATIVE</u>	
UPDATE,	
CHRISTINA	
PETERS, PROJECT	
DIRECTOR	
CHAIRMAN'S	This past quarter I attended 4 events as Board chair. In November, I attended the NIHB Board Retreat &
REPORT, ANDY	Strategic Planning meeting in Scottsdale, Arizona. We accomplished a lot at this meeting.
JOSEPH, JR,	
	I also attended the IHS Portland Area Budget Formulation meeting. There was a good turnout at this
	meeting. We made a request to Portland Area for full funding and they included a budget for full funding in
	their final budget submission
	In December, I attended ATNI's Transition Meeting in Tulalip. It was an important meeting to discuss the



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	priorities for the Northwest Tribes. I talked about health priorities and concern about repeal of the		
	Affordable Care Act and Indian Health Care Improvement Act.		
	7 inordable care rice and maintreath care improvement rica.		
	I was also able to attend the NPAIHB Office Party on December 9 at John's Incredible Pizza. Santa even		
	attended the party! It was great to celebrate the holidays with the staff and thank them for their hard work		
	on behalf of the Northwest Tribes.		
	Nick Lewis, Alternate SAMHSA motion by Marilyn Scott, Upper Skagit; second by Dan Gleason, Chehalis;	MOTION	
	MOTION CARRIED	CARRIED	
		<i>5,</i>	
DEGLUDENATALE			
REQUIREMENT	Via phone conference		
FOR EMPLOYER			
<u>SPONSORED</u>			
HEALTHCARE			
PROGRAMS			
ELIGIBILITY FOR			
MLR/PRC CLAIMS			
FOR TRIBAL			
EMPLOYEES,			
STARLA ROELS,			
PARTNER, HOBBS,			
STRAUS, DEAN &			
ACA REFORM	Via Phone Conference		
ISSUES, GEOFF			
STROMMER,			



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PARTNER HOBBS,	
STRAUS, DEAN &	
<u>WALKER</u>	
PORTLAND AREA	❖ FY 2017 Continuing Resolutions
IHS REPORT, DEAN	H.R. 5325 provides funding authority from October 1 through December 9, 2016 at 19.18%
SEYLER, PAO IHS	of the FY 2016 level, with a reduction of 0.496%.
DIRECTOR	H.R. 2028, provides funding authority from December 10, 2016 through April 28, 2017. The
	CR is 38.35% with a 0.1901% across the board reduction.
	❖ Funds Distribution Workgroup
	★ Met November 21, 2016 at Portland Area Office
	❖ Discussed Area-wide CHSDA Proposal
1	❖ A proposed CHSDA expansion pilot project for Tribes to opt into a secondary layer of
	coverage that would allow them to expand their individual CHSDA's throughout Portland
	Area (OR, WA & ID) in order to access Medicare Like and PRC Rates.
	❖ Submitted to HQ January 5, 2017
	❖ FY16 CHEF
	❖ \$2,560,556 submitted for Portland Area
	* \$2,333,164 approved and returned
	❖ Financial Management Officer
	Sharlene Andrew retired on December 31, 2016.
	❖ Nichole Swanberg was appointed to serve as Acting Financial Management Officer
	❖ <u>Division of Business Operations</u>
	❖ Moved to Office of Administration
	❖ Peggy Ollgaard, Director



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- Division of Information Resource Management
 - Moved to Office of Tribal and Service Unit Operations
 - Jonathan Hubbard, Director
- Office of Environmental Health & Engineering
 - CDR Celeste Davis retired on December 31, 2016
 - * Rich Truitt appointed to serve as Acting Environmental Health Director
 - ❖ LCDR Matthew Ellis, appointed to serve as the Acting Area Emergency Mgt Coordinator
- **❖** FY 2019 National Budget Work Session
 - When: February 16-17, 2017
 - **Location:** Arlington, VA
 - **❖** Portland Area Elected Representatives:
 - ❖ Andrew Joseph Jr., The Confederated Tribes of the Colville Reservation
 - Steve Kutz, Cowlitz Indian Tribe
- Indian Health Service Plans to Expand Community Health Aide Program
 - Dear Tribal Leader Letter dated January 4, 2017
 - Establish a National Workgroup Tribal Leaders and IHS Representatives
 - Develop a draft CHAP Expansion Policy and Implementation Plan
 - The Principal Deputy Director writes to Tribal Leaders to provide an update to the June 1, 2016, letter which initiated a Tribal Consultation on the Indian Health Service draft policy statement on creating a national IHS Community Health Aide Program.
 - ❖ Enclosure: Report on the Tribal Consultation for the Indian Health Service Policy Statement on Creating a National Indian Health Service Community Health Aide Program.
- Direct Service Tribe Advisory Committee Quarterly meeting
 - **A** May 3-4, 2017



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- Portland Area Host
- location TBD
- CSC/ISDEAA Specialist position update
- * FY14-16 Contract Support Cost (CSC) reconciliation is partially complete. Next steps:
 - ❖ If current IDC rate is the <u>same</u>: we will move forward with notification of any over or under payments
 - If your IDC rate <u>changed</u>: we will need to reconcile again to determine any over or under payments
- Facilities List Automated Tool
 - CMS Facilities list will be automated January 2017
 - Will use the recent Space Verification submissions to update the list
 - Peggy Ollgaard will be reaching out to Tribes who did not submit the annual Space Verification to complete first automated list
 - New process will require Area Director certification
 - Subsequent years will require Tribal participation in the annual data call in order to be included on the list
 - ❖ The automated tool will eventually house the OEHE Facilities, as well as the Statistical Officer facilities, creating one database for all I/T/U facility information
- **❖** IHS Tribal Medical Equipment Grant
 - Confederated Tribes of the Umatilla Indian Reservation Successfully Received a \$318,000 Grant to Support New Clinic.
 - ❖ IHS is Currently Accepting FY 2017 Applications -- Apply Online at https://facilops.ihs.gov/erds/ by March 10th.
 - ❖ PAO Point of Contact Jonathan McNamara (503) 414-7770



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Summary of Minutes

Healing Lodge of the Seven Nations

- A project in the amount of \$150,000 to Improve Standby Power Connection, Install New Fire Alarm System, Replace Dormitory Doors, and Install Energy Efficient LED Lighting.
- * Regional Specialty Referral Center Demonstration Project
- No Updates at this time.

Health Facilities Modernization

- Western Oregon Service Unit Active Construction
 - New Patient Entrance, Expanded Waiting Area, Additional Exam Rooms, IPC Provider Team Space, Consolidated Eye Care, Increased Patient Parking, IT Upgrades, New Windows, and New HVAC System.
 - Currently 80% Complete with August 2017 Completion.
- Wellpinit Service Unit Beginning Construction
 - Improved patient registration, New IPC Medical Teaming Space, Improved Signage, IT Upgrades, and HVAC Improvements.
 - Contract Award January 2017 with July 2017 Completion.
- ❖ Yakama Service Unit Active Design
 - Convert Former Physical Therapy to Six New Primary Care Exam Rooms With IPC Medical Teaming Space.
 - Design Complete April 2017 With Construction to Follow.
- Warm Springs Service Unit
 - ❖ Developing a Health Facilities Master Plan to Guide Facilities Improvements.
 - Considers Tribal and Federal Programs as Directed by the Joint Health Commission.
- Division of Sanitation Facilities Construction Recent Project Highlights



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Summary of Minutes

- Quileute Wastewater Disinfection Equipment Final inspection was held December 15. New Ultraviolet Disinfection Equipment was Installed at the Plant. Protects Public Health and the Local Beach.
- Spokane, Wellpinit Community Water System Improvements: Design is Complete for the Construction of an Additional Well and Connection to the Community Water System at Wellpinit. Bidding and Construction Expected to Occur in 2017.
- Spokane, West-End (McCoy Lake) Water Improvements: Design is Complete and Funding has Been Made Available to Replace a Booster Pump Station. The Tribe Plans to Directly Carry Out the Construction.
- Spokane, Emergency Project: In Response to the Cayuse Mountain Fire that Impacted Wellpinit Homes, in August 2016, IHS Sent a Team Out to Perform Evaluations in Coordination with Tribal Staff. As a Result of this Partnership, IHS Secured Emergency Funding from Headquarters to Replace or Repair Individual Homes' Sanitation Facilities.
- Colville, Nespelem Agency Water System: In November 2016, IHS secured \$22,500 in Special Project Funding From IHS Headquarters to Study the Water Quality and Production From a Well that was Drilled in 2004. This is One Important Step Towards Evaluating Long-term Water Supply Options for Nespelem Agency.
- Siletz Wastewater Collection Improvements: IHS has Developed Plans and Specifications and Assisted the Tribe in Procurement for Renovation of the Sewage Collection System that Serves 54 Tribal Homes. It is Expected that the Tribe Will have Their Contractor Initiate Construction in January or February 2017.

Healthcare Infection Prevention & Control

❖ Institutional Environmental Health is Facilitating an APIC Infection Prevention for Ambulatory Centers (ASC 101): Meeting CMS Conditions for Coverage Training Course June



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- 27-29 at Northern Quest
- * Target Audience: Infection Control Officers, QI Managers, Risk Managers, Administrators
- ❖ Why Attend:
 - Understand Regulatory Requirements
 - Protect or Obtain Accreditation Status
 - Implement New Evidence Based Interventions
 - Receive CD w/ Tools and Templates to Apply Lessons Learned
- LCDR Matthew Ellis, MPH, REHS, Institutional Environmental Health Officer/ EMPOC, Phone: 503.414.7788 or matthew.ellis@ihs.gov
- IHS Director's Customer Service Award
 - Farrell Lucei, EFDA, Warm Springs Service Unit
 - Clinton Kittrell, MSW, LCSW, Yellowhawk Tribal Health Center
 - Chemawa Integrated Behavioral Health/Primary Care Team, Western Oregon Service Unit
 - Community Health-Benewah Medical and Wellness Center, Coeur d'Alene Tribe
- IHS Director's Award
 - Mary Morphet-Brown, MSN, NP-C, Yakama Service Unit
 - ❖ Jonathan McNamara, BS, CBET, Portland Area OEHE
 - Yellowhawk Átawišamataš Home Visiting Program, Yellowhawk Tribal Health Center
 - Western Oregon Service Unit Pharmacy Department
- Portland Area Director's Recognition of Excellence
 - Open to All Federal, Tribal, and Urban staff
 - Nomination Period is Open until February 3, 2017
 - Email from Asha Petoskey dated December 23, 2016 with nomination forms
 - Ceremony scheduled for May 12, 2017 in Portland



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- IHS Scholarship and Loan Repayment Program
 - New Scholarship Applicants deadline is March 28, 2017
 - Current Scholarship recipients deadline is February 28, 2017
 - Loan repayment applicants deadline is August 15, 2017
 - Questions Contact Heidi Hulsey, EEO/Diversity Manager at <u>Heidi.hulsey@ihs.gov</u> or at 503-414-5555
 - https://www.ihs.gov/newsroom/index.cfm/pressreleases/2017pressreleases/ihs-scholarship-loan-repayment-programs-aim-to-recruit-more-health-care-providers/
- VA-IHS Consolidated Mail Outpatient Pharmacy (CMOP)
 - Interagency Agreement between the VA and IHS has recently been signed and formally announced on January 09, 2017
 - Authorizes Tribes and Tribal organizations with ISDEAA agreements to access the CMOP through the National Supply Service Center (NSSC)
 - To access the CMOP, Tribal pharmacies must:
 - Utilize the IHS Resource and Patient Management System (RPMS)
 - Meet the minimum technical requirements and agree to the terms, conditions, and responsibilities set forth by CMOP
 - Sign a customer agreement with the IHS NSSC and be responsible for the cost of the drugs purchased and any applicable CMOP fee
 - There are currently 12 Tribal Healthcare Facilities (5 formerly federal) which have been configured to utilize CMOP
 - ❖ Any questions related to access or eligibility may be directed to the IHS National CMOP Coordinator, CAPT Todd Warren (todd.warren@ihs.gov | 605-390-2371) or CDR Roney Won (roney.won@ihs.gov) 503-414-5555



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Summary of Minutes

❖ Accreditation

- ❖ IHS requires all federal sites to maintain accreditation.
- Portland Area utilizes the Accreditation Association for Ambulatory Health Care (AAAHC) as our accrediting body.
 - Full accreditation is awarded for a 3-year time period with potential unannounced surveys at any time.

Past support for SUs has involved an Area level workshop and single mock survey provided in the year prior to scheduled surveys

On-Going Survey Readiness

- ❖ Goal: Develop a process to maintain readiness throughout the year:
 - Maintaining high quality of care and business practices.
 - Spreading triennial work over three years.
 - * Reducing anxiety associated with surveys.
- Portland Area Survey Readiness Team (ASuRT)
 - ❖ Area-level team to coordinate and consult on accreditation issues.
 - Membership
 - Director (Office of Clinical Support), Chief Medical Officer, Area Environmental Health Officer, Director (OTSUO), other Area consultants as needed.
 - ❖ AAAHC Consultant (contracted)- Ray Lala, DDS

ASuRT Activities

- Collate and review SU Accreditation findings.
 - Trend findings to focus coordinated efforts across SUs.
- Provide a cycle of virtual and on-site training/consultation opportunities on priority



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standards.

- Continue AAAHC: Achieving Accreditation Workshop.
- Annual review of AAAHC standard revisions/updates.
- Conduct annual mock surveys.
 - Cross clinic participation of CEO, CDs, and QI Coordinators on survey team.
 Conduct PAO Support Staff training to increase accreditation awareness in support of SUs
- Portland Area Diabetes Consultant
 - LCDR Kathi Murray, MS, RDN, CDE
 - Prior IHS experience:
 - White Earth Diabetes Project (MN)
 - Pine Ridge SDPI Diabetes Prevention program (SD)
 - Sells Indian Hospital- nutritionist (AZ)
 - Expertise: diabetes, weight management, heart disease, and chronic kidney disease
- Influenza Update- disease activity
 - Influenza activity has increased in the Northwest since the Christmas holiday.
 - ❖ Hospitals in Washington State, especially those along the I-5 corridor, have been heavily impacted with large numbers of patients seeking care in Emergency Rooms; hospitalizations and intensive care unit admissions are at near or over-capacity levels
 - Area-wide influenza-like illness (ILI) is estimated at 1.9% compared to 1.6% nationally.
- ❖ Influenza Update- Vaccine Coverage



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- Influenza vaccine coverage is low at 32.4% for all 6 months and older; 48.4% for those 65 and older.
- ❖ There is still time to get vaccinated and it is recommended that everyone receive a seasonal flu vaccine. The current vaccine is well matched to the circulating strains of flu virus this year.
- Thanks to the IHS mandatory flu vaccine policy, influenza vaccine coverage among healthcare personnel at Federal sites ranges from 92% to 100%, the highest coverage recorded.

Mumps

- ❖ A mumps outbreak in Washington has been on-going since early December primarily in Seattle/King County but also affecting Pierce, Snohomish, Spokane and Yakima counties with 151 cases, currently.
- Activities are aimed at stopping the spread to more areas by focusing on vaccinating those who have not received two doses of MMR and identifying both cases and exposed individuals.
- Testing is recommended for suspect cases and can be done through the Washington State Public Health Lab
- ❖ A toolkit for Tribal communities has been developed with full details: http://www.doh.wa.gov/Portals/1/Documents/Pubs/348-589MumpsOutbreakTookitforTribes.pdf

❖ Hepatitis C (HCV)

- ❖ AI/ANs have a higher prevalence of infection and higher mortality from HCV than other races.
- ❖ A recent assessment in some Portland Area clinics showed over 600 patients



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currently infected with HCV, 60% of these were born between 1945 and 1965	
("Baby-Boomers")	
❖ Screening is recommended for all "Baby-Boomers" and for anyone else with certain	
risk factors. Only 35.8% of "Baby-Boomers" have been screened for HCV in Portland	
Area.	
❖ Hepatitis C (continued)	
NPAIHB will host an important training at Swinomish, January 30 th and 31 st to train	
primary care providers to screen for and treat HCV infection.	
Registration: https://www.surveymonkey.com/r/HCVtrainingSwinomish	
• Questions can directed to David Stephens, Jessica Leston, or Dr. Weiser	
dstephens@npaihb.org jleston@npaihb.org tweiser@npaihb.org	
Screening for HCV infection and treating those who are infected is an important	
priority for the Portland Area.	
❖ In support of this priority, a new agreement between IHS and the VA will allow IHS	1
and Tribal clinics to take advantage of discounted pricing for antiviral medications	
used to treat and cure HCV infections	
Executive Session – none needed	
WEDNESDAY JANUARY 18, 2017	



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	Call to order, Cheryle Kennedy, NPAIH Vice-Chairwoman	
	Recognize Leslie Wosnig, Suquamish will be retiring at the end of March 2017.	
OREGON STATE	No PowerPoint	
UPDATE, JULIE		
JOHNSON,		
INTERIM TRIBAL		
<u>AFFAIRS</u>		
<u>DIRECTOR</u> -		
<u>WASHINGTON</u>	No PowerPoint	
STATE MEDICAID		
UPDATE, JESSIE		
DEAN, TRIBAL		
AFFAIRS &		
ANALYSIS,		
DIVISION OF		
POLICY,		
PLANNING &		
<u>PERFORMANCE</u>		
<u>RESOLUTIONS</u>	17-02-01 Pathways into Health – Northwest Native American Center of Excellence	MOTION
	Ratified, motion by Dan Gleason, Chehalis; seconded by Shawna Gavin, Umatilla, MOTION CARRIES	CARRIES
	17-02-02 Authorization Related to National Indian Health Policy Education Foundation	MOTION
	Motion by Patti Kinswa, Cowlitz; seconded by Dan Gleason, Chehalis, MOTION CARRIES	CARRIES



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	17-02-03 Support submission of grant for CDC funding for Northwest Tribal Comprehensive Cancer Project Motion by Andy Joseph, Colville; seconded by Brent Simcosky, Jamestown, MOTION CARRIES 1717-02-04 Approval of Background Check Policy Motion by Shawna Gavin, Umatilla; seconded by Tino Batt, Shoshone-Bannock, MOTION CARRIES	MOTION CARRIES MOTION CARRIES	
FOUNDATIONAL	See Attached PowerPoint		
PUBLIC HEALTH	See Attached PowerPoint		
SERVICES (FPHS)			
WASHINGTON CTATE MARKE			
STATE, MARIE			
FLAKE SPECIAL			
<u>PROJECTS</u>			
Tribal Reports	Kootenai Tribe, Karen Hanson		
	Lummi, Justin Iwasaki		
	Colville Service Unit, Colleen Cawston		
HEALTH	See Attached PowerPoint		
RESOURCES &			
SERVICES			
ADMINISTRATION,			
SHARON TURNER,			
HEALTH			



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	Suffitting of Militates
RESOURCE &	
<u>SERVICES</u>	
<u>ADMINISTRATION</u>	
REGIONAL	
ADMINISTRATOR,	
OFFICE OF	
REGIONAL	
<u>OPERATIONS</u>	
LONG TERM CARE,	See Attached PowerPoint
BEA RECTOR,	
DIRECTOR, HOME	
AND COMMUNITY	
<u>SERVICES</u>	
DIVISION &	
<u>MARIETTA</u>	
BOBBA, MBA,	
TRIBAL AFFAIRS	
<u>ADMINISTRATOR</u>	
GOVERNOR'S	
<u>INTERAGENCY</u>	
COUNCIL ON	
<u>HEALTH</u>	
DISPARITIES,	
AGING AND LONG	



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TERM SUPPORT		
<u>ADMINISTRATION</u>		
DEPARTMENT OF		
SOCIAL AND		
HEALTH SERVICES		
<u>TRAUMA</u>	See Attached PowerPoint	
INFORMED CARE,		
KRISTI WOODARD,		
PORTLAND AREA		
IHS BEHAVIORAL		
<u>HEALTH</u>		
CONSULTANT &		
<u>MICAH</u>		
WOODARD,		
BEHAVIORAL		
<u>HEALTH,</u>		
WESTERN		
OREGON SERVICE		
<u>UNIT</u>		
Recess		
WEDNESDAY JAN	NUARY 19, 2017	
	Call to Order, Andy Joseph, Jr. NPAIHB Chairman	
	Invocation, Dan Gleason, Chehalis Tribe	
FINANCE REPORT,	Motion by Pearl Capoeman-Baller, Quinault Nation, second by Rhonda Metcalf, Sauk-Suiattle: MOTION MOTION	



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JACQUELINE LEFT	CARRIES	CARRIES
HAND BULL,		
<u>NPAIHB</u>		
ADMINISTRATOR		
<u>OFFICER</u>		
COMMITTEE	1. Elders – Dan Gleason, See Attached Report	
REPORTS:	2. Veterans - Chris Sanford, See Attached Report	
	3. Public Health – Victoria Warren-Mears, See Attached Report	
	4. Behavioral Health – Lisa Guzman, See Attached Report	
	5. Personnel – Shawna Gavin, See Attached Report	
	POM Revision – motion by Lisa Guzman, Kalispel Tribe, second by Leslie Wosnig, Suquamish:	MOTION
1	MOTION CARRIES	CARRIED
	7. Youth – Nanette Yandell, See Attached Report	
APPROVAL OF	August & October – Motion by Dan Gleason, Chehalis, seconded by Tino Batt, Shoshone-Bannock;	MOTION
<u>MINUTES</u>	MOTION CARRIES	CARRIED
ADJOURN at 10:00		
a.m.		





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Tuesday, January 17, 2017

Call to Order: Andy Joseph, Chairman,

Invocation: Dan Gleason, Chehalis Tribe

Welcome: Chehalis Chairman, Dan Secena

Posting of Flags: Chehalis Color Guard posted the flags.

Roll Call: Shawna Gavin, Secretary, called roll:

Burns Paiute Tribe – Absent	Nisqually Tribe – Absent		
Chehalis Tribe – Present	Nooksack Tribe – Absent		
Coeur d'Alene Tribe – Present	NW Band of Shoshone – Present		
Colville Tribe – Present	Port Gamble Tribe – Present		
Grand Ronde Tribe – Present	Puyallup Tribe – Absent		
Siletz Tribe – Absent	Quileute Tribe – Absent		
Umatilla Tribe – Present	Quinault Nation – Present		
Warm Springs Tribe – Present	Samish Nation – Absent		
Coos, Lower Umpqua & Siuslaw Tribes – Absent	Sauk Suiattle Tribe – Present		
Coquille Tribe – Present	Shoalwater Bay Tribe – Present		
Cow Creek Tribe – Present	Shoshone-Bannock Tribe – Present		
Cowlitz Tribe – Present	Skokomish Tribe – Present		
Hoh Tribe – Absent	Snoqualmie Tribe – Present		



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Jamestown S'Klallam Tribe – Present	Spokane Tribe – Absent
Kalispel Tribe – Present	Squaxin Island Tribe – Present
Klamath Tribe – Present	Stillaguamish Tribe – Present
Kootenai Tribe – Present	Suquamish Tribe – Present
Lower Elwha Tribe – Present	Swinomish Tribe – Present
Lummi Nation – Present	Tulalip Tribe – Present
Makah Tribe – Absent	Upper Skagit Tribe – Present
Muckleshoot Tribe – Present	Yakama Nation – Present
Nez Perce Tribe – Absent	

There were 30 delegates present, a quorum is established.

Executive Director Report, Joe Finkbonner

Personnel

- New Hires:
 - None
- Promotions:
 - None
- Interns:
 - Menolly Hart, Intern with HIV/HCV/STI Clinical Services Project
- Anniversaries
 - Joe 15 Years of Service
 - Eric Vinson 15 Years of Service
 - Birdie Wermy 10 Years of Service
 - Nancy Scott
 Employee of the Year: Plaque was given

Meetings

November

- Oregon Health Insurance Marketplace Advisory Committee, Portland, OR
- Public Health Leader/Mentor Panel at the NWC Public Health Leadership Institute, UW



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December

- WDSF Board Meeting & Alumni Lunch
- PHAB Board of Directors, Washington, DC
- NIHB Transition Meeting
- NPAIHB Annual Holiday Party
- Quality Improvement training (Dec 15th)

Upcoming Meetings

March

- NWIC Foundation QBM (March 3rd)
- WDSF Board meeting (March 17th)
- PHAB Board meeting (March 29-30) Washington, Dc

April

CMS I/T/U Training (April 4-5)

Business

Need a Representative for SAMHSA's Tribal Technical Advisory Committee (TTAC)

LEGISLATIVE UPDATE, LAURA PLATERO, GOVERNMENTAL AFFAIRS/POLICY DIRECTOR

Status of FY 2017 IHS Budget

- Congress enacted a second continuing resolution (CR) for FY 2017 for the period of December 10, 2016 to April 28, 2017.
- Based on FY 2016 levels and under the authority and conditions of the FY 2016 appropriations.
- Second CR provides an accelerated apportionment of funds for up-front needs, including IHS.
- House and/or Senate Appropriations Committees' proposed budgets are not in effect during the CR period.
- Appropriations bill must be negotiated for the remainder of FY 2017.

Status of FY 2017 IHS Budget

See graph on PowerPoint

Contract Support Costs

• . IHS has finally completed and published the new contract support cost (CSC) policy.



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- Several beneficial provisions were negotiated by Tribal representatives.
- A major victory is that the policy will use the Office of Management and Budget (OMB) medical inflation rate for annual adjustments to direct CSC.
- CSC workgroup will continue to convene

Veteran's Administration

- On September 12, 2016, the Veteran's Administration issued a Dear Tribal Leader Letter (DTLL)
- In October, 2015, VA submitted a Plan to Congress to Consolidate Programs of the Department of Veterans Affairs and conducted Tribal Consultations.
- As part of implementation of this Plan, Tribal consultation is being sought on Tribal health programs participation in the core provider network and potentially transitioning from the current reimbursement agreement structure to a model under which Tribal health programs deliver care to all those eligible for services.
- In person consultation occurred on September 28, 2016 and written comments were due by November 5, 2016 and then re-opened and extended to November 30, 2016
- VA's position is still pending.

CHAP Expansion

- On June 1, 2016, IHS issued a DTLL to create a National Indian Health Service Community Health Aide (CHA) Program.
- The goal is to fully utilize CHAs within the Indian health system.
- Tribal consultations (telephonic and in person) took place in September and October, and written comments were due on October 27, 2016.
- On January 5, 2016, IHS issued a DTLL and Report on the Tribal Consultation and comments received.
- IHS will move forward with nationalization of the CHAP program.

Tribal Premium Sponsorship

- On July 18, 2016, IHS issued a DTLL on a new draft circular to address the purchase of health insurance by Tribes, Tribal organizations and urban Indian organizations under Section 402 of IHCIA.
- Provides guidance on when T/TO can purchase health insurance coverage for IHS beneficiaries using in part or in whole ISDEAA funding or other IHS appropriated funding.
- Tribal consultations (telephonic and in person) took place in October and September; and written comments were due on October 31, 2016.
- IHS has not issued a response to the comments received on the draft circular.

Catastrophic Health Emergency Fund (CHEF)

Proposed rule issued on January 26, 2016 (81 Fed. Reg. 4239–44).



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- Adds "Tribal" resources to the list of alternate resources.
- No Tribal consultation on this rule before it was issued.
- DTLL issued on June 1, 2016 stating that IHS would engage in additional Tribal consultation.
- Tribal consultations (telephonic and in person) took place from August through September; and written comments were due on October 31, 2016.
- IHS's response is pending.

Other Policies

- CMS Medicare Expansion of Diabetes Prevention Program Final Rule Issued on November 2, 2016.
 - Sub-regulatory guidance will be issued.
- CMS Managed Care Final Rules
 - CMS issued an informational bulletin on the Indian provisions of the final
 Medicaid and CHIP managed care rule with a managed care Indian addendum.
- CMS 100% FMAP -- CMS issued a letter to State Health Officials on February 26, 2016 reinterpreting the scope of services to be considered "received through" an I/T to qualify for 100% FMAP:
 - CMS to issue a FAQ on new policy still pending.
- CMS All Tribes Call on December 15, 2016 on 4 walls limitation:
 - If 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.
 - If the Tribal facility is enrolled in the state Medicaid program as an FQHC, the Tribal facility may properly claim payment for services furnished by the non-Tribal provider at the facility rate.
- DHHS issued a DTLL and proposed rule to add new regulatory requirements to agreements under ISDEAA on November 10, 2016.
 - Telephonic Tribal consultation on December 9, 2016.
- IHS Re-alignment of IHS Headquarters
 - All Tribes Call on September 29, 2016 and in person discussion at NCAI on October 9, 2016.
 - Comments were due on January 13, 2016 (extended from November 5, 2016).
- SAMHSA's Draft Tribal Behavioral Health Agenda (TBHA)
 - Sets forth a framework, priorities and strategies to address behavioral health issues in Indian country.
 - Final version is available at: http://store.samhsa.gov/product/PEP16-NTBH-



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AGENDA

STAC Meeting Update

- Last meeting was December 7-8, 2016.
- Tribal leaders requested that STAC continue with the new administration.
- 2017 proposed meeting dates remain to be confirmed by the new administration:
 - March 7-8, 2017
 - May 31-June 1, 2017
 - September 19-20, 2017
 - December 5-6, 2017

MMPC & CMS TTAG Update

- Medicare, Medicaid and Health Reform Policy Committee's (MMPC) last call was on January 9; next face-to-face meeting is on February 28, 2017.
 - Priority List
- CMS TTAG last conference call was on January 12; next face-to-face meeting is March 1-2, 2017.

Indian Legislative Issues 115th Congress

- Repeal of ACA/IHCIA through budget reconciliation process
- Possible replacement provisions
- Medicaid reform

ELECTION OF OFFICERS

<u>Vice-Chair: Nomination Cheryle Kennedy, second Brent Simkosky, Jamestown; motion to close second by Bonnie Sanchez, Squaxin Island. Elected by acclamation</u>

<u>Treasure: Nomination Shawna Gavin, second by Tino Batt, Shoshone-Bannock; motion to close by Dan Gleason, Chehalis, second by Leland Bill, Yakama Nation. Elected by acclamation</u>

<u>Sergeant- at-Arms: nomination, Kim Thompson, 2nd by Shawna Gavin, Umatilla; motion to close by Dan Gleason, Chehalis, second by Leland Bill, Yakama. Elected by acclamation</u>



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THRIVE PROJECT AND PROJECT RED TALON UPDATES, COLBIE CAUGHLAN, THRIVE SUICIDE PREVENTION PROJECT MANAGER

Agenda

- Grant help Support for Expectant and Parenting Teens, Women, Fathers, and Their Families
- THRIVE updates
 - Suicide Prevention Signs
 - Zero Suicide Sites
 - WRN collaboration update on Concerning Post Webinar
 - Social Marketing Campaigns
- Project Red Talon and We R Native Updates
 - www.wernative.org
 - Gen I Bootcamps
 - Healthy Native Youth Portal

Support for Expectant and Parenting Teens, Women, Fathers, and Their Families https://www.surveymonkey.com/r/SupportParentingTeens

Suicide Prevention Signs

- Dissemination by summer
- Signs & Poles if wanted
- 10-11 trigger locks and resource list
- Contact info. to order large amounts of trigger locks
- Contact Colbie or Celena for the signs and locks
 - ccaughlan@npaihb.org or 503-416-3284
 - cmccray@npaihb.org or 503-416-3270

Zero Suicide

- 3 NW Tribes continue to pilot the implementation
- 3 additional Tribes hoping to begin the process
- Workforce Surveys
- Trainings
- Challenges
- Successes

Coming Soon...

Tool to help educators (or any caring adult) respond to concerning posts seen on social media



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Developed by NPAIHB and the Social Media and Adolescent Health Research Team (SMAHRT) https://vimeo.com/170679097

Concerning Posts Webinar

- Partnership with SMHRT
- Introduction to the topic and webinar
- Real life experiences
 - Suicide or self-harm posted on social media
 - Responses to posts
- Goals of the webinar
- Statistics
- Study *before* the webinar

https://vimeo.com/170679097

- Tools for educators/adults
- Resources
 - QPR
 - Factsheets
 - Websites
 - Videos
- Completing IRB
- Available for pilot testing Mar-May 2017
- Who is interested??

Suicide Prevention Social Marketing Campaign

WE ARE CONNECTED.

#WE NEED YOU HERE.

- Posters
- Blank Flyer
- Rack Card
- Tip Card
- Lanyard
- Flash Drives
- Radio PSAs
- T-shirts
- Lived Experience <u>Videos</u>



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LGBTQ, TWO SPIRIT Social Marketing Campaign

LOVED & ACCEPTED #WE NEED YOU HERE

- Posters
- Rack Card
- Tip Card
- Radio PSA
- Lived Experience Videos

Developing the....

Native Veterans Suicide Prevention Social Marketing Campaign

Please fill out the paper survey

Put in the box labeled "Veteran Surveys"

Fax attn: THRIVE to 503-228-4801 Deadline: Friday January 20, 2017

We R Native is a multimedia health resource for Native teens and young adults

- 1. Like us on Facebook
- 2. Follow us on Twitter
- 3. Subscribe to our **YouTube Channel**
- 4. Follow us on Instagram
- 5. Text "HEALTHY" to 97779 to get the latest health curricula and resources for Native youth!
- 6. If you're a young person:
 - Text "NATIVE" to 97779 to receive weekly health tips, contest, and life advice
 - Become a WRN Youth Ambassador
 - Make a positive difference in your community. Apply for up to \$475

Gen-I Social Media Boot Camps

- WeRNative Training
 - Leadership Skills
 - Youth Driven Social Marketing Project
 - Health Activism
- Site's Role
 - Schedule 2 full days
 - Recruit 15-20 AI/AN youth

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- Schedule a facility
- Provide adult chaperones to assist WRN staff
- Topics
 - Cultural identity & resilience
 - Substance abuse prevention
 - Suicide prevention
- WRN Role
 - Lead or contract a facilitator
 - Contract a professional media company
 - Edit the final social marketing project
- Offering 2-3 in 2017
 - Contact Tommy Ghostdog Jr. at tghostdog@npaihb.org

2016 Bootcamps

- We R Native Youth Ambassadors (Drug/Alcohol Prevention PSA) https://youtu.be/D7rlAjgb3tl 1:27
- Olympia Area Youth (Suicide Prevention PSA) https://youtu.be/X7k1h9FPLK0 1:42
- Quileute Youth (Culture/Native Pride PSA) https://youtu.be/gOGCVSFVX1M 1:53
- Interested? Contact Tommy Ghostdog Jr. at tghostdog@npaihb.org

Save-the-Date 7th Annual Thrive Conference June 26-30, 2017

Opportunities

- Native STAND
 - Students Together Against Negative Decision Making (STAND)
 - Recruiting 25 Tribes or AI/AN organizations for the final year
 - Mandatory training week, June 26-30, 2017 in Portland
 - Application deadline is Mar. 1
- Contact: Michelle Singer
 - Native STAND Project Manager
 - Oregon Health and Science University
 - Phone: 503-418-2199
 - Email: singerm@ohsu.edu
- PREP in WA State
 - Personal Responsibility Education Program (PREP)
 - Recruiting sites
 - Hoping Tribal sites identify curricula from the Healthy Native Youth website



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(description next slide)

Letters of Interest due Feb. 10

• Contact: Lauri Turkovsky, EdD

PREP Grant Coordinator

WA Dept. of HealthPhone: 360.236.3538

Email: <u>Lauri.Turkovsky@doh.wa.gov</u>

Raising Health Youth

New website that launched in late 2016 and is for educators!!

HealthyNativeYouth.org contains health promotion curricula and resources for American Indian and Alaska Native youth. The site is designed for Tribal health educators, teachers, and parents – providing the training and tools needed to access and deliver effective, age-appropriate programs. Filter and search for curricula by age group, delivery setting, and evidence of effectiveness. Each program includes lesson plans, handouts, and supplemental materials; many also include recorded videos and webinars to help prepare educators to facilitate lessons.

Training Opportunities

- Applied Suicide Intervention Skills Training (ASIST)
 - www.livingworks.net
 - 2 full days, CEUs offered (no fee for specific professions in some states)
- Working Minds Suicide Prevention in the Workplace
 - www.CarsonJSpencer.org
 - You pick a 2 or 4 hour training
- Question Persuade Refer (QPR)
- www.gprinstitute.com
- 2-3 hours, CEUs offered for a fee
- Request any of the listed trainings by contacting Colbie Caughlan at ccaughlan@npaihb.org or calling 503-416-3284

WORKING LUNCH & COMMITTEE MEETINGS



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NATIVE DENTAL THERAPY IMITATIVE UPDATE, CHRISTINA PETERS, PROJECT DIRECTOR

Our DHAT Pilot Goals

- Expand access to consistent, routine, high quality oral health care in Tribal communities;
- Grow the number of AI/AN oral health care providers available to Tribal communities;
- Bring culturally competent care into Tribal communities;
- Establish cost effective solutions to oral health challenges into Tribal communities;
- Bring care where it is needed most.

Oregon Tribes DHAT Pilot Project

Current Pilot Sites

Confederated Tribes of Coos, Lower Umpqua, Siuslaw and Coquille

CTCLUSI Dental Clinic

- Fully staffed 3-chair clinic serves primarily Tribal members/families
- CTCLUSI also provide services to Coquille Indian Tribe. Coquille serves CTCLUSI members at their Community Health Center
- CTCLUSI has a 5-county service area including Coos, Curry, Lane, Lincoln and Douglas

Our Students

Naomi Petrie, DHAT Class of 2017 Marissa Gardner, DHAT Class of 2018

Coquille Indian Tribe Health Services

- Coquille operates Community Health Clinic for their members/family, community members, and CTCLUSI members in the 5-county service area: Coos, Curry, Douglas, Jackson and Lane
- They currently do not have a dental clinic or dental team but are exploring facility expansion and other options for housing a dental program

Our Students

Alexandra Jones, DHAT Class of 2018 Jason Mecum, DHAT Class of 2018

Evaluation

- Working with an outside consultant to evaluate:
 - the effect of dental therapists on access to care
 - the quality of care
 - Patient satisfaction



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- Provider satisfaction
- Clinic productivity/personnel costs
- Staff turnover

New Pilot Site in Oregon

Rochelle Ferry, a former DHAT from Nome Alaska will be joining the NARA team in the first quarter of this year and begin offering services once we get approval from the Oregon Health Authority to add NARA as a pilot site. At the end of 2016, we requested an amendment to our project to add NARA as a site.

Demonstration in Washington

The Swinomish dental team has celebrated the first anniversary of Daniel's arrival to the clinic

Swinomish today

- Dentists working at the top of their Scope
- Daniel Kennedy (DHAT) out in the community
- A more efficient dental team
- Daniel is a natural fit to the clinic.
- Young Swinomish Tribal members considering Dental Therapy as their future career

Statewide Dental Therapy Bill

- The Statewide Dental Therapy Bill in Washington:
 - Has been renegotiated to reflect the language in the Tribal bill and
 - Creates a work group to establish a pathway for Federally certified or Tribally licensed DHATs to become licensed by the state.

SB 5079 Tribal DHAT Bill Summary

- Authorizes DHATs in Washington that are
 - Certified by a CHAP Certification board
 - Licensed by a Federally Recognized Tribe
- All DHAT services must be performed:
 - In a practice setting within the exterior boundaries of a Tribal reservation and operated by an Indian health program or an urban Indian organization
 - On persons who are members of a Federally recognized Tribe or otherwise eligible for services under Indian health service criteria, pursuant to the Indian health care improvement act, U.S.C. Sec. 1601 et seq.
- Directs HCA to coordinate with CMS for Medicaid Reimbursement



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SB 5079 Tribal DHAT Bill

Tribal DHAT Bill SB 5079 will have a hearing THURSDAY JANUARY 19th at 10 AM There are many ways for you to support this legislation:

- Attend the hearing
- Sign in "PRO" on the legislation (your lobbyist can do this for you if you can't make it to Olympia)
- Testify
- Call your Senator and let them know you support SB 5079
- Sign on to a letter from Tribal leaders to show broad Tribal support for the passage of the Tribal DHAT bill

How to Stay Informed

- Like our Facebook Page search for @nativedentaltherapy on Facebook to find the Native Dental Therapy Initiative Project FB Page
- Email Pam Johnson pjohnson@npaihb.org to get on the legislative updates email list

Momentum for modern dental teams is growing

While Momentum nationally continues to grow, in the Portland Area, we have now filled all of the spots for our demonstration and pilot projects until we can secure our next grant starting next year. Any Tribe that is interested in participating should continue to contact us, we cannot add sites in 2017 but hope to have funding to add 4 more sites in 2018-2020.

CHAIRMAN'S REPORT, ANDY JOSEPH, JR,

This past quarter I attended 4 events as Board chair. In November, I attended the NIHB Board Retreat & Strategic Planning meeting in Scottsdale, Arizona. We accomplished a lot at this meeting.

I also attended the IHS Portland Area Budget Formulation meeting. There was a good turnout at this meeting. We made a request to Portland Area for full funding and they included a budget for full funding in their final budget submission

In December, I attended ATNI's Transition Meeting in Tulalip. It was an important meeting to discuss the priorities for the Northwest Tribes. I talked about health priorities and concern about repeal of the Affordable Care Act and Indian Health Care Improvement Act.



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I was also able to attend the NPAIHB Office Party on December 9 at John's Incredible Pizza. Santa even attended the party! It was great to celebrate the holidays with the staff and thank them for their hard work on behalf of the Northwest Tribes.

<u>Nick Lewis, Alternate SAMHSA motion by Marilyn Scott, Upper Skagit; second by Dan</u> Gleason, Chehalis, motion carried

REQUIREMENT FOR EMPLOYER SPONSORED HEALTHCARE PROGRAMS
ELIGIBILITY FOR MLR/PRC CLAIMS FOR TRIBAL EMPLOYEES, STARLA ROELS,
PARTNER, HOBBS, STRAUS, DEAN & WALKER — via phone conference

ACA REFORM ISSUES, GEOFF STROMMER, PARTNER HOBBS, STRAUS, DEAN & WALKER – via phone conference

PORTLAND AREA IHS REPORT, DEAN SEYLER, PAO IHS DIRECTOR:

4:50:14.4. **DEAN SEYLER**: Thank you. Thank you. All right. Good afternoon everybody. My apologies for not being here this morning. I couldn't get out of my own driveway and down the road this morning. We did have a little bit of freezing rain hit the Portland Metro area although it wasn't the catastrophic level that the National Weather Service was predicting. I understand is this afternoon is supposed to get hit harder. In fact, they forecasted another half inch of ice in Portland metro and Vancouver areas. So last night I made a call and decided I'm not going to go to the area homes today. So there's nobody at work there. I think Multnomah County, City of Portland, Vancouver they didn't open all those schools. They're closed. So they may have been back to operations tomorrow. But was able to get on the road with Captain Rudd and Ann Arndt, and there was a lot of rain. So it's a wonder 4:51:25.7 [INAUDIBLE.]

4:51:30.1. We'll start off with sharing that there are two fiscal years FY 17 Continuing resolutions. We know that for the Title 1 Tribes that we are fairly confident that 99% of all those funds have been distributed to accounts. I know on Friday I saw where they found out the treasury did do some transmissions for the Title 5 Tribes. For the funds that we had received from Headquarters we've initiated the transfer of funds. There are still some Title 5 Tribes that have not completed their AFA with the headquarters. So if that's you, that's something you need to take a look at and get going. As you can see there, there is the



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percentage of funds that you have received.

4:52:33.7. The update on the Funds Distribution Workgroup that I asked them to come up with a proposal that would put forth the for CHSDA area wide expansion proposal. They came up with a good draft. We tweaked a little bit. I sent it out to headquarters. In fact, I was on call. I've been on calls this morning about it, and we have another call tonight. We're trying to get some clarification for Mary Smith before she leaves on Thursday. Not sure whether that's gonna happen or not, but we'll have more information regarding that later. But tonight we'll have more information. Basically what it is, is the proposal was to allow the Tribe to opted-in if they chose to, to offer a secondary level of PRC coverage to memberships anywhere in the three-state area. So we'll see how that goes.

4:53:47.8. The -- this is just an FYI on the FY16 on CHEF and we submitted 2.5 million to Headquarters in a return of \$2.3 million came back to the Portland area Tribes on that's year's program. I think that's probably our highest return the Tribes have seen in quite a few years.

4:54:16.3. An update on the staffing. Sharlene Andrew, you guys may have known her, you'll see on here at the Quarterly Board meetings she's retired as of December 31st. And Nichole Swanberg has been appointed as the acting financial officer. We'll be advertising that position once we get the green light from headquarters. With the new administration, they're pretty much putting the freeze on positions. They already froze all SCS positions. They haven't done this for GS positions, but we anticipate that to be coming out next week.

4:54:53.3. A couple changes for within the operation of the area office is I moved the division of business operations, which is business office folks, over to the office of administration management. That's the executive officer branch in the area. And the reason behind that is more and more work by the business office is being done in conjunction with our new financial system that the AC has been required to switch over to within the department. So it makes that transition a lot smoother. In addition, and not to overload Anne, I moved our IT folks over to the Office of Tribal and Service Operation which really makes a lot of sense because Terry supervises the CEO's, and all the clinical operations are pretty much going by electronic health record. So they have IT support in answer to the person who will receive the person who oversees the Service Units kind of blends it in and dovetails better.

4:56:02.4. Another retirement was Commander Celeste Davis who you may know or worked with her there she's in environmental health for the within out office. She retired December 31st. Rich Truitt is appointed to serve as the Acting until such time it's filled. And then



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Lieutenant Commander Matthew Ellis was appointed to serve as the Acting Environmental Health Director Manager Coordinator.

4:56:32.4. The FY19 National Budget work session went well. That was held at the Embassy Suites Airport. And I thank the Tribes who were present, who contributed and provided input to that process. So as you can see, the upcoming meeting in February. And both Andy and Steve are the two designated Tribal reps for the Portland area.

4:57:00.1. Something new. For many, you'll see the latest emails we had, and in particular I've given some handouts regarding the IHS clients to expand the community health aid program. We're gonna need to establish a national work group, and knowing the Portland area will need to work on identifying some Tribal representation, I think, and also some Federal myself or Dr. Rudd will be involved with this. I think it's a good thing. This will be something we can take a look at how we can implement throughout the Portland area.

4:57:43.9. This is an FYI, the Direct Service Tribe Advisory committee is coming up. It will be hosted in Portland, not sure exactly where. May 3rd and 4th. I was talking to Janice here. Janice, have you heard? She may not. Janice, do you know where the meeting's going to be in Portland, for the direct service -- the direct service Tribes?

4:58:07.4. [INAUDIBLE.]

DEAN SEYLER: No, the Portland meeting in May.

4:58:14.6. [INAUDIBLE.]

DEAN SEYLER: [INAUDIBLE.] Okay. Hosting at Ka-nee-ta all the Tribes as our CSC is a specialist position. Many of you had worked with Wes Simmons. He transferred to the California area a few months ago. And we're gonna be hitting that position out on the street, to advertise and then we'll focus pretty much all our time on CSC calculations. That is currently a full time job for all of the IHS area offices when it comes to administering contracts. I think for Portland, and you know there are a couple other areas; we have 25 Title 5 contracts and 24 Title 1 contracts. So as you can imagine, that keeps Terry's shop pretty busy. But this year, Portland Areas FY14-16 CSC reconciliation is partially complete. For the most part, the IDC rate is the same, and we're moving forward with the notification. With any overage or underpayments. But if your ICD rate has changed, we're gonna need to sit down and reconcile again to determine if you, you know, either overpaid or underpaid. So please look for that in the coming months.



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4:59:52.0. Recently facilities list Automated tool is in the process of coming out. And some of you have filled this out before. It has to do with the space of your facilities where you are providing those 5:00:09.1 [INAUDIBLE.] And we're willing to have this become automated to where I'm gonna have to validate pretty much all the entries are existing. So this year, Peggy Ollgaard will be reaching out to the Tribes who haven't submitted any annual space verification so we can complete the first automated list. I don't have that list with me, and Anne is not in the room. She had to step out, she was on a call for me. But we'll hopefully have a list of who we are and who we contact soon.

5:00:48.8. The IHS Tribal Medical Equipment Grant, this is hot off the press, has just started accepting applications for fiscal year 17. I got a link there on your iPad as you can see there. You can go there and submit an application, due by March 10th. Jonathan McNamara in our office is the main contact if you have any questions. He'll be more than happy to assist you. As you can see there, Umatilla was successful in receiving a \$200,000 grant. So did you guys know that? Yeah? Okay. I was hoping you were just learning now but that's fine.

5:01:33.8. The Healing Lodge of the Seven Nations, just to let you know, we have a project in the queue. I just signed off on the paperwork last week, and it's \$150,000 to improve their standby power connection. I think last year, they had to put the kids in a room in a hotel for a while because they lost power in Spokane. I think that was last year. So we're gonna fix that so they already have a little contract in place to get a generator transported there and hooked up in the near future. And also installing a new fire alarm system and replacing doors that are updated with fire rating. And install some LED lighting.

As part of the Regional Specialty Referral Center, there are no updates at this time. It is still, you know, I presented the PJR to headquarters, to Mrs. Smith. And there's been no activity. So if I find out who the next director is, is making a trip back there to see if we can have a discussion about that. So I may need some help down the road, letting you guys know.

5:02:56.8. This I'm not gonna go over in a lot of detail. You can take a look at it as an FYI, just to share with you the modernization project that are going on in four of the Service Units. This list here, I'm not gonna go over in detail. But these are for SSE's and sanitation facilities instruction. They're just some recent highlights of what's been going on out there.

5:03:30.9. This upcoming, this slide here is Healthcare Infection and prevention control. This is, the target audience Infection control Officers, QI Managers, risk managers at dual locations.



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And it is the Tribe, if you have left your environmental health shares with the area, there's no charge for any of your staff to attend this. If you have holding shares, then we'll have to -- Matthew Ellis will be able to tell you what the fee is for it, but it's gonna be at Northern Quest in June.

5:04:15.2. [INAUDIBLE] had asked about the annual National Directors Award Ceremony. For whatever reason, and I don't know what the reasons were, why that wasn't held. It was scheduled but briefly. Some of you may have seen that email that came out from headquarters a couple weeks ago, and they were going to actually have it today. I think it's today or tomorrow. Tomorrow. And so at the last minute, Friday, they decided to cancel it, and I'm not sure whether Chris Buchanan is gonna be the Active Director of IHS until the Trump administration brings forth their appointee. But we'll find out. But I want to share with you who will be recognized. They will be receiving letters from Mary Smith. And it's Farrell Lucei from Warm Springs Service Unit. And Clinton Kittrell from Yellowhawk, and Chemawa Intergrated Behavioral Health Primary care team, which tomorrow you're going to be hearing about a new service they're gonna be providing. And then the community health Benewah Medical and Wellness Center. And as you can see there, the access directors' award. Mary Brown from Yakama. Jonathan McNamara from my office. The Yellowhawk and I'm not going to trying to pronounce that Home Visiting Program, and then the Western Oregon Unit Pharmacy. So 5:05:44.2 [INAUDIBLE] programs to congratulate.

5:05:48.7. For my recognition of excellence, that has just opened up, the nomination period has been opened up and is open until February 3rd. You should have seen an email that came out from Asha Petoskey, if not, we're going to be getting that up to the Health Board to be asked to put on the website. It's open to all Federal, Tribal and Urban folks. Last year, I had quite a few Tribal folks that didn't nominate for that. And they had a great event. So we're scheduling that on May 12th and it will be in Portland.

5:06:18.6. The IHS Scholarship and Loan Repayment program. There's going to be an estimated \$13.7 million that will be available for scholarships. And \$30 million is gonna be available for loan repayment. The new scholarship applications are due on March 28th. And the current scholarship recipients, if you have any of those at your location that are interested in extending another year, must be in by February 28th. The loan repayment applicants must apply by August 5th. So if your facility rating falls within that milestone -- do you know the number, the rating percentage as far as the loan repayment?

5:07:04.4. **Dr. Rudd**: I don't know where they have that set. That's the HIPSA score that we



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look at, that influences that, along with some other factors that Headquarters use to weight it for certain programs that may have greater need.

5:07:18.4. **DEAN SEYLER:** Well, that's good. That's August 15th is the deadline for that. This one is a big A+, and Dr. Rudd may talk more about this later on. It's the VA-IHS consolidated mail outpatient pharmacy, the CMOP. All six of the Federal sites participate in this. This is not an easy or quick prep time to get to the point where you're actually doing this. There's a lot of prep work that has to go on with your IT folks. One of the things you can see as far as requirements go, to access the CMOP if your Tribal pharmacy, you have to be using RPMS. I know that's not the case for all the Tribes. You use other software. But in order to participate in the VA to do this, you have to be on the IHS RPMS system. And then there's the minimum technical requirements that you have to read through. And those are set forth by the VA. Those aren't anything that we set forth. And then sign a customer agreement with that, the IHS National Supply Center. And there is fees that the VA charges. But they're really minimal. They're just like postage, handling type charges. So the twelve Tribal Health facilities that are using them, none of them are in the Portland area. Those are all mainly in the southwest, or in Oklahoma. But so as you can see there, I put a link there you can contact Capt. Todd Warren or Capt. Roney Won online to be able to talk to me about it. At this time, it is our understanding The National Supply Service Center will only work with sites that have left their shares with the Area offices related to pharmacy. So if you hold your shares for pharmacy, then we can talk about if you want to participate in this from the back end. So that's been official Tribe.

5:09:44.5. At this point, I'm gonna turn it over to Dr. Rudd

5:09:48.3. **Dr.Rudd**: So good to be here, everybody. It's a pleasure to be here with everybody. I wasn't able to get back in the fall, in October, so it's good to be back with the group. IHS requires all of our Federal sites to be accredited and maintain accreditation. I know many of your Tribal sites choose to do that as well, as a measure to your community about the good work that your facilities do. Portland area has utilized the accreditation association ambulatory health care, or what we call AAAHC since back in the late 90's as our accrediting body. And all of our sites continue to get full accreditation for a 3-year time period each time they undergo a survey, though there's also that potential for an announcer base as well, which some of our sites have had those occur, and continue to do well with that. In the past, from an area level, the support for our Service Units related to receiving accreditation that's involved with area level workshop preparation usually done about a year before our sites were gonna undergo the survey, and as well as doing at least a single mock survey that's provided in the year prior to when we anticipate a survey. In the past year, we've been looking at the Area office to just sort



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of restructure how we can best provide support to those Federal programs related to their survey preparedness. And it's been part of what we're terming ongoing survey readiness. So the goal of this is really to develop and maintain readiness of our sites by maintaining high quality care and business practice, spreading that three years' worth of work over a 3-year time period rather than pushing it to the single year before the survey's anticipated. And then trying to reduce some of the anxiety that our sites can often feel as they go into the survey. It's normal when somebody's coming in to evaluate you that you might feel a little nervous and anxious about it. We want them to feel assured that they're ready to go at any time. So part of this was to develop what we call a Portland Area Survey Readiness Team, or we have an acronym, ASRT. It's an area level team that's coordinating and consulting on accreditation issues. We have as our leader or director of the office of clinical support, I'm part of that team as Chief Medical Officer. We have our area Environmental Health Officer, director of our office and Tribal and Service Unit jobs, as the supervisor for our Federal CEO's. And then other area consultants as we need. As well, we have a consultant, Dr. Ray Lala, who is a dentist. He used to work in Portland area out at Nimipuii some years ago. He then worked in IHS Headquarters. And now is retired from Indian Health Service, working for the Department of Health in South Carolina. But he has also been a AAAHC surveyor for a long number of years. So we have contracted with him as an expert in the process to help support our facilities.

5:12:56.9. The ASuRT activities, the things that we're trying to do to better support our facilities in all of this, one is we've gone through the process of collating and reviewing all the Service Unit accreditation findings from their last surveys, and we've trended the findings to find ones that were common between multiple facilities. We've also developed action plans for those facilities to address anything. None of our sites had anything that was deemed to be noncompliant. We did have issues that were considered to be partially compliant, and those will be focused on to make sure that you're meeting what the standards require. What we were anticipating, providing a cycle of virtual and onsite trainings and consultation opportunities on priority standards. We do anticipate continuing the AAAHC achieving accreditation workshop that we've done in the past. We've opened that up to Tribal programs and had good participation for Tribes when we've offered that in the past. What's significantly different is now our plan is to conduct annual mock surveys rather than once every three years. And we're right in the midst of that process for this year. So as of last week, we did the first of these annual mock surveys for the Yakama Service Unit. And it seemed to go quite well. We've set this up where we do a pre-conference, or a pre-survey call with the Service Unit about 6 weeks ahead of the mock survey to really prep for what's needed in the survey, get their input as we develop an agenda for that day. We also have developed a SharePoint site where the sites can upload documents for review by the team ahead of time to really get them in the best



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position to conduct the survey. Then we do a full one-day onsite survey with an agenda that's had a lot of input from the Service Unit as to really being responsive to their needs. Then in follow-up, our consultant Dr. Lalo will be providing each of the sites with a written report afterwards of findings from that day's survey. So we finished -- we just concluded the Yakama mock survey. We have one scheduled in Wellpinit in February. And we'll be doing one of these each month between now and June when we'll finish up with the Colville Service Unit in June. So this is a new process for us to see if this will be a better way for Service Units to really get prepared for this process.

5:15:25.1. Had the weather not been a problem, I had intended to be able to introduce to you our new Portland area diabetes consultant, Lieutenant Commander Kathi Murray. But she was not able to travel up today because of the weather. Kathi did start with us back in early December. She comes to us from Tucson area. She is a diabetic nutritionist. She has her certification in diabetes education. She also had a Master's degree in nutrition. She has worked previously not only in the Tucson area at Sells Indian Hospital, but also previously at Pine Ridge in South Dakota and Wide Earth in Minnesota. So she's -- her service with Indian Health Service, she's really had a broad perspective on that. And almost always, this has been directly related to diabetes care. Recently, I was able to sit in and participate in a meeting between Kathi and Sharon Stanphill, one of our team TDLC reps, Cassie I don't believe was able to make it that day. But we had a really good session together, just speaking about what the needs are in Portland area and the ways that she can hopefully best support Tribes under your SDPI grant. There's an upcoming TDLC meeting in February is it Sharon? Yeah. In February. So Kathi will be participating in that as well. So I want you to all be aware that we have a new person, new in this role in the area after so long a period of Dr. Lee doing it. It's gonna be a little odd and a little strange to have someone new. But Kathi is very excited about being here and what she can hopefully do for the Portland area Tribes.

5:17:04.6. Dr. Wiser is preparing two slides that he has to share with you as well. One was to give you an update on influenza. You know, going into December, we received very little influenza activity nationally, and that all changed right around the Christmas holiday, where the number of cases of people showing up at the facilities nationwide started to escalate. And we've definitely seen that here in the Pacific Northwest. Most of it's been influenza A which is pretty typical, and it's been the H3N2 strain. That was the same strain we saw much of last year as well. As Dr. Wiser indicated hospitals in Washington State, especially along that I-5 corridor, have seen a really significant impact from influenza, people showing up at the hospital sick, related to -- for some facilities putting them at near or over capacity. When we talk about influenza, often not everybody gets tested. So we in turn often talk about influenza-like illness,



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the people who show up with symptoms that look like influenza to a facility, that sometimes get diagnosed with the flu and other times with a cold and other times with bronchitis or other presentations that could all be part of that. So that's one of the ways we watch for those diagnoses to determine when the level of flu activity is increasing and that we need to be aware. So currently in the Portland area, we're seeing about 1.9%, and this was true as of the data we had last week when we put these slides together, so it's a little above what was being seen nationally.

5:18:45.3. Of course, Dr. Wiser also pointed out about influenza vaccination coverage. The vaccination coverage is still a bit low, at only 32.4% for all patients over 6 months of age. 48.4% for the seniors over 65. There -- as he points out, there's still time to get vaccinated. Although influenza's showing up in the communities, the season often lasts for a few months. It's likely to be late March or early April before we see the influenza season burn itself out. So there is still opportunity to try and vaccinate people within your communities. He also wanted to highlight for us the good results we've had related to getting health care workers at our Federal facilities vaccinated against influenza. Last year, a policy went into place, and when I say last year I mean fiscal year 2015, I guess was when the policy came out, making it mandatory that all Federal health care staff receive the influenza vaccination. There was a bit of time where they had some negotiation to do with the major union that represents some of our health care staff, and that was resolved this past fall so that it does also apply to our union employees as well. And as he reports here, within the Portland area the response of that is we have 92 to 100% depending on the facility, of the staff that have gone through influenza vaccination. For those staff that do have a reason not to be vaccinated or otherwise choose to opt out, we do require them to wear masks while they're providing care to patients during the influenza season, to not only protect themselves but also to protect patients.

5:20:33.5. Also many of you may have heard over the last month to month and a half about mumps outbreak that's been going on particularly in Washington State. Primarily this has been in Seattle King County area, though there have also been cases that have shown up in other counties like Pierce, Snohomish, Spokane, and Yakama. And at the time we had completed this slide, there had been about 151 cases that had been seen. Activities that the state has in place to try and combat this has primarily been focused on trying to stop further spread to other areas of the state, and then to focus on those people who may not have received two doses of the combined measles-mumps-rubella vaccine. The vaccine may be the best way that the person has of protecting themselves from getting infected with mumps. They recommend testing suspected cases, and that can be done through the Washington State Public Health lab. There's also a toolkit that's been developed by the Washington Department of Health that



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includes a lot of information that can be shared within the communities, either through radio stations or newspapers, and as posters that can be placed in places within the community and help educate the community about mumps and what they can do to help protect themselves in this situation.

5:22:01.1. And then lastly, he had also asked me to make mention about Hepatitis C which is a topic we've talked about as a group several times over the last several years. As many of you are aware, there are higher prevalence rates of infection with hepatitis C among American Indians / Alaska Natives. A recent assessment at a Portland area clinic showed that we have approximately 600 patients currently infected with hepatitis C among those facilities. 60% of those were within that baby boomer age range. And so when we speak of the baby boom, typically they talk about those people born between the years of 1945 - 1965. So this is why this group has been targeted nationally to get testing for Hepatitis C, because they seem to be at higher risk for having developed the infection. So screening is recommended for baby boomers, and then other people that may have other risk factors for the disease. In Portland area, we had about 35.8% of our baby boomer population that's been tested for Hepatitis C, so there remains a significant portion of the population that may not be aware of their status related to Hepatitis C.

5:23:17.7. Coming up at the end of the month, the Health Board is hosting a training in Swinomish on January 30th and 31st. It will be designed to help train primary care providers in screening and treating Hepatitis C virus infection. The slide contains a link to registration for that meeting. Any questions can be either directed to David Stevens, Jessica Leston, or Dr. Wiser who can assist about trying to take part in that. And you know, this certainly falls in line with other efforts that we're making as an Agency to really combat Hepatitis C. I know from my own experience in clinical situations, typically I was seeing patients who would otherwise live for at least another 20 years, who were dying earlier with cirrhosis related to the Hepatitis C, particularly combined with alcoholism and just the huge impact that this has on the length of their life and the community. So we really want to encourage people to send some representative from your community from your medical team who could then hopefully bring this back to your community to start efforts in treating this disease within your local population.

5:24:34.4. Lastly, Dr. Wiser had included on here a little bit of what Dean was talking about, CMOP. One of the advantages of being able to participate in the VA's mail outpatient pharmacy program is the VA has some pricing for certain drugs that we're not able to access from the Indian Health Service in other ways. So about 10 of our Tribal programs are utilizing the VA's pharmacy prime vendor to get your medications that you're distributing through your



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pharmacies, and you get some VA cost breaks for that. But there are some additional cost advantages through the CMOP program. One of those being that there's a number of these drugs that treat Hepatitis C virus infection, that the VA gets some significant discount on through the CMOP program. So in the private sector where these drugs may cost in the -- for a 12-week course of medication anywhere from \$80 to \$100,000 and through IHS pharmacy prime vendor costs, can be in the neighborhood of \$30 to \$40,000; through the CMOP program a 12-week course can be as low as \$15,000. So it certainly brings the cost of those medications down into a range that may actually allow more patients to be treated and get better access to that. So I was pretty excited the day I learned about CMOP. I reached out to Jessica Leston pretty immediately and we were both on the same mind that we are hopeful that more Tribes can participate in CMOP with time and maybe access drugs like this that can be really important for your communities. And that's all I have. Were there questions for either Dean or myself?

Dr. Wiser's on the phone too.

Dr. Rudd: Oh yeah. Tom's on the phone if you have questions for him.

Brent Simcosky: Dr. Rudd

Dr. Rudd: Yeah.

Brent Simcosky: Yeah. On your AAAHC surveys, have you found out, what are the sizes of the Service Units from the staffing center? Because it seemed like when I've been involved in those, they're really resource intensive. I mean, did you have dedicated people that do nothing but the AAAHC work on it 5:26:46.4 [INAUDIBLE.]

5:26:50.8. **Dr. Rudd**: Well, our Federal Service Units, you know, run in size from the smallest being the welcoming Service Unit for the Spokane reservation, where their medical staff is made up of 3.5 providers and medical clinic. So fairly small program. All the way up to the Yakama Service Unit which is really our largest medical staff there, where they have probably 10 providers all total in their facility. None of our Service Units necessarily have dedicated staff working on accreditation as is the case in the Indian Health Service. Nobody gets to wear one hat. Everybody in these facilities can have some role related to preparedness for this. I think in terms of what we did in Warm Springs when I was clinical Director there, we assigned the chapters from the accreditation manual to various staff members, and had each of those staff members focus on that chapter and determine themselves working with the group how well we're meeting those, and if there were things that were found within the chapter that we felt



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we needed to address, then we would work on it as a group to try to come to terms with it. But we shared that load among the whole facility to be able to do that work. Sharon?

5:28:05.2. **Sharon Stanphill**: So along that same line, do you have a group that works on this? Like we have a QI committee that does this. So we break 16 chapters into 16 months and try to do them twice for each three-year cycle. Would you be able to assist us if our QI committee needed help with a certain chapter, or is there any we can link in or see what the direct Service Units are finding or they found a way to do something that maybe can help us?

5:28:33.5. Dr. Rudd: Yeah. Absolutely, Sharon. Any time that you need some sort of technical assistance along this line, Jonathan or myself would be happy to have you reach out and we'll provide you with what we can. You know, one of the beauties of having a SharePoint site for people to put documents in is now I can more easily access these key policies, QI studies, things like that, that Service Units have put together. Another thing I forgot to highlight as part of that, with our teams that are going out on the mock surveys, another thing we're doing different this year is each one of those teams that goes out is having participation by one of the CEO's and one of the clinical directors from one of the other Federal Service Units as part of the team. I'm trying to foster getting folks into different facilities so they can see how they operate. I'll tell you with the first one that we did, Colleen Cawston from Colville came in to Yakama, and Rachel Locker, the clinical director at Warm Springs came up for that. Both of them at the end of the day said they felt like they got more out of it than they felt like they were contributing to the group. But they definitely received a benefit. Of course, I saw the things that they were contributing to the group that maybe they missed. But there really was a lot of value for that cross-pollination of work and being able to see what each other's doing. It's often the case when you're sitting at your clinic, you don't know what you don't know. So you don't always know the right questions to even ask. So it's being there onsite that lets you see the way somebody else is doing something that sparks that idea of how you might do something different or how you figured this out and can help them.

MALE SPEAKER: Oh. I didn't see where, but okay.

5:30:15.5. MALE SPEAKER: Was your question in relationship to that? Okay. 5:30:18.3 [INAUDIBLE] previously was only available to Service Units. And it sounds like now 5:30:28.7 [INAUDIBLE] expand at the 5:30:30.3 [INAUDIBLE.] Can you talk a little bit more about the process for a Tribe that might be interested in CMOP?

5:30:34.9 **Dr. Rudd**: Yeah. So we're in a -- this was granted by -- we're talking the last 7 to 10



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days we have learned about that this was being opened up. I know for our Federal facilities, there was a process to get them up to the speed to actually be able to utilize CMOP. So with CMOP, the VA maintains several really large facilities spread out geographically within the country that process pharmacy orders that come in. So you -- for facilities that have this, the patient from their side calls into a phone line. They enter in a prescription number to request a refill for that prescription. Someone at the Service Unit processes that and sends it onto the CMOP and there's a facility. I think the one that's primarily working for the IHS is in Leavenworth, Kansas. And it processes that, puts together that medication, has pharmacists that do checks on all of that, and then that is mailed out to the patient and they receive it through their US Mail to a post office box. So there's a lot that goes into being able to get all those steps of the process to work, because you have to have computer systems that talk to each other available. You also then have to be able, for your pharmacy, to demonstrate that if the national system went down for some reason, that you have the capacity to provide it for a short term to see them through until the national system gets back up. So each of our Federal systems had to develop their own internal policies about how they would manage mailing out those prescriptions if the national system was down. So there are multiple levels of steps that need to be prepared for to really be able to activate CMOP. But if you can get through the process, patients really like this. I know from my time in Warm Springs, I had patients sometimes that were coming from Lake View to get care at the clinic in Warm Springs four times a year for, say, their diabetes care. And for them to be able -- if they got stuck because of the weather in Lake View and couldn't get up to Warm Springs, they had a system where they could receive their medications and not have a lapse in their care. And so for some of your community members that may drive long distances to come to your clinic and access care, this could be really critical for them to make sure they continue to receive their medications at various times of the year.

5:32:54.2. **Mark Johnston**: Yeah. We've found that mail order is really advantageous to the patients. But I just want to be clear. So you have to have a pharmacy onsite for access.

5:33:03.9. **Dr. Rudd**: Yeah. Yeah. Because there is a stem of the local pharmacists related to processing the order, and there is other checks that they do any time they receive a medication order. They're checking to make sure it's the right drug, that the right follow-up's being conducted for the patient. Maybe there's lab monitoring that needs to occur. Things like that, that the pharmacists at the CMOP center would never be able to check or know about for that patient.

Mark Johnston: Thank you.



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5:33:32.0. FEMALE SPEAKER: [INAUDIBLE.]

5:33:34.9. **Dr. Rudd**: Because the VA system and RPMS were developed around the same time, they use the same computer language, and that's the way the VA is set up is utilizing that. So the VA system doesn't use other programs like EPIC and other things. They use their own internal process. They're giving us the ability to access this program that they administer, but we have to make sure our computer systems can talk to their computer systems.

5:34:09.0. **Mark Johnston**: Are there any sites that have just like a quasi pharmacy or a way to check that internally without having a pharmacy?

5:34:16.6. **Dr. Rudd**: At this point 5:34:17.0 [INAUDIBLE.] Because we've only been dealing with Federal Service Units. And all of them have a full-fledged pharmacy. So this would be new territory for us to go into.

Mark Johnston: Okay. Thank you.

5:34:31.2. **Denise Walker**: This is actually for Dean. Could you go back to your slide with the Tribal 5:34:35.2 employment grant. There is a website there. In yellow that we can't read

5:34:51.0. **Dean Seyler**: www.facilops.ihs.gov/erds/

Denise Walker: Thank you.

FEMALE SPEAKER: I have a question that I'm not sure if you're going to be able to answer or not, but the healthcare authority is requiring us to do -- to enter our data into the repository, Washington repository. And apparently RPMS cannot do that at this time. And so I'm wondering, do you have an update about that at all? Or do you have anything? Does that sound familiar?

5:35:38.2. **Dean Seyler**: I'm trying -- I think I saw a little bit of information on it. I don't know the details about it. That's the state of Washington's requirement, right?

FEMALE SPEAKER: Correct.

Dean Seyler: Right.



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FEMALE SPEAKER: Yeah, for those that have managed care. They have to enter their data into a Washington repository.

5:35:53.9. **Dean Seyler**: Right. No, I have no information on that. Sorry. We'd be more than happy to look into it and see what --

FEMALE SPEAKER: That'd be great, because it's a requirement and it may affect many Tribes.

5:36:03.6. **Dean Seyler**: So maybe if you can give to Terry, Terry oversees it used to be the business office, but now the IT program. Do you have anything?

Terry Dean: The last I heard was that they were going to actually try to use the data. That was at the Washington State Tribal Health Meeting a few weeks ago. Is that right, Marilyn?

Marilyn Scott: Yeah. 5:36:33.2. [INAUDIBLE.]

5:36:43.0. **Tim Gilbert**: Thank you Tim Gilbert, Umatilla, Couple quick things, the IHS moneys Johnathan McNamara stated that in subsequent year or future years other competition within the IHS area 5:37:06.9 [INAUDIBLE] you could also resubmit after 5:37:10.6 [INAUDIBLE] that would be great.

5:37:15.3. **Dean Seyler**: Good thing Rich Truitt is sitting right in front of you, Rich if you could take not and could get an email and copy us.

5:37:25.1. **Tim Gilbert**: Just two quick questions. If there's on the CHSDA [INAUDIBLE] if there's any paper with that or any kind of summary that I could take a look at, that would be great. Or if by any chance, actually Umatilla is entertaining a proposal for CHSDA extension of our health commission, looking at it. We're following the guidelines that are in the Federal register, and if this is going to change the process at all or have an excessive timeframe, that would be great to know.

5:37:59.8. **Dean Seyler**: So probably be best if you would ask Mark Johnston for his draft of what he came up with for the draft from the Fund Distribution Workgroup, the final version, I can't share just because it's in the decisional phase. And I'm not allowed to share internal documents until the director of the AC makes a decision one way or another.

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5:38:23.0. **Tim Gilbert**: So my question is since we are 5:38:25.4 [INAUDIBLE] our proposal again were following the receipt from the Federal Register for CHSDA expansion are we on pretty safe ground until you folks make a decision.

5:38:40.6. **Dean Seyler**: Yes. The Indian Health Manual has those steps that are required for a CHSDA expansion request. Follow all that, and then our office will be more than happy to help you with that too.

5:38:54.3. **Tim Gilbert**: That's really kind of all of the clarification we'd really appreciate that.

5:38:59.1. **Dean Seyler**: Oh yeah. Whatever comes from tonight's call, and in the future I'll make sure to share it with all the Tribes.

5:39:05.8. **Tim Gilbert**: And my third point was last November or the year prior you provided ISDEAA 638 training, I believe you said you were going to do that every year. I think that was 2015 in Issaquah. We had folks there it was very informative are you going to do it again this year or any time soon?

5:39:28.2. **Dean Seyler**: If we did that in 15, Terry, you were facilitating then, weren't you? You and Anne? Are you guys looking at 17?

Terry Dean: IF you tell us to... Sure, put me on the spot. 5:39:44.5 [INAUDIBLE.] If it's due, then we'll do it. But I know it was very beneficial Tribes who were there, really those new staff and recognize the Tribal staff turnover. Yeah. We'll do it.

5:40:05.6. FEMALE SPEAKER: Just a question you didn't answer if there's a timeframe for that decision.

5:40:11.8. **Dean Seyler**: [INAUDIBLE.] As is, I don't supervise the director of IHS.

FEMALE SPEAKER: But do you have any idea?

5:40:21.8. **Dean Seyler**: There are no timeframe. There is no deadline on it.

FEMALE SPEAKER: Okay.

5:40:27.8. FEMALE SPEAKER: Thank you. 5:40:28.9 [INAUDIBLE.] I have a question on the



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CMOP. I read the letter that came through. And it appeared like it was for VA patients only. Is it for all IHS patients?

5:40:44.6. **Dean Seyler**: Yes. Yes.

FEMALE SPEAKER: Thank you.

Dean Seyler: Any of your patients that you're seeing.

5:40:55.9. **Dean Seyler** So thank you for your time and thank you for allowing us to to be late

on the agenda.

Recess at 4:16 p.m.





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WEDNESDAY JANUARY 18, 2017

Call to order, Cheryle Kennedy, NPAIH Vice-Chairwoman

Recognize Leslie Wosnig, Suquamish will be retiring at the end of March 2017.

OREGON STATE UPDATE, JULIE JOHNSON, INTERIM TRIBAL AFFAIRS DIRECTOR-No PowerPoint

WASHINGTON STATE MEDICAID UPDATE, JESSIE DEAN, TRIBAL AFFAIRS &
ANALYSIS, DIVISION OF POLICY, PLANNING & PERFORMANCE – No PowerPoint
BREAK

RESOLUTIONS

<u>17-02-01 Pathways into Health – Northwest Native American Center of Excellence</u>

<u>Ratified, motion by Dan Gleason, Chehalis; seconded by Shawna Gavin, Umatilla, MOTION</u>

<u>CARRIES</u>

17-02-02 Authorization Related to National Indian Health Policy Education Foundation Motion by Patti Kinswa, Cowlitz; seconded by Dan Gleason, Chehalis, MOTION CARRIES

17-02-03 Support submission of grant for CDC funding for Northwest Tribal Comprehensive Cancer Project

Motion by Andy Joseph, Colville; seconded by Brent Simcosky, Jamestown, MOTION CARRIES

1717-02-04 Approval of Background Check Policy

Motion by Shawna Gavin, Umatilla; seconded by Tino Batt, Shoshone-Bannock, MOTION

CARRIES



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FOUNDATIONAL PUBLIC HEALTH SERVICES (FPHS) WASHINGTON STATE, MARIE FLAKE SPECIAL PROJECTS

A New Vision for Public Health in Washington State

Rebuilding Core Services & Modernizing the System

Several graphs please to the PowerPoint

The Problem

- 1. Changing nature of preventable disease
- 2. Increasing demand for core public health services
- 3. Diminished and inequitable funding for core public health services

2017 & Beyond

- Legislative Proposal policy bill & budget request
- System-wide Assessment evaluate current FPHS capacity and update cost, current spending and funding need estimates
- Service Delivery implement and evaluate pilot projects; further develop ideas and models; identify which FPHS fit best at local, zone, state level
- Accountability tracking the investments, spending, capacity, performance, impacts
- Funding Allocation funding to follow the work
- Process for Routine Updates definitions, costs, services delivery, accountability, allocation

Why I/T/Us are Part of our Governmental Public Health System

- Respecting sovereignty: Tribal governments provide public health functions and services to their communities; Tribal FPHS framework must be Tribal-driven
- State and local health departments have no jurisdiction on Tribal lands
- I/T/U, state and local partnerships will be enhanced where shared services are needed
- 2017 LEGISLATION includes defining the governmental public health system in Washington as: DOH, SBOH, LHJS and their boards and the sovereign Tribal Nations of Washington

Tribal Participation History

- 2014 FPHS Policy Workgroup
 - Tribal Leader Representation
 - Co-chaired by Tribal Leader
- 2015 Tribal Consultation
 - Secretary 'ask' to determine I/T/U interest in pursuing Tribal-specific FPHS



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- Positive response to move forward
- 2015-2016 Presentations at Tribal meetings
- AIHC, NPAIHB, Other
- 2016 FPHS Tribal Technical Workgroup Formed

Foundational Public Health Services (FPHS) Tribal Technical Workgroup Workgroup Goal

Assure I/T/Us are a key component of the overall WA State governmental public health system by considering & evaluating FPHS concepts and framework and assessing & identifying Tribal-prioritized foundational public health services and funding opportunities

Workgroup Objectives

Through continuous I/T/U engagement:

- Identify current I/T/U public health services, gaps, and desired role in overall system
- Develop foundational services and definitions
- Identify current FPHS expenditures and funding sources
- Estimate potential FPHS funding gaps
- Convene decision makers to determine funding sources
- Create strategies for funding advocacy

2017 & Beyond for Tribal Work

- Engage I/T/Us
 - Tribal Survey What services are already being provided?
 - Regional Meetings What FPHS services should be provided everywhere?
 - Shared services discussion Where might Tribal, local and state core/FPHS services be shared for efficiency and effectiveness?
- Develop I/T/U FPHS Model (Services/Capabilities)
 - Prepare FPHS definitions for Tribal input
 - Identify FPHS Costs and funding gaps

www.doh.wa.gov/fphs

http://publichealthisessential.org

Modernizing the Governmental Public Health System, Together!

LUNCH



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Tribal Reports

Kootenai Tribe, Karen Hanson Lummi, Justin Iwasaki Colville Service Unit, Colleen Cawston

HEALTH RESOURCES & SERVICES ADMINISTRATION, SHARON TURNER, HEALTH RESOURCE & SERVICES ADMINISTRATION REGIONAL ADMINISTRATOR, OFFICE OF REGIONAL OPERATIONS

Health Resources and Services Administration

Improve health and achieve health equity through access to quality services, a skilled health workforce and innovative.

HRSA Programs

Here is an example collage of some of the 90+ programs that are under HRSA Primary Health Care is probably the most visible HRSA funded program. I will talk more about them later....

HRSA Major Program Areas

- Primary Health Care
- Health Workforce
- Healthcare Systems
- HIV/AIDS Care
- Maternal and Child Health
- Rural Health

HRSA FY 2017 Budget Request Overview of Principal Programs

- HRSA annual budget of approximately \$10 billion.
- HRSA operates more than 80 programs and awards more than 10,000 grants and supplements to approximately 3,000 partner organizations.
- Comprised of five bureaus and ten offices, HRSA provides leadership and support to health care providers, schools for health professionals, local health systems, states, and other entities throughout the United States and its territories.



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Other HRSA Programs

- HRSA is responsible for the Federal designation of Health Professional Shortage Areas and Medically Underserved Areas/Populations. HRSA also oversees or supports many other activities that are critical to the nation's health and well-being. These include:
 - Healthy Start Program
 - National network of poison control centers
 - National organ procurement and allocation activities
 - National Vaccine Injury and Countermeasures Injury Compensation Programs
 - o 340B Drug Pricing Program
 - o Maternal, Infant, and Early Childhood Home Visiting Program
 - Hansen's Disease treatment, training, and research programs

National Practitioner Data Bank that helps improve healthcare quality, protect the public, and reduce healthcare fraud and abuse.

Increase Access to Quality Health Care and Services

- One in 3 people living at or below the poverty level relies on a HRSA-supported health center for primary medical care
- One in 2 people diagnosed with HIV receives care through the Ryan White HIV/AIDS Program
- 9.7 million people living in health professional shortage areas receive primary medical, dental or mental health care from a National Health Service Corps clinician

Increase Access to Quality Health Care and Services

- More than half of pregnant women and a more than a third of infants and children benefit from maternal and child health block grants
- More than 700,000 rural Americans receive health services thanks to rural communitybased grants
- About 115,500 parents and children participate in the national Home Visiting Program
- About 6,000 life-saving unrelated blood stem cell transplants facilitated annually

Strengthen the Health Workforce

- 11,400 medical, dental, and mental and behavioral health care providers in the National Health Service Corps and NURSE Corps work in health professional shortage areas
- 1,100 students, residents, and health providers in training receive NHSC scholarships to work in underserved communities upon graduation and licensure
- Support for targeted health professions training programs focused on inter-professional care, geriatrics and autism, among others, as well as programs that increase workforce diversity



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Strengthen the Health Workforce

- Support health centers that employ multi-disciplinary teams 10,700+ physicians and 8,000+ nurse practitioners, physician assistants, and certified nurse midwives
- Support primary care residency programs in 60 Teaching Health Centers to help train more than 550 residents annually
- Trained 4,000 new mental health providers to increase access to mental health services, and make schools safer

Build Healthy Communities

- Coordinate health care activities for 62 million rural Americans
- Support providers in rural and isolated areas improve patient care with the use of telehealth, telemedicine and health IT
- Improve perinatal health outcomes and reduce racial and ethnic disparities by using community-based service delivery through Healthy Start

Improve Health Equity

- Provide linguistically appropriate enabling services (e.g., housing, food, and job support)
 to more than two million patients through community health centers
- Ryan White HIV/AIDS clients' viral suppression rates improved nine percent in three years from 70% to 79% from 2010 to 2013. Viral suppression rates improved the most within disproportionally affected demographic groups, decreasing health disparities
- Save qualified safety net organizations about \$3.8 billion annually through the 340B
 Drug Pricing Program

ORO Mission Statement

To improve health equity in underserved communities through on the ground outreach, education, technical assistance and partnering with local, state, and Federal organizations.

ORO Core Functions

The Role of ORO is different than other components of HRSA. With the risk of losing your complete attention, I'll mention that unlike most other parts of HRSA, ORO does not award or manage grants or cooperative agreements. **INSTEAD**, we work across all of HRSA's program areas to extend the reach of the Bureau's and Offices and to provide an additional touchpoint for HRSA's stakeholders.

Our work can be categorized by these Core Functions.

External Affairs & Outreach: Agency liaison and Regional leadership



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Strategic Stakeholder Partnerships: Engage partners and broker relationships

Regional Surveillance: Identify and report ground-level information

Regional Management: Ensure efficacy of HRSA Resources Now let's discuss each Core Function in a little more detail.

ORO Core Functions

External Affairs & Outreach

To effectively serve as the Agency liaison and regional leader conducting outreach, to increase knowledge about HRSA's programs and priorities.

Represent HRSA: Affordable Care Act Events, Tribal Consultations, National and State Conferences, Ribbon Cutting Ceremonies

Strategic Stakeholder Partnerships

To meaningfully engage partners at Federal, state, and local levels to advance HHS/HRSA priorities

Regional Surveillance

To proactively identify and report critical ground-level communications and information about regional/state activities to inform HRSA's operations, decision-making, and allocation of resources.

Examples: Environmental Snapshot, Regional Director's Report, Public Health Emergencies

HRSA ORO Region X Tribal Highlights

Regional Investments

HRSA's Health Center Program grantees served 261,568 American Indian and Alaska Native patients in 2015. Also in 2015, Region X's community health centers served 74,729 American Indian and Alaska Native patients

Primary Care Services

- HRSA's Health Center Program grantees served over 259,000 American Indian and Alaska Native patients in CY 2013.
- Region X's community health centers served over 65,648 American Indian and Alaska Native patients in CY 2013.

Additional graphs in PowerPoint



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LONG TERM CARE, BEA RECTOR, DIRECTOR, HOME AND COMMUNITY SERVICES
DIVISION & MARIETTA BOBBA, MBA, TRIBAL AFFAIRS ADMINISTRATOR
GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES, AGING AND
LONG TERM SUPPORT ADMINISTRATION DEPARTMENT OF SOCIAL AND HEALTH
SERVICES

DSHS Aging and Long-Term Support Administration (ALTSA)

Vision

Seniors and people with disabilities living in good health, independence, dignity, and control over decisions that affect their lives

Mission

To **Transform Lives** by promoting choice, independence and safety through innovative services **We Value**

The Pursuit of Excellence, Collaboration, Honesty, Respect, Open Communication, Diversity, Accountability, and Compassion

ALTSA Serves approximately 74,000 individuals per year

Focus of Home and Community Services

- Financial eligibility for Medicaid LTSS programs, also determines state/Federal programs such as cash and food benefits for LTSS recipients
- Initial assessment for LTSS functional eligibility, service planning and service authorization for new clients, including those choosing in-home services
- Case management for Medicaid clients in licensed residential care settings
- APS investigation of abuse, abandonment, neglect, and self-neglect of vulnerable adults in the community, and the provision of protective services
- Assist individuals to relocate from institutional to community based settings
- Develop housing, resources and system capacity to serve clients in community settings
- Develop local partnerships and work directly with local agencies to improve service delivery to clients, including 7.01 planning with Tribes and Tribal organizations

Focus on Adult Protective Services



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- *Investigates* and prioritizes allegations of abuse, abandonment, neglect, self-neglect or financial exploitation of vulnerable adults in their own homes.
- Offers protective services to alleged victims in situations where allegations were substantiated.
- Educates, networks and coordinates with other community entities to serve vulnerable adults

Authority: RCW 74.34

Focus of Area Agencies on Aging (AAA)

- Specialized Senior Information & Assistance/Community Living Connections
- Local contracting and quality assurance oversight of community service providers
- Case management and nursing services for in-home clients
- Family Caregiver Support and Kinship Caregiver Services
- Other community services (senior nutrition, transportation, legal services, etc.)
- Advocacy and work at local level to develop programs and coordinate services, including coordinating service delivery with Tribes and Tribal organizations within their service area through 7.01 planning

Focus on Money Follows the Person Tribal Initiative

Create sustainable, culturally competent mechanisms to support American Indians/Alaska Natives (AI/ANs) currently residing in institutions and at risk of institutional placement to either return home or avoid placement through access to the most culturally relevant living environments, as identified by the individual.

- Increased accessibility to Medicaid LTSS to eligible individual Tribal members who need them;
- Identification of Tribal infrastructure needs to enable T/TOs to provide services directly and/or contract to provide services;
- Development of accessible reimbursement mechanisms for service delivery;
- Identification of opportunities to obtain higher Federal medical assistance percentages (FMAP) and/or encounter rates as defined in the Federal register.

See PowerPoint for graphs

Targeting Services Can Address Diverse Needs and Keep Services Affordable for Taxpayers "The Right Support at the Right Time"

- Long-term care is now six percent of Washington State's operating budget
- Long-term care spending increases an average of 12% every biennium
- The state's aging population will nearly double between 2015-2035



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Continued success is contingent on continued innovation

HCBS: Improving Outcomes and Controlling Costs

- Provide wellness education and training through existing 1915(c) waiver
- Offer skills acquisition training and assistive devices to clients through new state plan option (1915 (k) Community First Choice)
- Improve worker skills and interventions for clients who are high-risk
- Engage in Health Homes to improve outcomes for high risk individuals and share in Medicare savings
- Provide supports and services to unpaid caregivers to reduce stress and delay need for Medicaid

ALTSA Residential Care Services

Aging and Long-Term Support Administration Residential Care Services (RCS)

Mission: To protect the rights, security, and well-being of individuals living in licensed or certified residential settings.

- RCS is responsible for the licensing/certifying and oversight of:
 - Adult Family Homes
 - Assisted Living Facilities
 - Nursing Homes
 - Intermediate Care Facilities for Individuals with Intellectual Disabilities
 - Supported Living
 - Enhanced Services Facilities.

The Continuum of Care

Leadership and partnership:

RCS and residential providers and caregivers are working to improve the quality of life and quality of care for our residents through respectful communications and professional relationships.

The development and delivery of strategic services and innovative funding:

New Home and Community-Based Service rules and requirements with a focus on personcentered planning and providing full access to the benefits of community living.

Making the connections and understanding the transformation of services

We are all working together to ensure quality options for our residents, their families and friends, and our communities.

Provider Online Complaint Reporting



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Owners, caregivers, social workers, nurses, physicians and other employees of RCS-licensed and/or certified facilities or agencies are mandated reporters and must report if they have reasonable cause to believe abandonment, abuse, financial exploitation, or neglect has occurred to a vulnerable adult.

Report Concerns Involving Vulnerable Adults

All reports will be screened by Adult Protective Services and/or Residential Care Services. *If the person is in immediate danger, call 911*. You do not need proof to report suspected abuse and you do not need to give your name.

https://www.dshs.wa.gov/altsa/home-and-community-services/report-concerns-involving-vulnerable-adults

Action Plan for RCS Continuous Quality Improvement

- 1. New performance metrics with improved data and reporting.
- 2. Continued Lean practices to promote process improvements.
- 3. Pilot mobile technology for field staff to speed up workflow and timeliness.
- 4. Focused recruitment and retention of qualified nurses and other staff.
- 5. Partner with providers to think creatively about quality and service delivery.

Candace Goehring

Director, Residential Care Services State of Washington
Department of Social and Health Services
Aging and Long-Term Support Administration
Home and Community Services

Goehrcs@dshs.wa.gov 360.725.2401

https://www.dshs.wa.gov/adult-care

TRAUMA INFORMED CARE, KRISTI WOODARD, PORTLAND AREA IHS BEHAVIORAL HEALTH CONSULTANT & MICAH WOODARD, BEHAVIORAL HEALTH, WESTERN OREGON SERVICE UNIT

What is Trauma?

□ Trauma refers to intense and overwhelming experiences that involve serious loss, threat or harm to a person's physical and/or emotional well being.



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- These experiences may occur at any time in a person's life. They may involve a single traumatic event or may be repeated over many years.
- These trauma experiences often overwhelm the persons coping resources. This often leads the person to find a way of coping that may work in the short run but may cause serious harm in the long run. (SAMHSA)

Trauma Informed

- A trauma-informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. (SAMHSA TIP 57)
- It involves viewing trauma through an ecological and cultural lens and recognizing that
 context plays a significant role in how individuals perceive and process traumatic events,
 whether acute or chronic. (SAMHSA TIP 57)

Trauma Informed Care (TIC)

TIC is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p.82). (SAMHSA TIP 57)

Trauma Informed Care & Indian Country

- The Indian Country Childhood Trauma Center (ICCTC) further defines trauma to address the specific conditions and experiences of American Indians and Alaska Natives (AI/ANs) as a "unique individual experience associated with a traumatic event or enduring conditions, which can involve an actual death or other loss, serious injury, or threat to a child's well-being, often related to the cultural trauma, historical trauma, and intergenerational trauma that has accumulated in AI/AN communities through centuries of exposure to racism, warfare, violence, and catastrophic disease."
- Several distinct forms of trauma have been identified in Indian Country:

 - **3** Historical Trauma
 - Intergenerational Trauma

(NICWA)

Innovations in TIC Model

School Based Service Delivery Application

Introduction



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- Number of youth seen in primary care who present with mental health related problems has nearly tripled over the last 20 years
- Over one in five children have a mental health disorder severe enough to disrupt their daily functioning, and of those identified, nearly 70 percent will not receive any services. Over 25,000 schools across 50 states are implementing School-Wide Positive Behavior

Intervention and Supports, a multi-tiered prevention based framework

Adverse Childhood Experiences (ACE)

"Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid retraumatization." (SAMHSA)

PowerPoint has several graphs please see attached Big Ideas...

- How <u>Positive Behavioral Intervention and Supports (PBIS)</u>(Multi-tiered Systems of Support (MTSS)) enhance mental health in schools within an <u>Interconnected Systems</u>
 <u>Framework (ISF) that is Trauma-Informed.</u>
- How can <u>School-Based Health Centers</u> integrate an <u>Interconnected Systems Framework</u> that is Trauma-Informed.
- How can <u>client/community centric design thinking</u> significantly impact <u>outcomes</u> (<u>Trauma Informed</u>, 0 Suicide, Child Adolescent Needs Strengths (CANS), Systems of Care/Wrap Around, Quality Management, etc.)

Recess 4:24 p.m.



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MINUTES

THURSDAY JANUARY 19, 2017

Call to Order, Andy Joseph, Jr. NPAIHB Chairman

Invocation, Dan Gleason, Chehalis Tribe

Finance Report, Jacqueline Left Hand Bull, NPAIHB Administrator Officer

Motion by Pearl Capoeman-Baller, Quinault Nation, second by Rhonda Metcalf, Sauk-

Suiattle: MOTION CARRIES

***Action Item: letter to Tribe for lobby

COMMITTEE REPORTS:

- 1. Elders Dan Gleason, See Attached Report
- 2. Veterans Chris Sanford, See Attached Report
- 3. Public Health Victoria Warren-Mears, See Attached Report
- 4. Behavioral Health Lisa Guzman, See Attached Report
- 5. Personnel Shawna Gavin, See Attached Report

<u>POM Revision – motion by Lisa Guzman, Kalispel Tribe, second by Leslie Wosnig,</u> <u>Suquamish: MOTION CARRIES</u>

7. Youth – Nanette Yandell, See Attached Report

APPROVAL OF MINUTES

<u>August & October – Motion by Dan Gleason, Chehalis, seconded by Tino Batt, Shoshone-Bannock; MOTION CARRIES</u>

Future Board Meeting Sites:

- April 18-20, 2017 Quinault Nation
- July 18-20, 2017 Joint Meeting w/ CRIHB Canyonville, OR (Cow Creek)

Adjourn at 10 a.m.



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MINUTES

Prepared by Lisa L. Griggs,	Date
Executive Administrative Assistant	
Reviewed by Joe Finkbonner, RPh, MHA, NPAIHB Executive Director	Date
Approved by Greg Abrahamson,	
NPAIHB Secretary	Date





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AGENDA

TUESDAY, JANUARY 17, 2017 – (SALON D,E,F)

7:30 AM	Executive Committee Meeting	Eagles Landing Boardroom
9:00 AM	Call to Order Invocation Welcome Posting of Flags Roll Call	Andy Joseph, Chairman Dan Gleason Chehalis Chairman, Don Secena Chehalis Color Guard Shawna Gavin, Treasurer
9:15 AM	Area Director Report (1)	Dean Seyler, Portland Area IHS Director
10:00 AM	Executive Director Report (2)	Joe Finkbonner, NPAIHB Executive Director
10:15 AM	Break	
10:30 AM	Election of Officers ✓ Vice-Chairman ✓ Treasurer ✓ Sergeant-at-Arms	
11:00 AM	Policy & Legislative Update (3)	Laura Platero, Government Affairs/Policy Director
12:00 PM	<u>LUNCH</u>	
	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: Colbie Caughlan
	5. Personnel	Staff: Andra Wagner Staff: Laura Platero
	6. Legislative/Resolution7. Youth	Staff: Nanette Yandell
1:30 PM	THRIVE Project & Project Red Talon (PRT) Updates (4)	Colbie Caughlan, THRIVE Suicide Prevention Project Manager

2:00 PM	Requirements for Employer Sponsored Healthcare Programs Eligibility for MLR/PRC claims for Tribal Employees (5)	Starla Roels, <i>Partner</i> , Hobbs, Straus, Dean & Walker
2:45 PM	ACA Reform Issues (ACA) (5)	Geoff Strommer, <i>Partner</i> Hobbs, Straus, Dean, & Walker
3:30 PM	BREAK	
3:45 PM	Native Dental Therapy Initiative Update (6)	Christina Peters, Project Director
4:30 PM	Executive Session	
6:00 PM	Cultural Dinner hosted by Chehalis Tribe a	t Lucky Eagle Casino

WEDNESDAY JANUARY 18, 2017-(SALON D,E,F)

9:00 AM	Call to Order Invocation	Cheryle Kennedy, Vice-Chairman
9:15 AM	Oregon State Update	Julie Johnson, Interim Tribal Affairs Director, State of Oregon
9:30 AM	Washington State's Medicaid Transformation 1115 Waiver & 1915(b) Waiver Update (7)	Jessie Dean, Administrator, Tribal Affair & Analysis, Division of Policy, Planning & Performance
10:30 AM	BREAK	
10:45 AM	Community Health Aid Program (CHAP) (8)	Christina Peters, Native Dental Therapy Initiative Project Director
11:15 AM	Foundational Public Health Services (FPHS) Washington State DOH (9)	Marie Flake, MPH, BSN Special Projects
		Special Frejects
12:00 PM	LUNCH	
1:30 PM	Tribal Updates	
	1. Kootenai	
	2. Lummi	
	3. Makah	
2:15 PM	Health Resources & Services Administration (HRSA) (10)	Sharon D. Turner, MSW, MPA Health Resources & Services Administration Regional Administrator, Office of Regional Operations

2:45 PM	Long Term Care (11)	Bea Rector, Director, Home and Community Services Division & Marietta Bobba, MBA, Tribal Affairs Administrator Governor's Interagency Council on Health Disparities, Aging and Long Term Support Administration Department of Social and Health Services
3:30 PM	BREAK	
3:45 PM	Colville Service Unit Update (12)	Collen Cawston, CEO Colville Service Unit
4:15 PM	Trauma Informed Care (13)	Kristi Woodard, Portland Area IHS Behavioral Health Consultant & Micah Woodard, Behavioral Health, Western Oregon Service Unit

THURSDAY, JANUARY 19, 2017- (SALON D,E,F)

8:30 AM	Call to Order Vice Chair Invocation
8:35 AM	Chairman's Report
9:00 AM	Committee Reports: 1. Elders 2. Veterans 3. Public Health 4. Behavioral Health 5. Personnel 6. Legislative/Resolution 7. Youth
9:30 AM	Unfinished/New Business 1. Approval of Minutes • August • October 2. Resolutions 3. Future Board Meeting Sites: • April 18-20, 2017 – Quinault Nation • July 18-20, 2017 Joint Meeting w/ CRIHB – Canyonville, OR (Cow Creek) • October 17-19, 2017 - TBD • January 2018 – TBD • April 2018 – TBD • July 2018 - TBD
12:00 PM	Adjourn

PORTLAND AREA DIRECTOR'S UPDATE





Dean M Seyler - Area Director January 17, 2017 NPAIHB Quarterly Board Meeting Great Wolf Lodge Grand Mound, WA



Indian Health Service Portland Area



* FY 2017 Continuing Resolutions

- H.R. 5325 provides funding authority from October 1 through December 9, 2016 at 19.18% of the FY 2016 level, with a reduction of 0.496%.
- H.R. 2028, provides funding authority from December 10, 2016 through April 28, 2017. The CR is 38.35% with a 0.1901% across the board reduction.



Indian Health Service Portland Area



* Funds Distribution Workgroup

- ❖ Met November 21, 2016 at Portland Area Office
- Discussed Area-wide CHSDA Proposal
- A proposed CHSDA expansion pilot project for Tribes to opt into a secondary layer of coverage that would allow them to expand their individual CHSDA's throughout Portland Area (OR, WA & ID) in order to access Medicare Like and PRC Rates.
- Submitted to HQ January 5, 2017

* FY16 CHEF

- * \$2,560,556 submitted for Portland Area
- * \$2,333,164 approved and returned





- Financial Management Officer
 - Sharlene Andrew retired on December 31, 2016.
 - Nichole Swanberg was appointed to serve as Acting Financial Management Officer
- Division of Business Operations
 - Moved to Office of Administration
 - Peggy Ollgaard, Director
- Division of Information Resource Management
 - Moved to Office of Tribal and Service Unit Operations
 - Jonathan Hubbard, Director
- * Office of Environmental Health & Engineering
 - CDR Celeste Davis retired on December 31, 2016
 - Rich Truitt appointed to serve as Acting Environmental Health Director
 - LCDR Matthew Ellis, appointed to serve as the Acting Area Emergency Mgt Coordinator



Indian Health Service Portland Area



- FY 2019 National Budget Work Session
- When: February 16-17, 2017
 Location: Arlington, VA

 - * Portland Area Elected Representatives:
 - Andrew Joseph Jr., The Confederated Tribes of the Colville Reservation
 Steve Kutz, Cowlitz Indian Tribe
- Indian Health Service Plans to Expand Community Health Aide Program
 - Dear Tribal Leader Letter dated January 4, 2017
 - Establish a National Workgroup Tribal Leaders and IHS Representatives
 Develop a draft CHAP Expansion Policy and Implementation Plan



Indian Health Service Portland Area



- Direct Service Tribe Advisory Committee Quarterly meeting
 - May 3-4, 2017
 Portland Area Host

 - location TBD
- CSC/ISDEAA Specialist position update
- FY14-16 Contract Support Cost (CSC) reconciliation is partially complete. Next steps:

 If current IDC rate is the <u>same</u>: we will move forward with notification of any over or under payments.

 If your IDC rate <u>changed</u>: we will need to reconcile again to determine any over or under payments.





Facilities List Automated Tool

- CMS Facilities list will be automated January 2017
- * Will use the recent Space Verification submissions to update the list
- · Peggy Ollgaard will be reaching out to Tribes who did not submit the annual Space Verification to complete first automated list
- ❖ New process will require Area Director certification
- Subsequent years will require Tribal participation in the annual data call in order to be included on the list
- * The automated tool will eventually house the OEHE Facilities, as well as the Statistical Officer facilities, creating one database for all I/T/U facility information



To Improve the Quality of and **Access to Care**



♦ IHS Tribal Medical Equipment Grant

- Confederated Tribes of the Umatilla Indian Reservation Successfully Received a \$318,000 Grant to Support New Clinic.
- IHS is Currently Accepting FY 2017 Applications -- Apply Online at by March 10th.
- PAO Point of Contact Jonathan McNamara (503) 414-7770

Healing Lodge of the Seven Nations

- A project in the amount of \$150,000 to Improve Standby Power Connection, Install New Fire Alarm System, Replace Dormitory Doors, and Install Energy Efficient LED Lighting.
- * Regional Specialty Referral Center Demonstration Project
 - No Updates at this time.



To Improve the Quality of and **Access to Care**



- Health Facilities Modernization

 ❖ Western Oregon Service Unit Active Construction

 New Patient Entrance, Expanded Waiting Area, Additional Exam Rooms, IPC Provider Team Space, Consolidated Eye Care, Increased Patient Parking, IT Upgrades, New Windows, and New ItVAC System.

 Currently 80% Complete with August 2017 Completion.

- Wellpinit Service Unit Beginning Construction
 Improved patient registration, New IPC Medical Teaming Space, Improved Signage, IT Upgrades, and HVAC Improvements
 Contract Award January 2017 with July 2017 Completion.
- Yakama Service Unit Active Design
 Convert Former Physical Therapy to Six New Primary Care Exam Rooms With IPC Medical Teaming Spaces
 - Design Complete April 2017 With Construction to Follow.
- ❖ Warm Springs Service Unit

 - Developing a Health Facilities Master Plan to Guide Facilities Improvements.
 Considers Tribal and Federal Programs as Directed by the Joint Health Commission.





Division of Sanitation Facilities Construction - Recent Project Highlights

- Quileute Wastewater Disinfection Equipment Final inspection was held December 15. New Ultraviolet Disinfection Equipment was Installed at the Plant. Protects Public Health and the Local Beach.
- Spokane, Wellpinit Community Water System Improvements: Design is Complete for the Construction of an Additional Well and Connection to the Community Water System at Wellpinit. Bidding and Construction Expected to Occur in 2017.
- Spokane, West-End (McCoy Lake) Water Improvements: Design is Complete and Funding has Been Made Available to Replace a Booster Pump Station. The Tribe Plans to Directly Carry Out the Construction.
- Spokane, Emergency Project: In Response to the Cayuse Mountain Fire that Impacted Wellpink Homes, in August 2016, IHS Sent a Team Out to Perform Evaluations in Coordination with Tribal Staff. As a Result of this Partnership, IHS Secured Emergency Funding from Headquarters to Replace or Repair Individual Homes' Sanitation Facilities.
- Colville, Nespelem Agency Water System: In November 2016, IHS secured \$22,500 in Special Project Funding From IHS Headquarters to Study the Water Quality and Production From a Well that was Drilled in 2004. This is One Important Step Towards Evaluating Long-term Water Supply Options for Nespelem Agency.
- Siletz Wastewater Collection Improvements: IHS has Developed Plans and Specifications and Assisted the Tribe in Procurement for Renovation of the Sewage Collection System that Serves 4 Tribat Homes. It is Expected that the Third Park Tribat Contractor Initiate Construction in January or February 2017.



Indian Health Service Portland Area



- * Healthcare Infection Prevention & Control
 - Institutional Environmental Health is Facilitating an APIC Infection
 Prevention for Ambulatory Centers (ASC 101): Meeting CMS Conditions for
 Coverage Training Course June 27-29 at Northern Quest
 - Target Audience: Infection Control Officers, QI Managers, Risk Managers, Administrators
 - Why Attend:
 - Understand Regulatory Requirements
 Description Assessition Control
 - Protect or Obtain Accreditation Status
 - Implement New Evidence Based Interventions
 - Receive CD w/ Tools and Templates to Apply Lessons Learned
 - LCDR Matthew Ellis, MPH, REHS Institutional Environmental Health Officer/ EMPOC Phone: 503.414.7788 or matthew.ellis@ihs.gov



Indian Health Service IHS Director's Award



- IHS Director's Customer Service Award
 - * Farrell Lucei, EFDA, Warm Springs Service Unit
 - * Clinton Kittrell, MSW, LCSW, Yellowhawk Tribal Health Center
 - Chemawa Integrated Behavioral Health/Primary Care Team, Western Oregon Service Unit
 - Community Health-Benewah Medical and Wellness Center, Coeur d'Alene Tribe
- IHS Director's Award
 - * Mary Morphet-Brown, MSN, NP-C, Yakama Service Unit
 - * Jonathan McNamara, BS, CBET, Portland Area OEHE
 - Yellowhawk Átawišamataš Home Visiting Program, Yellowhawk Tribal Health Center
 - * Western Oregon Service Unit Pharmacy Department





- Portland Area Director's Recognition of Excellence
 - * Open to All Federal, Tribal, and Urban staff
 - Nomination Period is Open until February 3, 2017
 - Email from Asha Petoskey dated December 23, 2016 with nomination forms
 - * Ceremony scheduled for May 12, 2017 in Portland
- IHS Scholarship and Loan Repayment Program
 - * New Scholarship Applicants deadline is March 28, 2017
 - Current Scholarship recipients deadline is February 28, 2017
 - Loan repayment applicants deadline is August 15, 2017
 Questions Contact Heidi Hulsey, EEO/Diversity Manager at
 - Questions Contact Heidi Hulsey, EEO/Diversity Manager at Heidi.hulsey@ihs.gov or at 503-414-5555
 - https://www.ihs.gov/newsroom/index.cfm/pressreleases/2017pressreleases/fihs-scholarship-loan-repayment-programs-aim-to-recruit-more-health-care-providers/



Indian Health Service Portland Area



- * VA-IHS Consolidated Mail Outpatient Pharmacy (CMOP)
 - Interagency Agreement between the VA and IHS has recently been signed and formally announced on January 09, 2017
 - Authorizes Tribes and Tribal organizations with ISDEAA agreements to access the CMOP through the National Supply Service Center (NSSC)
 - * To access the CMOP, Tribal pharmacies must:
 - Utilize the IHS Resource and Patient Management System (RPMS)
 - Meet the minimum technical requirements and agree to the terms, conditions, and responsibilities set forth by CMOP
 - Sign a customer agreement with the IHS NSSC and be responsible for the cost of the drugs purchased and any applicable CMOP fee
 - There are currently 12 Tribal Healthcare Facilities (5 formerly federal) which have been configured to utilize CMOP
 - Any questions related to access or eligibility may be directed to the IHS National CMOP Coordinator, CAPT Todd Warren (todd.warren@ihs.gov) 605-390-2371) or CDR Roney Won (roney.won@ihs.gov) 503-414-5555



Indian Health Service Portland Area



- Accreditation
 - . IHS requires all federal sites to maintain accreditation.
 - Portland Area utilizes the Accreditation Association for Ambulatory Health Care (AAAHC) as our accrediting body.
 - Full accreditation is awarded for a 3-year time period with potential unannounced surveys at any time.
 - Past support for SUs has involved an Area level workshop and single mock survey provided in the year prior to scheduled surveys.





On-Going Survey Readiness

- Goal: Develop a process to maintain readiness throughout the year:
 - Maintaining high quality of care and business practices.
 - · Spreading triennial work over three years.
 - · Reducing anxiety associated with surveys.
- Portland Area Survey Readiness Team (ASuRT)
- · Area-level team to coordinate and consult on accreditation issues.
- Membership
- Director (Office of Clinical Support), Chief Medical Officer, Area Environmental Health Officer, Director (OTSUO), other Area consultants as needed.
- · AAAHC Consultant (contracted)- Ray Lala, DDS



Indian Health Service Portland Area



ASuRT Activities

- Collate and review SU Accreditation findings.
- Trend findings to focus coordinated efforts across SUs.
- Provide a cycle of virtual and on-site training/consultation opportunities on priority standards.
- * Continue AAAHC: Achieving Accreditation Workshop.
- Annual review of AAAHC standard revisions/updates.
- Conduct annual mock surveys.
- Cross clinic participation of CEO, CDs, and QI Coordinators on survey team.
- Conduct PAO Support Staff training to increase accreditation awareness in support of SUs.



Indian Health Service Portland Area



Portland Area Diabetes Consultant

- * LCDR Kathi Murray, MS, RDN, CDE
 - · Prior IHS experience:
 - White Earth Diabetes Project (MN)
 - Pine Ridge SDPI Diabetes Prevention program (SD)
 - Sells Indian Hospital- nutritionist (AZ)
 - Expertise: diabetes, weight management, heart disease, and chronic kidney disease





Influenza Update- disease activity

- Influenza activity has increased in the Northwest since the Christmas holiday.
- Hospitals in Washington State, especially those along the I-5 corridor, have been heavily impacted with large numbers of patients seeking care in Emergency Rooms; hospitalizations and intensive care unit admissions are at near or over-capacity levels
- Area-wide influenza-like illness (ILI) is estimated at 1.9% compared to 1.6% nationally.



Indian Health Service Portland Area



Influenza Update- Vaccine Coverage

- Influenza vaccine coverage is low at 32.4% for all 6 months and older; 48.4% for those 65 and older.
 - There is still time to get vaccinated and it is recommended that everyone receive a seasonal flu vaccine. The current vaccine is well matched to the circulating strains of flu virus this year.
 - Thanks to the IHS mandatory flu vaccine policy, influenza vaccine coverage among healthcare personnel at Federal sites ranges from 92% to 100%, the highest coverage recorded.



Indian Health Service Portland Area



Mumps

- A mumps outbreak in Washington has been on-going since early December primarily in Seattle/King County but also affecting Pierce, Snohomish, Spokane and Yakima counties with 151 cases, currently.
- Activities are aimed at stopping the spread to more areas by focusing on vaccinating those who have not received two doses of MMR and identifying both cases and exposed individuals.
- Testing is recommended for suspect cases and can be done through the Washington State Public Health Lab
- A toolkit for Tribal communities has been developed with full details: http://www.doh.wa.gov/Portals/1/Documents/Pubs/348-589MumpsOutbreakTookitforTribes.pdf



Hepatitis C (HCV)

- Al/ANs have a higher prevalence of infection and higher mortality from HCV than other races.
- A recent assessment in some Portland Area clinics showed over 600 patients currently infected with HCV, 60% of these were born between 1945 and 1965 ("Baby-Boomers")
- Screening is recommended for all "Baby-Boomers" and for anyone else with certain risk factors. Only 35.8% of "Baby-Boomers" have been screened for HCV in Portland Area.



Indian Health Service Portland Area



Hepatitis C (continued)

- NPAIHB will host an important training at Swinomish, January 30th and 31st to train primary care providers to screen for and treat HCV infection.
 - * Registration:

 - Questions can directed to David Stephens, Jessica Leston, or Dr. Weiser
- Screening for HCV infection and treating those who are infected is an important priority for the Portland Area.
- . In support of this priority, a new agreement between IHS and the VA will allow IHS and Tribal clinics to take advantage of discounted pricing for antiviral medications used to treat and cure HCV infections





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

Great Wolf Lodge January 17, 2017

Joe Finkbonner, RPh, MHA



Personnel

- New Hires:
 - None
- Promotions:
 - None
- Interns:
 - Menolly Hart, Intern with HIV/HCV/STI Clinical Services Project



Personnel

- Joe 15 Years of Service
- Eric Vinson 15 Years of Service
- Birdie Wermy 10 Years of Service
- · Nancy Scott- Employee of the Year



Meetings

November

- Oregon Health Insurance Marketplace Advisory Committee, Portland, OR
- Public Health Leader/Mentor Panel at the NWC Public Health Leadership Institute, UW

- WDSF Board Meeting & Alumni Lunch
- PHAB Board of Directors, Washington, DC
- NIHB Transition Meeting
- NPAIHB Annual Holiday Party



Meetings

- · December Cont...
 - Quality Improvement training (Dec 15th)



Upcoming

March

- · NWIC Foundation QBM (March 3rd)
- WDSF Board meeting (March 17th)
- PHAB Board meeting (March 29-30) Washington, Dc

April

• CMS I/T/U Training (April 4-5)



Business

 Need a Representative for SAMHSA's Tribal Technical Advisory Committee (TTAC)

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Northwest Portland Area	
Indian Health Board	一 作字 身 生

Questions...?

Policy & Legislative Update

NW Portland Area Indian Health Board Quarterly Board Meeting Hosted by The Chehalis Tribe

January 17, 2017



Report Overview

- 1. Status of FY 2017 IHS Budget
- 2. Contract Support Costs
- 3. Veteran's Administration
- 4. Community Health Aide Program (CHAP) Expansion
- 5. Tribal Premium Sponsorship
- 6. Catastrophic Health Emergency Fund
- 7. Other Policy Updates
- 8. STAC Meeting Update
- 9. MMPC CMS TTAG Update
- 10. Legislative Issues 115th Congress



Status of FY 2017 IHS Budget

- Congress enacted a second continuing resolution (CR) for FY 2017 for the period of December 10, 2016 to April 28, 2017.
- Based on FY 2016 levels and under the authority and conditions of the FY 2016 appropriations.
- Second CR provides an accelerated apportionment of funds for up-front needs, including IHS.
- House and/or Senate Appropriations Committees' proposed budgets are not in effect during the CR period.
- Appropriations bill must be negotiated for the remainder of FY 2017.



Status of FY 2017 IHS Budget

	FY2016	President	Senate	House
Overall	\$4.8B	\$5.2B \$377M ↑ FY 2016	\$4.99B \$186m ↑ FY 2016	\$5.07B \$271m ↑ FY 2016
Clinical	\$3.23B	\$3.47B	\$3.31B	\$3.37B
PRC	\$914.1m	\$962m	\$914.1m	\$960m
Preventative Health	\$155m	\$166m	\$157m	\$166m
Other services	\$173m	\$175m	\$172m	\$176m
CSC	\$717m	\$800m	\$800m	\$800m
Facilities	\$523m	\$569m	\$543m	\$557m



Contract Support Costs

- · IHS has finally completed and published the new contract support cost (CSC) policy.
- · Several beneficial provisions were negotiated by tribal representatives.
- · A major victory is that the policy will use the Office of Management and Budget (OMB) medical inflation rate for annual adjustments to direct CSC.
- CSC workgroup will continue to convene.



Veteran's Administration

- On September 12, 2016, the Veteran's Administration issued a Dear Tribal Leader Letter (DTLL)
- In October, 2015, VA submitted a Plan to Congress to Consolidate Programs of the Department of Veterans Affairs and conducted Tribal Consultations.
- As part of implementation of this Plan, tribal consultation is being sought on tribal health programs participation in the core provider network and potentially transitioning from the current reimbursement agreement structure to a model under which tribal health programs deliver care to all those eligible for services.
- In person consultation occurred on September 28, 2016 and written comments were due by November 5, 2016 and then re-opened and extended to November 30, 2016
- VA's position is still pending.

CHAP Expansion

- On June 1, 2016, IHS issued a DTLL to create a National Indian Health Service Community Health Aide (CHA) Program.
- The goal is to fully utilize CHAs within the Indian health system.
- Tribal consultations (telephonic and in person) took place in September and October, and written comments were due on October 27, 2016.
- On January 5, 2016, IHS issued a DTLL and Report on the Tribal Consultation and comments received.
- IHS will move forward with nationalization of the CHAP program.



Tribal Premium Sponsorship

- On July 18, 2016, IHS issued a DTLL on a new draft circular to address the purchase of health insurance by tribes, tribal organizations and urban Indian organizations under Section 402 of IHCIA.
- Provides guidance on when T/TO can purchase health insurance coverage for IHS beneficiaries using in part or in whole ISDEAA funding or other IHS appropriated funding.
- Tribal consultations (telephonic and in person) took place in October and September; and written comments were due on October 31, 2016.
- IHS has not issued a response to the comments received on the draft circular.



Catastrophic Health Emergency Fund (CHEF)

- Proposed rule issued on January 26, 2016 (81 Fed. Reg. 4239–44).
 - Adds "tribal" resources to the list of alternate resources.
- No tribal consultation on this rule before it was issued
- DTLL issued on June 1, 2016 stating that IHS would engage in additional tribal consultation.
- Tribal consultations (telephonic and in person) took place from August through September; and written comments were due on October 31, 2016.
- IHS's response is pending.



Other Policies

- CMS Medicare Expansion of Diabetes Prevention Program Final Rule Issued on November 2, 2016.
 - Sub-regulatory guidance will be issued.
- · CMS Managed Care Final Rules
 - CMS issued an informational bulletin on the Indian provisions of the final Medicaid and CHIP managed care rule with a managed care Indian addendum.
- CMS 100% FMAP -- CMS issued a letter to State Health Officials on February 26, 2016 re-interpreting the scope of services to be considered "received through" an I/T to qualify for 100% FMAP:
 - CMS to issue a FAQ on new policy still pending.



Other Policies-cont'd

- CMS All Tribes Call on December 15, 2016 on 4 walls limitation:
 - If 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.
 - If the Tribal facility is enrolled in the state Medicaid program as an FQHC, the Tribal facility may properly claim payment for services furnished by the non-Tribal provider at the facility rate.
- DHHS issued a DTLL and proposed rule to add new regulatory requirements to agreements under ISDEAA on November 10, 2016.
 - Telephonic Tribal consultation on December 9, 2016.



Other Policies-cont'd

- IHS Re-alignment of IHS Headquarters
 - All Tribes Call on September 29, 2016 and in person discussion at NCAI on October 9, 2016.
 - Comments were due on January 13, 2016 (extended from November 5, 2016).
- SAMHSA's Draft Tribal Behavioral Health Agenda (TBHA)
 - Sets forth a framework, priorities and strategies to address behavioral health issues in Indian country.
 - Final version is available at: http://store.samhsa.gov/product/PEP16-NTBH-AGENDA

STAC Meeting Update

- Last meeting was December 7-8, 2016.
- Tribal leaders requested that STAC continue with the new administration.
- 2017 proposed meeting dates remain to be confirmed by the new administration:
 - March 7-8, 2017
 - May 31-June 1, 2017
 - September 19-20, 2017
 - December 5-6, 2017

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MMPC & CMS TTAG Update

- Medicare, Medicaid and Health Reform Policy Committee's (MMPC) last call was on January 9; next face-to-face meeting is on February 28, 2017.
 - Priority List
- CMS TTAG last conference call was on January 12; next face-to-face meeting is March 1-2, 2017.



Indian Legislative Issues 115th Congress

- Repeal of ACA/IHCIA through budget reconciliation process
- Possible replacement provisions
- · Medicaid reform



Indian Health Service Rockville MD 20852

OCT 27 2016

Dear Tribal Leader:

Today I am pleased to announce that the Indian Health Service (IHS) has updated its Contract Support Costs (CSC) policy. It has been 10 years since the last CSC policy update. I want to extend my thanks and gratitude to Tribal Leaders and the CSC Workgroup for the hard work and collaboration that helped make this happen.

As part of this exciting news, I also want to inform you that the IHS will apply the medical inflation rate to calculate estimated annual increases to ongoing direct CSC. This provides Tribes with additional access to resources. This is a major accomplishment and has been a high priority for the IHS and for Tribes.

Another significant change I want to point out in the updated CSC policy relates to an option available to Tribes to reconcile and determine the full, final CSC expenditures within 90 days of the end of the annual performance period. In addition, the policy includes new tools, such as the CSC Negotiation Template, which provides a way to calculate CSC consistently and in a transparent manner. These updates are consistent with changes to the CSC appropriation, which allows the IHS to fully fund CSC.

The CSC policy serves as a guide for the IHS and Tribes in the preparation, negotiation, determination, payment, and reconciliation of CSC funding used to support new, expanded, and ongoing services provided through compacts and contracts pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA).

In accordance with the ISDEAA, CSC are costs associated with administering the compacts and contracts through which Tribes assume responsibility for the operation of IHS programs, services, functions, or activities (or portions thereof). CSC are the reasonable costs for activities that Tribes must carry on to ensure compliance with the terms of the contract and prudent management, but that normally are not carried on by the IHS in its direct operation of the program or are provided by the IHS from resources other than those under contract.

The IHS publishes its CSC policy in the IHS *Indian Health Manual* at Part 6, Chapter 3. Copies of the updated CSC policy will be mailed out soon. You may access the policy on the IHS Web site at: https://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p6c3.

Again, I extend my sincere appreciation to the IHS CSC Workgroup for all their hard work and dedication. The CSC Workgroup will continue its work on addressing policy issues that you will find footnoted in the updated policy. The CSC Workgroup will reconvene after the New Year to continue their work.

Page 2 – Tribal Leader

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,

/Mary Smith/

Mary Smith Principal Deputy Director





Home > Newsroom > Media Release Database > Fact sheets > 2016 Fact sheets items > Medicare Diabetes Prevention Program (MDPP) Expanded Model

Medicare Diabetes Prevention Program (MDPP) Expanded Model

Date 2016-11-02

Title Medicare Diabetes Prevention Program (MDPP) Expanded Model

Contact press@cms.hhs.gov

Medicare Diabetes Prevention Program (MDPP) Expanded Model

BACKGROUND

Diabetes affects more than 25 percent of Americans aged 65 or older[1] and its prevalence is projected to increase approximately 2 fold for all U.S. adults (ages 18-79) by 2050 if current trends continue.[2] We estimate that Medicare will spend \$42 billion more in the single year of 2016 on fee-for-service, non-dual eligible, over age 65 beneficiaries with diabetes than it would spend if those beneficiaries did not have diabetes -- \$20 billion more for Part A, \$17 billion more for Part B, and \$5 billion more for Part D. On a per-beneficiary basis, this disparity is just as clear. In 2016 alone, Medicare will spend an estimated \$1,500 more on Part D prescription drugs, \$3,100 more for hospital and facility services, and \$2,700 more in physician and other clinical services for those with diabetes than those without diabetes. [3] Fortunately, type 2 diabetes is typically preventable with appropriate lifestyle changes.

The Medicare Diabetes Prevention Program (MDPP) expansion was announced in early 2016, when the Secretary of Health and Human Services determined that Diabetes Prevention Program model test <u>met the statutory criteria for expansion</u>. The final rule establishing the expansion was finalized in the Calendar Year 2017 <u>Medicare Physician Fee Schedule (PFS) Final Rule published in November 2016</u>.

WHAT IS THE MDPP EXPANDED MODEL

The MDPP expanded model is a structured behavioral change intervention that aims to prevent the onset of type 2 diabetes among Medicare beneficiaries diagnosed with pre-diabetes. The MDPP expanded model is a CMS Innovation Center model test expanded in duration and scope under section 1115A(c) of the Social Security Act and will be covered as an additional preventive service with no cost-sharing under Medicare. Beginning on January 1, 2018, eligible beneficiaries will be able to access MDPP services in community and health care settings and furnished by coaches that are trained community health workers or health professionals.

OVERVIEW OF WHAT IS IN THE 2017 PFS FINAL RULE

The 2017 PFS rule finalizes aspects of the expansion that will enable organizations, including those new to Medicare, to prepare for enrollment into Medicare as MDPP suppliers. Finalized policies include the definition of the MDPP benefit, beneficiary eligibility criteria, and supplier eligibility and enrollment criteria. Future rulemaking will address policies related to payment, virtual providers, and other program integrity safeguards.

DESCRIPTION OF THE MDPP BENEFIT

The MDPP core benefit is a 12-month intervention that consists of at least 16 weekly core hour-long sessions, over months 1-6, and at least 6 monthly core maintenance sessions over months 6-12, furnished regardless of weight loss. In addition, beneficiaries have access to three month intervals of ongoing maintenance sessions after the core 12-month intervention if they achieve and maintain the required minimum weight loss of 5 percent in the preceding three months. Medicare cost-sharing will not apply to MDPP services.

ELIGIBLE BENEFICIARIES

Coverage of the MDPP services will be available for beneficiaries who meet the following criteria:

- · Enrolled in Medicare Part B;
- Have, as of the date of attendance at the first core session, a body mass index (BMI) of at least 25 if not self-identified as Asian or a BMI of at least 23 if self-identified as Asian;
- Have, within the 12 months prior to attending the first core session, a hemoglobin A1c test with a value between 5.7 and 6.4 percent, a fasting plasma glucose of 110-125 mg/dL, or a 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerance test);
- · Have no previous diagnosis of type 1 or type 2 diabetes with the exception of gestational diabetes; and
- Do not have end-stage renal disease (ESRD).



SUPPLIER ELIGIBILITY AND ENROLLMENT

MDPP supplier enrollment in Medicare is expected to begin following rulemaking in 2017, and ahead of implementation of the MDPP expanded model on January 1, 2018. Additional rulemaking is required to finalize enforcement activities related to supplier enrollment. In this rule, we finalize the following policies specific to organizations seeking to enroll as MDPP suppliers:

- MDPP suppliers are obligated to comply with all statutes and regulations that establish generally applicable
 requirements for Medicare suppliers.
- At the time of enrollment, organizations must have full recognition by the <u>CDC Diabetes Prevention Recognition Program (DPRP)</u>. Due to timing issues with CDC standards updates, we are not finalizing any proposals for preliminary recognition at this time. We intend to address this issue in future rulemaking.
- All coaches who will be furnishing MDPP services on the organization's behalf must obtain and maintain active and valid NPIs.
- Organizations must submit a roster of all coaches who will be furnishing MDPP services. The roster will include
 the coaches' first and last names, SSN, and NPI.
- Upon enrollment as an MDPP supplier, organizations must pass application screening at a high categorical risk level per 42 CFR 424.518(c).
- All existing Medicare providers and suppliers are required to adhere to the same enrollment requirements as MDPP suppliers.

PAYMENT STRUCTURE

We expect to finalize the payment structure for the MDPP expanded model in rulemaking during 2017 and expect to begin payment for MDPP services in 2018.

ADDITIONAL INFORMATION

Have additional questions? Please visit: https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/

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[1] Centers for Medicare & Medicaid Services, "Chronic Conditions Among Medicare Beneficiaries, Chartbook: 2012 Edition," *Centers for Medicare & Medicaid Services*, 2012, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/chronic-conditions/downloads/2012chartbook.pdf.

[2] James Boyle, et al., "Projection of the Year 2050 Burden of Diabetes in the US Adult Population: Dynamic Modeling of Incidence, Mortality, and Pre-Diabetes Prevalence," *Population Health Metrics* 8, no. 29 (2010): 1-12.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services 7500 Security Boulevard, Mail Stop S2-26-12 Baltimore, MD 21244-1850



CMCS Informational Bulletin

DATE: December 14, 2016

FROM: Vikki Wachino

Director

Center for Medicaid & CHIP Services

SUBJECT: Indian Provisions in the Final Medicaid and Children's Health Insurance Program Managed Care Regulations

The Center for Medicaid and CHIP Services (CMCS) is issuing this Informational Bulletin to summarize the relevant Indian provisions of the final Medicaid and the Children's Health Insurance Program (CHIP) managed care regulation into one document, clarify current statute and regulation regarding mandatory enrollment of Indians into managed care, and provide sample language for an Indian Addendum that can be offered to managed care plans on a voluntary basis when executing network provider agreements with Indian health care providers (IHCPs).

Introduction

On April 25, 2016, CMS published a final rule on managed care in Medicaid and CHIP. The final rule is available at https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

The final rule codifies a range of Indian managed care protections, including those in section 1932(h) of the Social Security Act (Act), as added by section 5006 of American Recovery and Reinvestment Act of 2009 (ARRA). These provisions allow Indians enrolled in Medicaid and CHIP managed care plans to continue to receive services from an IHCP and ensures IHCPs are reimbursed appropriately for services provided.

The final rule addresses other Tribal issues, such as sufficient network and payment requirements for managed care plans that serve Indians, network provider agreements with IHCPs, state-Tribal consultation requirements, and referrals and prior authorization requirements. The Indian-specific provisions are located in the Medicaid rules at §438.14, and made applicable in CHIP by a cross reference in the CHIP rules at §457.1209. They are titled: "Standards for Contracts Involving Indians, Indian Health Care Providers and Indian Managed Care Entities." These provisions must be implemented for Medicaid managed care plans by the start of the rating period for contracts starting on or after July 1, 2017, noting that the Indian managed care protections in 1932(h) were effective July 1, 2009. (The rating period is the 12 month contract period during which a particular rate is certified.) States with separate CHIP programs ¹ that have plans that contract separately from their Medicaid managed care plans must

 $^{^{1}}$ If you have further questions concerning a CHIP program in a particular state, contact the state CHIP program.

come into compliance with these provisions no later than the state fiscal year beginning on or after July 1, 2018.

CMS engaged with Tribes throughout the rulemaking process and received several comments from Tribes and Tribal organizations which were incorporated into the final rule to the extent possible. CMS also engaged with Tribes in the development of this Informational Bulletin.

Specific Provisions in the Final Rule Applicable to Medicaid and CHIP that Impact American Indians and Alaska Natives and Indian Health Care Providers.

The final rule implements section 1932(h) of the Social Security Act (the Act) which added additional protections for the treatment of Indians, Indian health care providers and Indian managed care entities in Medicaid and CHIP managed care programs. Section 1932(h) was added to the Act by section 5006(d) of the American Reinvestment and Recovery Act of 2009 (ARRA). The rule applies the Indian protections in section 1932(a)(2)(C) and 1932(h) of the Act, to all types of managed care programs, including Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), Primary Care Case Management programs (PCCM), and Primary Care Case Management Entities (PCCM Entities), as applicable. In this bulletin, we collectively refer to these entities as, "managed care plans."

Definitions

The final rule defines the following terms consistent with statutory and existing regulatory definitions.

"Indian" means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual is a member of a federally recognized Indian Tribe or resides in an urban center and meets one or more of the following criteria:

- Is a member of a Tribe, band, or other organized group of Indians, including those Tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member;
- Is an Eskimo or Aleut or other Alaska Native;
- Is considered by the Secretary of the Interior to be an Indian for any purpose;
- Is determined to be an Indian under regulations issued by the Secretary;
- Is considered by the Secretary of the Interior to be an Indian for any purpose; or
- Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

"Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

"Indian Managed Care Entity (IMCE)." means a MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

Network Sufficiency Standards and Provider Choice

The final rule at §§438.14(b)(1) and 457.1209 requires every MCO, PIHP, PAHP, or PCCM entity, to the extent the PCCM entity has a provider network, to demonstrate that there are sufficient IHCPs participating in the network to ensure timely access to services available under the contract from IHCPs for Indian enrollees who are eligible to receive services. In the event that timely access to IHCPs in network cannot be guaranteed due to few or no network participating IHCPs, §§438.14(b)(5) and 457.1209 provides that the sufficiency standard in §§438.14(b)(1) and 457.1209 is satisfied if (1) Indian enrollees are permitted by the MCO, PIHP, PAHP, or PCCM entity (if applicable) to access out-of-state IHCPs or (2) this circumstance is deemed a good cause reason under the managed care plan contract for Indian enrollees to disenroll from the state's managed care program into fee-for-service in accordance with §§438.56(c) and 457.1212.

The final rule at §§438.14(b)(3) and 457.1209 permits any Indian who is enrolled in a non-Indian managed care plan and eligible to receive services from a network IHCP to choose that IHCP as his or her primary care provider, as long as that provider has the capacity to provide the services.

Payment and Contracting

When an IHCP is enrolled in Medicaid or CHIP as a federally qualified health center (FQHC) but is not a participating provider with a MCO, PIHP, PAHP, or PCCM entity, §§438.14(c)(1) and 457.1209 requires that the IHCP be paid the FQHC payment rate under the state plan, including any supplemental payment due from the state.

When an IHCP is not enrolled in Medicaid or CHIP as a FQHC, and regardless of whether the IHCP participates in the network of an MCO, PIHP, PAHP and PCCM entity, §438.14(c)(2) and §457.1209 requires that the IHCP receive the applicable encounter rate published annually in the Federal Register by IHS, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the state plan's FFS payment methodology.

Per §§438.14(c)(3) and 457.1209, when the amount an IHCP receives from a MCO, PIHP, PAHP, or PCCM entity is less than the applicable encounter or fee-for-service rate, whichever is applicable, the state must make a supplemental payment to the IHCP to make up the difference between the amount the MCO, PIHP, PAHP, or PCCM entity pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

Indian Managed Care Entity (IMCE)

The rule at §§438.14(d) and 457.1209 codifies provisions of section 1932(h) that define IMCEs and set out a special rule for enrollment in an IMCE. The special enrollment rule permits an IMCE to restrict its enrollment to Indians in the same manner as IHCPs may restrict the delivery of services to Indians.

Avoiding Duplicate Visits for Referrals

The final rule at §§438.14(b)(6) and 457.1209 adds a new requirement to specify that MCOs, PIHPs, PAHPs, and PCCM entities (if applicable)s must permit an out-of-network IHCP to refer an Indian to a network provider for covered services. This provision is intended to avoid duplicate visits to a network provider to obtain a referral and any delay in treatment when referrals are made under these circumstances.

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Auto-assignment

When auto-assigning Indians to primary care physicians (PCP), managed care plans should review their auto-assignment algorithm to ensure that an appropriate logic is used to accomplish the most appropriate PCP assignment. Such criteria could include an enrollee's historical relationship with a PCP. Additionally, managed care plans should ensure that information on the process for changing PCPs is easily accessible and, at a minimum, described in the enrollee handbook and on the managed care plan's website as required in \S438.10(f)(2)(x)$, $\S438.10(f)(3)$, and 457.1207.

Mandatory Enrollment of Indians into Medicaid Managed Care

To require Medicaid or CHIP beneficiaries to enroll in managed care to receive coverage, a state must obtain approval from CMS either through a Medicaid state plan amendment, a 1915(b) waiver, or through the section 1115 demonstration authority. States also have the option to exempt Indians from mandatory managed care. Consistent with the CMS Tribal Consultation Policy, and the requirements of section 1902(a)(73) of the Act, added by ARRA §5006(e), states are required to engage in a meaningful consultation process with federally recognized Tribes and/or IHCPs located in their state prior to the submission of a SPA, waiver, or demonstration having Tribal implications.

The final rule reiterates previous CMS guidance and transparency requirements for Medicaid demonstrations and Medicaid waivers that impact Indians and Tribes. States must consult with Tribes in accordance with the state's Tribal consultation policy if the state is proposing to mandate Indians into managed care (MCOs, PIHP, or PIHP) to receive coverage. Because states have authority to exclude Indians from mandatory enrollment into managed care, states should, through Tribal consultation, consider such factors as access to specialty providers, contracting and payment difficulties with MCEs, and ensuring continued access to culturally appropriate providers before a decision is made to mandatorily enroll Indians into managed care.

Medicaid State Plan

Through a state plan amendment that meets standards set forth in section 1932 of the Act, states can implement a mandatory managed care delivery system for certain populations. However, section 1932(h) of the Act prohibits states from mandatory enrollment of an individual who is an Indian unless the MCO, PIHP, PAHP, PCCM or PCCM entity contracted with the state is an IMCE.

1915(b) Waiver

CMS may grant a waiver under section 1915(b) of the Act that permits a state to require all Medicaid beneficiaries to enroll in a managed care delivery system, including Indians. However, states have the option to exempt Indians from a 1915(b) mandatory managed care waiver request in light of the special statutory treatment of Indians in federal statutes and other considerations listed above. In reviewing such waiver requests, CMS will consider any input the state received through its state-Tribal consultation process. Frequently, through Tribal consultation, a state and the Tribes could reach mutual consensus to exempt Indians from 1915(b) managed care waivers.

1115(a) Demonstration

Section 1115(a) of the Act authorizes the Secretary to waive provisions of section 1902 of the Act and grant expenditure authority to treat demonstration costs as federally matchable expenditures under section 1903 of the Act. As part of a section 1115(a) demonstration project, CMS may authorize mandatory enrollment in managed care programs for Medicaid beneficiaries, including for dually eligible

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beneficiaries, Indians, and children with special health care needs. Demonstration approval is discretionary, and must be based on a finding that the demonstration is likely to promote objectives of the Medicaid program. Similar to the 1915(b) authority, CMS will consider any input the state received in the Tribal consultation process. In addition, there are opportunities for Tribal consultation through the CMS consultation process and the public comment process at the federal level under the Medicaid procedural rules at §431.416. States have the option to exempt Indian populations from mandatory enrollment in a managed care delivery system (permitting Indian populations to obtain access to health care through a fee for service delivery system) in light of the special statutory treatment of Indians in federal statutes concerning Medicaid managed care.

Historically, as a result of state-Tribal consultation and CMS-Tribal consultation with participation from the state, CMS has not approved section 1115(a) demonstrations that have mandated Indians into managed care; instead managed care enrollment has been voluntary. We strongly encourage states and Tribes to engage in meaningful consultation when considering mandating Indians into managed care. States are required to consult consistent with the process outlined in its approved ARRA Tribal consultation state plan amendment.

CHIP State Plan

Section 1932(h) of the Act (made applicable to CHIP through section 2107(e)(1)(M) of the Act) prohibits states from mandatory enrollment of an individual who is an Indian unless the MCO, PIHP, PAHP, PCCM or PCCM entity contracted with the state is an IMCE. CMS expects that states will continue to submit any planned managed care program changes through the state plan amendment process and comply with their Tribal consultation process.

Indian Managed Care Addendum

Consistent with the rule, this guidance provides sample language for a Medicaid and CHIP Indian Managed Care Addendum ("ITU Addendum"). Indian Tribes are entitled to special protections and provisions under federal law, which are described further in Section II of the ITU Addendum. The ITU Addendum outlines all the federal laws, regulations, and protections that are binding on MCOs, PIHPs, PAHPs, and PCCM entities (if applicable) and identifies several specific provisions that have been established in federal law that apply when contracting with IHCP. The use of this ITU Addendum benefits both MCOs, PIHPs, PAHPs, PCCM entities and IHCPs by lowering the perceived barriers to contracting, assuring that key federal laws are applied when contracting with IHCPs, and minimizing potential disputes. For example, MCOs, PIHPs, and PAHPs typically require participating providers to have private malpractice insurance. However, the ITU Addendum explains that IHCPs, when operating under a contract or compact with IHS to carry out programs, services, functions, and activities, (or programs thereof) of the IHS, are covered by federal tort immunity and private malpractice insurance is not required.

We anticipate that offering contracts that include an ITU Addendum will provide managed care plans with an efficient way to establish network provider agreements with IHCPs, and that such agreements include the federal protections for IHCPs. Furthermore, the ITU Addendum helps to integrate IHCPs into managed care networks and ensures that Indian beneficiaries have access to a comprehensive and integrated benefits package and ensure that Indians can continue to be served by their IHCP of choice. Indians enrolled in managed care plans will be better served when IHCPs can coordinate their care through the managed care provider network.

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ATTACHMENTS:

Model Medicaid and CHIP Managed Care Addendum for Indian Health Care Providers

Model Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (IHCPs)

1. Purpose of Addendum; Supersession.	
The purpose of this Medicaid Managed Care Addendur	n for Indian Health Care Providers (IHCPs) is to
apply special terms and conditions necessitated by fede	ral law and regulations to the network provider
agreement by and between	(herein "Managed Care Plan") and
(herein "In	dian Health Care Provider (IHCP)"). To the extent
that any provision of the Managed Care Plan's network	provider agreement or any other addendum
thereto is inconsistent with any provision of this Adden	dum, the provisions of this Addendum shall
supersede all such other provisions. ²	

2. Definitions.

For purposes of this Addendum, the following terms and definitions shall apply:

- (a) "<u>Indian</u>" means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual is a member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:
- Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
- Is an Eskimo or Aleut or other Alaska Native;
- Is considered by the Secretary of the Interior to be an Indian for any purpose;
- Is determined to be an Indian under regulations issued by the Secretary.

The term "Indian" also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

- (b) "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).
- (c) "Managed Care Plan" includes a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Manager (PCCM) or Primary Care Case Managed Entity (PCCM entity) as those terms are used and defined in 42 C.F.R. 438.2, and any subcontractor or instrumentality of such entities that is engaged in the operation of a Medicaid managed care contract.
- (d) "<u>Indian Health Service or IHS</u>" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCIA Section 601, 25 U.S.C. § 1661.

² Please note that if the contract includes Medicaid and separate CHIP beneficiaries this Addendum can be used for both populations if references to Medicaid are modified to reference both Medicaid and CHIP. If you have a separate managed care contract for CHIP that includes IHCPs, please use this addendum and replace the references to Medicaid with references to CHIP.

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- (e) "Indian tribe" has the meaning given in the IHCIA Section 4(14), 25 U.S.C. § 1603(14).
- (f) "Tribal health program" has the meaning given in the IHCIA Section 4(25), 25 U.S.C. § 1603(25).
- (g) "Tribal organization" has the meaning given in the IHCIA Section 4(26), 25 U.S.C. § 1603(26).
- (h) "<u>Urban Indian organization</u>" has the meaning given in the IHCIA Section 4(29), 25 U.S.C. § 1603(29).

3. Description of IHCP.

The IHCP identified in Section 1 of this Addendum is (check the appropriate box):

/_/ IHS.

/_/ An Indian tribe that operates a health program under a contract or compact to carry out programs,
services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C
§450 et seq.

/_/ A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C.§450 et seq.

/_/ A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).

/_/ An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.

4. Cost-Sharing Exemption for Indians; No Reduction in Payments.

The Managed Care Plan shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services. Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, (42 U.S.C. §1396o-(j)), 42 C.F.R. 447.56 and §457.535.

5. Enrollee Option to Select the IHCP as Primary Health Care IHCP.

The Managed Care Plan shall allow any Indian otherwise eligible to receive services from an IHCP to choose the IHCP as the Indian's primary health care provider if the IHCP has the capacity to provide primary care services to such Indian, and any referral from such IHCP to a network provider shall be deemed to satisfy any coordination of care or referral requirement of the Managed Care Plan. Section 1932(h)(1) of the Social Security Act, (42 U.S.C. § 1396u-2(h)), 42 CFR 438.14((b)(3), and 457.1209.

6. Agreement to Pay IHCP.

The Managed Care Plan shall pay the IHCP for covered Medicaid managed care services in accordance with the requirements set out in section 1932(h) of the Social Security Act, (42 USC 1396u-2(h)), 42 CFR 438.14 and 457.1209.

7. Persons Eligible for Items and Services from IHCP.

- (a) Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136.
- (b) No term or condition of the Managed Care Plan's network provider agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The Managed Care Plan acknowledges that pursuant to 45 C.F.R. 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

8. Applicability of Federal Laws not Generally Applicable to other Providers.

Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving MCO enrollees. Applicable provisions may include, but are not limited to, those laws cited in Appendix A.

9. Non-Taxable Entity.

To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a Managed Care Plan to collect or remit any federal, state, or local tax.

10. Insurance and Indemnification.

- (a) Indian Health Service. The Indian Health Service (IHS) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the managed care plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.
- (b) Indian Tribes and Tribal Organizations. A provider which is an Indian tribe or a tribal organization operating under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed Care Plan will be held harmless from liability. This is because Indian tribes and tribal organizations operating under a contract or compact to carry out programs, services, functions, and activities, (or programs thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, are covered by the FTCA, which means the United States consents to be sued in place of employees of a tribe or tribal organization (including contractors) for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of employees acting within the scope of their employment. Nothing in the Managed Care Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate such provider, any employee of such provider, or any personal services contractor to perform any act outside the scope of his/her employment.
- (c) Urban Indian Organizations. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability to the extent the provider attests that it is covered by the FTCA. Nothing in the Managed Care Plan network provider agreement or any

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addendum thereto shall be interpreted to authorize or obligate such provider or any employee of such provider to perform any act outside the scope of his/her employment.

11. Licensure and Accreditation.

Pursuant to 25 USC 1621t and 1647a, the managed care organization shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, the managed care organization shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.

12. Dispute Resolution.

In the event of any dispute arising under the Managed Care Plan's network provider agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Notwithstanding any provision in the Managed Care Plan's network agreement, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.

13. Governing Law.

The Managed Care Plan's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail. Nothing in the Managed Care Plan's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

14. Medical Quality Assurance Requirements.

To the extent the Managed Care Plan imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCIA (25 U.S.C. § 1675).

15. Claims Format.

The Managed Care Plan shall process claims from the IHCP in accordance with Section 206(h) of the IHCIA (25 U.S.C. § 1621e(h)), which does not permit an issuer to deny a claim submitted by a IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

16. Payment of Claims.

The Managed Care Plan shall pay claims from the IHCP in accordance section 1932(h)(2) of the Act, (42 U.S.C. §1396u-2(h)), 42 C.F.R. 438.14(c)(2), and 457.1209, and shall pay at either the rate provided under the State plan in a Fee For Service payment methodology, or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is higher.

17. Hours and Days of Service.

The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the Managed Care Plan as to its hours and days of service. At the request of the Managed Care Plan, such IHCP shall provide written notification of its hours and days of service.

18. Coordination of Care/Referral Requirements.

The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the Managed Care Plan.

19. Sovereign Immunity.

Nothing in the Managed Care Plan's network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

20. Endorsement.

IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the managed care plan.

APPROVALS	
For the Managed Care Plan:	For the IHCP:
Date:	Date:

APPENDIX A

- (a) The IHS that is an IHCP:
- (1) Anti-Deficiency Act, 31 U.S.C. § 1341;
- (2) ISDEAA, 25 U.S.C. § 450 et seq.;
- (3) Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
- (4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- (5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
- (6) IHCIA, 25 U.S.C. § 1601 et seq.
- (b) An Indian tribe or a Tribal organization that is an IHCP:
- (1) ISDEAA, 25 U.S.C. § 450 et seq.;
- (2) IHCIA, 25 U.S.C. § 1601 et seq.;
- (3) FTCA, 28 U.S.C. §§ 2671-2680;
- (4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- (5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
- (6) HIPAA, 45 C.F.R. Parts 160 and 164.
- (c) An urban Indian organization that is an IHCP:
- (1) IHCIA, 25 U.S.C. § 1601 et seq.
- (2)Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
- (3) HIPAA, 45 C.F.R. Parts 160 and 164.



SAVE THE DATE: ALL TRIBES' CALL TRIBAL CONSULTATION: REIMBURSEMENT RATE FOR SERVICES PROVIDED OUTSIDE OF AN IHS/TRIBAL FACILITY

Thursday, December 15th from 2:30 to 4:00 ET Dial-in number: (844) 224-0415; Participant code: 30624758

On February 26, 2016, CMS issued a <u>State Health Official letter</u> (SHO) expanding the circumstances under which services furnished to American Indian and Alaska Native (AI/AN) Medicaid beneficiaries could be considered to be "received through" an Indian Health Service (IHS) or Tribal facility. Under the updated policy, IHS/Tribal facilities may enter into written care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries. Those services provided per the care coordination agreements are eligible for federal matching funds at the enhanced federal matching rate (FMAP) of 100 percent.

Under the SHO, either the Tribal facility or the non-IHS/Tribal practitioner may bill Medicaid for services furnished by the non-IHS/Tribal practitioner. If the non-IHS/Tribal provider were to bill the state Medicaid program directly, the provider would be reimbursed at the rate authorized under the Medicaid state plan applicable to the provider type and the service rendered, not at the facility rate that the IHS/Tribal facility would receive. If the Tribal facility were to bill for the service, the Tribal facility would have to separately identify services provided by non-IHS/Tribal providers under the care coordination agreement that can be claimed as services of the Tribal facility from those that cannot. Services that can properly be claimed as services of the IHS/Tribal facility ("IHS/Tribal facility services") are reimbursed at the facility rate authorized under the Medicaid state plan. Those services that do not qualify as "IHS/Tribal facility services" are reimbursed at the rate applicable under the Medicaid state plan to the provider type and service rendered.

Whether services furnished by non-Tribal providers can be billed as facility services depends on whether the Tribal facility is enrolled in the state Medicaid program as a provider of "clinic services" or as a Federally Qualified Health Center (FQHC). If the Tribal facility is enrolled in the state Medicaid program as a provider of "clinic services" under 42 CFR 440.90, the Tribal facility may not bill for the services furnished by a non-Tribal provider or Tribal employee at the facility rate for services that are provided outside of the facility. This is referred to as the 'four walls' limitation. Instead, the Tribal provider would bill for the services at the rate applicable to the non-Tribal provider and the service. (As noted above, the Tribal provider has the option to allow

the non-Tribal provider bill to bill directly for the service rather than bill on the provider's behalf). If the Tribal facility is enrolled in the state Medicaid program as an FQHC, the Tribal facility may properly claim payment for services furnished by the non-Tribal provider at the facility rate.

We understand that states may not have been paying for services provided by Tribal clinics in accordance with the 'four walls' limitation. In reviewing possible solutions that will minimize the impact on Tribal clinics, we have determined that the FQHC benefit provides the most flexibility since there is no Federal requirement that FQHC services be provided within the 'four walls' of the facility. In addition, section 1905(I)(2)(B)(iv) of the Social Security Act recognizes outpatient Tribal health programs as FQHCs. Pursuant to the Benefits Improvement and Protection Act (BIPA) of 2000, FQHCs must be paid no less than a rate developed based on 1999/2000 cost trended forward by the MEI. However, BIPA also permits states to establish higher payment rates under an alternative payment methodology (APM). In light of the unique nature of Tribal Health programs, CMS could support payment of the outpatient IHS/AIR for FQHC services under an APM.

To effectuate this change, Tribal Health programs should work with their Medicaid agencies to have their provider designation changed from clinic to FQHC. No other steps need be taken by the Tribal Health program. The state Medicaid agency will be required to submit a state plan amendment to designate payment for Tribal FQHC services at the IHS AIR as an APM. States will be given a grace period to consult with Tribes and to modify the state plan.

The purpose of the All Tribes' Call is to hold Tribal Consultation to explain CMS' interpretation of the "four walls" limitation and answer any questions and hear comments. On the call, CMS will also explain the option for Tribal clinics to convert to Medicaid FQHC status and answer any questions and respond to comments.

If you have any questions regarding this call, please feel free to contact Kitty Marx, Director, Division of Tribal Affairs, IEAG, CMCS at kitty.marx@cms.hhs.gov

Submitted via e-mail: Victoria.Wachino1@cms.hhs.gov

December 22, 2016

Victoria Wachino, Director Center for Medicaid and CHIP Services Department of Health and Human Services 200 Independence Avenue, SW Washington, DC 20201

RE: Request for Five-Year Grace Period for States and Indian Health Programs to Designate Tribal Clinics as Medicaid FQHCs, and Pay them under an Alternative Payment Methodology, to Mitigate the "Four-Walls" Interpretation of the Medicaid Clinic Benefit.

Dear Ms. Wachino:

As you know, on December 15, 2016, the Centers for Medicare and Medicaid Services (CMS) held an All Tribes' Call on the so-called "four walls limitation" of the Medicaid clinic services benefit. CMS staff explained that, although the limitation means Tribal clinics cannot be paid at the Tribal outpatient facility encounter rate for services that are provided outside the facility by the clinic's staff or by non-Tribal providers under a care coordination agreement, the impact can be minimized if clinics can be redesignated as FQHCs for Medicaid purposes, and States amend their Medicaid Plans to adopt an Alternative Payment Methodology (APM) that would allow Tribal clinics designated as Medicaid FQHCs to bill at the OMB encounter rate or an alternative payment method to be determined in consultation with Tribes. Announcing the call, CMS acknowledged that "states may not have been paying for services provided by Tribal clinics in accordance with the 'four walls' limitation;" suggested the transition would be easy because Tribal outpatient programs have statutory FQHC status; and assured that States would be "given a grace period to consult with Tribes and to modify the state plan." CMS invited Tribes to suggest an appropriate grace period.

The Tribal Technical Advisory Group¹ ("TTAG") does not agree with CMS's "four walls" interpretation of the clinic benefit, but we sincerely appreciate CMS's desire to mitigate any

¹ The TTAG advises the Centers for Medicare and Medicaid Services on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program, and any other health care programs funded (in whole or in part) by CMS. In particular, the TTAG focuses on providing policy advice designed to improve the availability of health care services to American Indians and Alaska Natives under these federal health care programs, including through providers operating under the health programs of the Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations.

resulting harm. For the reasons outlined below, we believe a grace period of at least five years is needed, along with technical assistance and clear assurances that, during the grace period, Tribal clinics may provide and be paid at the OMB Tribal outpatient facility rate for off-site services they deliver directly or through care coordination agreements with non-Tribal providers, and such services will qualify for 100% FMAP if all other applicable requirements of the February 26, 2016 State Health Official Letter are satisfied.

1. The Federal Medicaid benefits for clinic and FQHC services are not identical. Differences may also exist at the State level. Tribal programs need time and assistance to identify, compare, and evaluate coverage differences, and to make programmatic, staffing, and other changes to respond to them.

CMS has advised that federal law imposes a "four-walls" limitation on Medicaid clinic services but not on Medicaid FQHC services. But there are many other potentially important differences between the two service categories that CMS has not yet discussed with Tribal programs, and that they will need to fully understand and evaluate before deciding whether to make the change from clinic to FQHC Medicaid enrollment. CMS has also not yet formally advised whether a clinic that elects to convert to FQHC enrollment for Medicaid, must also convert to FQHC enrollment for Medicare. On the All Tribes' Call, CMS stated that a clinic that elects to be designated as an FQHC for Medicaid purposes would not also have to meet the requirements to bill as an FQHC for Medicare purposes. As discussed below, the TTAG supports this, as the governance and cost-reporting requirements for Medicare FQHCs impose burdens that many smaller Tribal clinics will not readily be able to meet in a cost-effective manner. We urge CMS to make this distinction clearly in any guidance it issues. We remain concerned, however, that even being redesignated as an FQHC for Medicaid purposes may involve requirements and limitations imposed by individual State plans that Tribes may not be aware of.

Comparing the two options is no easy task, and the sheer volume and complexity of the federal FQHC provisions are daunting. The Social Security Act and federal Medicaid regulations define "clinic" services both broadly and briefly, each in a single provision of 100 words or less.² By contrast, Medicaid FQHC services are defined as services of the type described in the Medicare FQHC provisions, and the Medicare provisions are found in a dizzying array of statutory and regulatory references and cross-references, at least twelve layers deep and thousands of words long, that describe covered services with great specificity.³ It is not immediately clear whether the 49-page Medicare Benefit Policy Manual chapter on FQHC services applies to Medicaid FQHCs. (It might, since Medicaid defines the benefit by reference to the Medicare provisions.) But to further confuse matters, the Manual states that some of its provisions may not apply to

² 42 U.S.C. 1396d(a)(9); 42 CFR 440.90.

³ 42 U.S.C. 1396d(*I*); cross-referencing 42 U.S.C. 1395x(aa)(1)(A)-(C) and 1395x(ddd)(3); which cross-reference, in turn and among other provisions, 42 U.S.C. 1395x(s)(2)(A), 42 U.S.C. 1395x(hh)(1), 42 U.S.C. 1395x(ddd), 42 U.S.C. 1395x(ww), 42 U.S.C. 1395x(s)(10), 42 U.S.C. 1395x(bb), and 42 U.S.C. 1395x(hhh); see also 42 CFR 405.2446, 42 CFR 405.2448, 42 CFR 405.2449, 42 CFR 405.2450, and 42 CFR 405.2452.

Tribal FQHCs, without identifying which provisions those might be.⁴ We urge CMS to clarify that a Tribal clinic that enrolls as an FQHC for *Medicaid* does not have to meet the regulatory and policy requirements for entities enrolled as an FQHC for *Medicare*.

CMS correctly observes that Tribal outpatient clinics automatically qualify for FQHC status under section 1905(l)(2)(B) of the Social Security Act.⁵ But while this means Tribal clinics do not have to satisfy the generally-applicable eligibility requirements in order to achieve FQHC status, it does not necessarily follow that they are also excused from the generally-applicable programmatic, service, reporting, and other requirements that apply to entities that operate and bill Medicaid or Medicare as FQHCs.

Federal Medicare FQHC programmatic and service requirements that may be problematic for some Tribal clinics include:

- The requirement to furnish all diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at the entry point into the healthcare delivery system;⁶
- The requirement to provide first-response medical procedures, drugs, and biologicals for common life-threatening injuries and acute illnesses during regular operating hours, and to provide telephone coverage and referrals for such services after-hours; and
- The requirement to have agreements or arrangements with hospitals and other providers to furnish certain services that are not available at the FQHC, including inpatient hospital care, physician services, and certain diagnostic and laboratory services.

Also of potential concern are federal supervision requirements and billing rules for FQHC services that are furnished by non-physician practitioners or by other staff members "incident to" the services of a physician or other practitioner. Under the clinic benefit, State Medicaid programs have been at liberty to develop standards that accommodate the unique circumstances of their State's Tribal clinics, and these may differ in important respects from the very detailed federal requirements for FQHCs.⁹

⁴ Medicare Benefit Policy Manual, Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf. The following "Note" appears at p. 9: "NOTE: Information in this chapter applies to FQHCs that are Health Center Program Grantees and Health Center Program Look-Alikes. It does not necessarily apply to Tribal or urban Indian FQHCs or grandfathered Tribal (GFT) FQHCs."

⁵ 42 USC .

⁶ 42 C.F.R. 491.9(c)(1).

⁷ 42 CFR 491.9(c)(3); Medicare Benefit Policy Manual Chapter 13, Sec. 50.3.

⁸ 42 CFR 491.9(d); Medicare Benefit Policy Manual Chapter 13, Sec.

⁹ 42 CFR 405.2413, 42 CFR 405.2414, 42 CFR 405.2415; Medicare Benefit Policy Manual Chapter 13, Sec. 110 – 180.

As a result, we strongly support clarification from CMS that enrolling as an FQHC for Medicaid purposes would not require a Tribal facility to meet the federal requirements for FQHCs for Medicare purposes. We remain concerned, however, that some States may as a matter of State law require entities that enroll as an FQHC for Medicaid purposes to meet the federal requirements for entities enrolled as Medicare FQHCs. The State of Alaska's FQHC regulations require an FOHC to be enrolled in Medicare and comply with the applicable federal regulations. See, e.g., 7 AAC 140.200 and 7 AAC 140.205. As a result, unless an exception is explicitly made, State requirements to comply with federal Medicare FQHC requirements could pose a significant barrier to Tribal facilities seeking redesignation as a Medicaid FQHC for purposes of the proposed workaround. Federal provisions aside, States may also cover different services under their "clinic" and "FQHC" benefits, or may impose limits on one but not the other. These will vary from state to state, and must also must be identified and assessed by any Tribal program considering a change from clinic to FQHC enrollment. For example, The Kaiser Family Foundation reported that, for 2012, 18 State Medicaid programs imposed limits on FQHC services, with at least 8 of these capping the number of visits per recipient per year. ¹⁰ Ironically, while Alaska's Medicaid program has consistently covered Tribal clinic services delivered outside the clinic facility in any appropriate community setting, it covers off-site FQHC services only if they are provided to homebound recipients. 11 Other State-coverage differences may include whether, to what extent, and under what conditions coverage is provided for behavioral health services, dental services, laboratory and radiology services, and services delivered by nonphysician practitioners including Clinical Social Workers, Psychologists, other behavioral health clinicians, Nurse Practitioners, Physician Assistants, Physical Therapists, Occupational Speech-Language Pathologists, Dietitians, Podiatrists, Chiropractors Audiologists. In this regard, it is important to recognize the vital role played by non-physician practitioners in Tribal health programs, particularly those serving small, rural, or remote communities.

Tribal health programs will need substantial time and technical assistance to determine which of their current or planned Medicaid-covered clinic services would qualify as FQHC services, whether they would be covered as FQHC services to the same extent and under the same circumstances as they have been covered as clinic services, whether there are new services they could offer as an enrolled FQHC, whether the benefits of switching to FQHC status would outweigh the disadvantages and the cost and disruption such a switch would entail, and how to structure their programs and staffing to minimize the disadvantages and maximize the advantages of changing from clinic to FQHC status. For some Tribal programs, decisions of that magnitude

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The Report is available at http://kff.org/medicaid/state-indicator/federally-qualified-health-center-services/view/print/?currentTimeframe=0&print=true. Service caps per recipient ranged from 10 to 24 visits per year. The report does not address whether the same limits applied to clinic services.
 7 AAC 140.200 – 7 AAC 140.220. Comparing Medicaid Clinic and FQHC coverage in Alaska, where many affected Tribal clinics are located, is further complicated by the fact that the 180-page FQHC "Provider Billing Manual," last revised in 2003, is currently "under revision" and providers are instructed not to rely on it.

may require training, consideration, and formal action by the Tribal council or other governmental body, adding more complexity and exponentially to the time required to make the decision.

Once a Tribal program decides to convert to FQHC Medicaid enrollment, it will then need even more time to implement that choice. Among other things, this may entail significant changes to programs, policies, staffing, medical record and billing systems, and arrangements with other health service providers.

2. States that restrict FQHC services will need time to consider whether to modify or lift those restrictions, the financial consequences of doing so, and whether they may impose different restrictions on Tribal and non-Tribal FQHCs.

CMS has proposed the FQHC work-around as a way to minimize the impact of the four-walls clinic services limitation. As CMS recognizes, this will require all States to amend their Medicaid Plans to adopt the Tribal outpatient facility encounter rate as an alternative payment methodology for Tribal FQHC services. But, to minimize the impact for affected Tribal clinics, some States would also have to amend their Plan's FQHC coverage provisions to remove or modify service limits that do not apply to Tribal clinic services. As noted above, at least 18 States imposed annual visit caps or other restrictions on FQHC services in 2012, the last year on which that information was reported by The Kaiser Family Foundation.

We do not know whether States may lawfully lift service restrictions only for Tribal FQHCs, and if so, whether they would need to obtain a waiver to do so. But if they may not, or if for other reasons a State prefers to apply the same limitations to Tribal and non-Tribal FQHCs, the State will need time to consider its options, confer with other stakeholders, and determine the fiscal impact of removing or modifying its FQHC service limitations.

3. In addition to amending their State Plans, some States will need to amend State statutes, regulations, and sub-regulatory advice; adequate time must be allowed for those processes.

To implement the FQHC work-around, States will need to amend more than just their Medicaid State Plans. All States will likely have to amend their regulations, after giving the required public notice and giving due consideration to public comment. Billing manuals and other sub-regulatory materials will also have to be revised. In some States, statutory changes will be required, and Tribal programs and Medicaid agencies will need time to educate and work with their State legislatures to accomplish the changes — a process that can require several years, especially in States whose legislatures meet only every other year. And at least one State requires legislative approval of all Medicaid State Plan amendments.

Given the work involved, States should not be expected to make these changes until affected Tribal programs have had time to evaluate their options and at least one has decided to

convert to FQHC enrollment. Yet all the changes must be in place before the conversion can occur.

4. States will need time to design, test, and implement changes to their Medicaid information and reimbursement systems.

In addition to amending their State Plans, statutes, regulations, and sub-regulatory materials, States agreeing to implement the FQHC solution will need to change their Medicaid information and reimbursement systems. We understand that the required changes can be extensive, costly, and time-consuming to design and implement. For example, Alaska's Medicaid agency has informed us that, in order for its system to pay Tribal FQHCs at the Tribal outpatient facility rate, it will have to create up to three different FQHC provider types – one each for general, behavioral health, and dental services — that will have to be designed, aligned with appropriate billing and procedure codes, and thoroughly tested before it goes live. States must be granted ample time to make the necessary system changes, to ensure a smooth transition for Tribal clinics converting to FQHC enrollment. This will need to be balanced against other competing State priorities and system changes; historically, some State Medicaid programs have not classified as a high priority, changes that are relevant to only a few or small Indian health providers.

5. State Medicaid agencies and Tribal health programs have competing demands on their limited time and resources. These must be prioritized and deadlines set accordingly. Given other ongoing and anticipated priorities, a five-year grace period is reasonable.

Even if State Medicaid agencies and Tribal programs had no other demands on their time, they would need several years to fully understand, evaluate, and implement the proposed FQHC work-around, for the reasons we outlined above. But in fact they have a tremendous amount of other important work to do and are likely to face unprecedented challenges in the near term. They are striving to implement Medicaid managed care and to comply with the new managed care regulations. They are working to design and adopt important Medicaid waivers and reforms. And they must be prepared to quickly evaluate and respond to more extensive changes and initiatives that seem likely to emerge under the Trump administration. Under the circumstances, we think a five-year grace period is both reasonable and necessary, and we respectfully ask it be granted.

Thank you for considering this request and for your efforts to mitigate the impact on Tribal programs of the clinic "four walls" limitation.

Sincerely,

W. Ron Allen,

W. Ron alla

Tribal Chairman and CEO, Jamestown S'Klallam Tribe Chairman, Tribal Technical Advisory Group

cc: Tim Hill, Deputy Director, Center for Medicaid and CHIP Services
Deidre Gifford, M.D., Deputy Director, Center for Medicaid and CHIP Services
Kitty Marx, Director, Division of Tribal Affairs, IEAG, CMCS, CMS

Targeted State Call

Reimbursement Rate for Services Provided Outside Of an IHS/Tribal Facility

Thursday, December 22nd from 5:00 to 6:00 pm ET

Dial-in number: (877) 267-1577; Participant code: 992 033 790

The purpose of this targeted state call is to explain CMS' interpretation of the "four walls" limitation; obtain state input, and answer questions and hear comments.

Background:

On February 26, 2016, CMS issued a <u>State Health Official letter</u> (SHO) expanding the circumstances under which services furnished to American Indian and Alaska Native (AI/AN) Medicaid beneficiaries could be considered to be "received through" an Indian Health Service (IHS) or Tribal facility. Under the updated policy, IHS/Tribal facilities may enter into written care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries. Those services provided per the care coordination agreements are eligible for federal matching funds at the enhanced federal matching rate (FMAP) of 100 percent.

Under the SHO, either the Tribal facility or the non-IHS/Tribal practitioner may bill Medicaid for services furnished by the non-IHS/Tribal practitioner. If the non-IHS/Tribal provider were to bill the state Medicaid program directly, the provider would be reimbursed at the rate authorized under the Medicaid state plan applicable to the provider type and the service rendered, not at the facility rate that the IHS/Tribal facility would receive. If the Tribal facility were to bill for the service, the Tribal facility would have to separately identify services provided by non-IHS/Tribal providers under the care coordination agreement that can be claimed as services of the Tribal facility from those that cannot. Services that can properly be claimed as services of the IHS/Tribal facility ("IHS/Tribal facility services") are reimbursed at the facility rate authorized under the Medicaid state plan. Those services that do not qualify as "IHS/Tribal facility services" are reimbursed at the rate applicable under the Medicaid state plan to the provider type and service rendered.

Whether services furnished by non-Tribal providers can be billed as facility services depends on whether the Tribal facility is enrolled in the state Medicaid program as a provider of "clinic services" or as a Federally Qualified Health Center (FQHC). If the Tribal facility is enrolled in the state Medicaid program as a provider of "clinic services" under 42 CFR 440.90, the Tribal facility may not bill for the services furnished by a non-Tribal provider or Tribal employee at the facility rate for services that are provided outside of the facility. This is referred to as the 'four walls' limitation. Instead, the Tribal provider would bill for the services at the rate applicable to the non-Tribal provider and the service. (As noted above, the Tribal provider has the option to allow the non-Tribal provider bill to bill directly for the service rather than bill on the provider's behalf). If the Tribal facility is enrolled in the state Medicaid program as an FQHC, the Tribal

facility may properly claim payment for services furnished by the non-Tribal provider at the facility rate.

We understand that states may not have been paying for services provided by Tribal clinics in accordance with the 'four walls' limitation. In reviewing possible solutions that will minimize the impact on Tribal clinics, we have determined that the FQHC benefit provides the most flexibility since there is no Federal requirement that FQHC services be provided within the 'four walls' of the facility. In addition, section 1905(I)(2)(B)(iv) of the Social Security Act recognizes outpatient Tribal health programs as FQHCs. Pursuant to the Benefits Improvement and Protection Act (BIPA) of 2000, FQHCs must be paid no less than a rate developed based on 1999/2000 cost trended forward by the MEI. However, BIPA also permits states to establish higher payment rates under an alternative payment methodology (APM). In light of the unique nature of Tribal Health programs, CMS could support payment of the outpatient IHS/AIR for FQHC services under an APM.

To effectuate this change, CMS is encouraging Tribal Health programs to work with state Medicaid agencies to have their provider designation changed from clinic to FQHC. No other steps need be taken by the Tribal Health program. The state Medicaid agency will be required to submit a state plan amendment to designate payment for Tribal FQHC services at the IHS AIR as an APM. States will be given a grace period to consult with Tribes and to modify the state plan.

Contact for the Call:

If you have any questions regarding this call, please feel free to contact Robin Preston, Acting Director, Intergovernmental and External Affairs Group (IEAG), CMCS at robin.preston@cms.hhs.gov.

Robin A. Preston

Acting Director, Intergovernmental and External Affairs Group (IEAG) Center for Medicaid and CHIP Services (CMCS)

Office: 410-786-3420 Mobile: 443-934-1161 Follow us on Twitter at



Indian Health Service Rockville MD 20852

JAN 04 2017

Dear Tribal Leader:

I am writing to update you on my June 1, 2016, letter which initiated a Tribal Consultation on the Indian Health Service (IHS) draft policy statement on creating a national IHS Community Health Aide Program (CHAP). After careful review of all comments received, I am pleased to announce that the IHS will begin the process of developing a formal policy and implementation plan to create a national CHAP under the provisions outlined in the Indian Health Care Improvement Act (IHCIA) as amended at 25 U.S.C. § 1616*l*(d).

Partnership and collaboration are part of our ongoing work to deliver quality health care to patients. Increased access to care is a top priority, which is why the Agency will begin the process, along with our Tribal partners, of developing a formal policy and implementation plan to increase the utilization of community health aides across the IHS system.

Community health aides are proven partners, and utilizing them to the fullest extent permissible in hospitals and clinics operated by the IHS and Tribes will increase the availability of health workers in American Indian and Alaska Native communities. Community health aides include workers in health education, communicable disease control, maternal and child health, dental health, behavioral health, family planning, environmental health, and other areas.

IHS received comments on the draft policy statement from Tribes and Tribal organizations during the Tribal Consultation sessions conducted in-person in Arizona on September 19, 2016, and October 9, 2016; over the telephone on October 4, 2016; and through written comments during the comment period ending October 27, 2016.

In the enclosed report, you will see that several themes emerged, which will provide the framework for the development of the formal policy and implementation plan. Generally speaking, all comments were in favor of establishing a national CHAP and/or provided guiding principles for IHS to consider as it moves forward.

The following principles will guide the development of the formal policy and implementation plan:

- (1) The CHAP can improve access to quality care for American Indians and Alaska Natives.
- (2) Any program needs to be Community- and Area-based.
- (3) Some baseline standards with sufficient flexibility will be needed to ensure that each Area can establish its own program.
- (4) Each Area would establish its own certification board.
- (5) The policy will not disrupt programs that are currently established, such as those in Alaska.
- (6) Legislative changes will be needed to fully implement the use of DHATs in CHAPs.

As part of our ongoing work to deliver quality health care to patients, and in consideration of available resources, the IHS will begin to establish a National Workgroup, comprised of Tribal leaders and IHS representatives, to develop a draft CHAP Expansion Policy and implementation Plan, in accordance with section 11 of the IHS Tribal Consultation policy. After the National Workgroup develops a draft, IHS will seek input on the draft CHAP Expansion Policy and Implementation Plan through the Tribal Consultation process.

The IHS, in partnership and collaboration with Tribes, looks forward to the next steps in this process.

Sincerely,

/Mary Smith/

Mary Smith Principal Deputy Director

Enclosure: Report on the Tribal Consultation for the Indian Health Service (IHS)
Policy Statement on Creating a National IHS Community Health Aide Program



Indian Health Service Rockville MD 20857

REPORT ON THE TRIBAL CONSULTATION FOR THE INDIAN HEALTH SERVICE POLICY STATEMENT ON CREATING A NATIONAL INDIAN HEALTH SERVICE COMMUNITY HEALTH AIDE PROGRAM

On June 1, 2016, Ms. Mary Smith, Principal Deputy Director, Indian Health Service (IHS or Agency), issued a letter to Tribal Leaders to initiate a Tribal Consultation to seek input on a policy statement describing the intention of the IHS to create a national Community Health Aide Program (CHAP) similar to the Alaska model that could ultimately lead to greater numbers of dental providers (e.g., dental health aide therapists) and other community health aides. A copy of the June 1, 2016, letter to Tribal Leaders is available on the IHS website at: https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2016_Letters/55744-1_DTLL_CHAP_Expansion.pdf.

The Tribal Consultation on the draft policy statement concluded on October 27, 2016. After careful review of all comments received from the Tribal Consultation, the IHS will pursue next steps to begin the process to develop a policy to create a national CHAP under the provisions outlined in the Indian Health Care Improvement Act (IHCIA) as amended at 25 U.S.C. § 16161. Tribal consultation to review the policy will follow.

Background

With rising demands for comprehensive, quality health care, communities are increasingly looking for innovative approaches to health care delivery.

From 1976 through 2010, the IHCIA, at 25 U.S.C. § 1616*l*(a), directed the Secretary of the Department of Health and Human Services (HHS), by and through the IHS, to create and maintain a CHAP in Alaska. Community health aides work in a variety of health program settings, such as health education, communicable disease control, maternal and child health, and family planning. They provide a broad range of services, from taking patient histories to performing certain treatment procedures.

Community Health Aides (CHAs) employed by CHAPs are paraprofessionals who work as nursing aides, community health workers, and psychiatric aides. In 2007, the Alaska CHAP added a Dental Health Aide Program called "Dental Health Aide Therapists (DHATs)," a specialized category of community health aides who are trained and certified to perform various dental procedures, including some irreversible procedures authorized under Federal law. (See 25 U.S.C §§ 1616*l*(b)(7)).

While the 2010 amendments to the IHCIA, at 25 U.S.C. § 1616*l*(d), authorize the Agency to create a national CHAP, the statute explicitly excludes the use of DHATs. However, the IHCIA at 25 U.S.C. §§ 1616*l*(d)(2) and (3), provides a waiver to the prohibition when a Tribe elects to utilize DHAT services in those States that authorize the use of DHATs or the use of other mid-level dental health providers. From its inception, the CHAP has evolved to improve access to care to meet the health needs of Alaska Natives in rural villages.

On June 1, 2016, Ms. Smith shared with Tribal leaders a draft policy statement that proposes "to see community health aides (including DHATs) utilized to the fullest extent permissible

Page 2 - Report on the Tribal Consultation for the Indian Health Service Policy Statement on Creating a National Indian Health Service Community Health Aide Program

in the IHS and tribally run hospitals and clinics." The policy statement is available on-line at: https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2016_Letters/55744-1 IHSPolicyStatementontheExpansionofCHAP.pdf).

Tribes and Tribal organizations provided comments on this important draft policy statement in writing and through telephone and in-person Tribal Consultation sessions through the October 27, 2016, submission deadline.

- Three consultation sessions were completed:
 - Face-to-Face: National Indian Health Board (NIHB) Consumer Conference in Scottsdale, Arizona, on Monday, September 19, 2016;
 - Over 150 participants
 - o Telephone: October 4, 2016;
 - Approximately 50 participants
 - o Face-to-Face: National Congress of American Indians (NCAI) Consultation in Phoenix, Arizona, on Sunday, October 9, 2016.
 - Approximately 20 participants
- Number of Organizations/Individuals providing comments:
 - o 27 Tribal organizations;
 - o 14 National American Indian/Alaska Native organizations; and
 - o 10 Individual American Indians or Alaska Natives with comments/questions.

The 2010 IHCIA amendments, at 25 U.S.C. §§ 1616l(d)(1) - (3), authorize the HHS Secretary acting through the IHS to establish a national CHAP outside of Alaska with specific statutory requirements that prohibits the reduction of funding for CHAPs in Alaska and prohibits the use of DHATs in CHAPs unless DHAT services are authorized in the state and a Tribe elects to use them.

As stated above, DHATs are a type of dental health therapist created specifically for use in a CHAP. These DHATs are not licensed by any State, but are required to be certified by a Community Health Aide Certification Board. Currently, DHATs are only being certified and utilized in Alaska pursuant to 25 U.S.C. 1616*l*(a) and (b). This Federal certification is confirmation that the DHAT provider has successfully completed the curriculum established by the Board so that he/she may provide services in a tribally or federally managed CHAP.

CHAPs, including those utilizing DHATs, must comply with Federal training, certification, and scope of practice requirements. See 25 U.S.C. § 1616*l*(b), which includes the IHS creation of a national Community Health Aide Certification Board and a training curriculum before sending CHAs and/or DHATs into field locations to practice. While Congress has not prohibited the use of DHATs in those States that have authorized the use of DHAT or mid-level Dental Health Provider

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services, a Federal law must be enacted to authorize the use of DHAT services in those States that do not permit DHAT services. The IHS will develop a policy and implementation plan using the guiding principles received from the Tribal Consultation process.

Summary of Comments Received

Generally speaking, all comments were in favor of establishing a national CHAP and/or provided guiding principles for IHS to consider as it moves forward. Several themes emerged:

• The CHAP can improve access to quality care for American Indians and Alaska Natives.

- o "One of the greatest areas of need in our Tribal communities is access to reliable, high quality, affordable dental care. Inclusion of DHATs in the CHAP is a necessary element for Tribes to support such a policy."
- o "We welcome the assistance of the IHS to address a critical need in Indian Country to access skilled and culturally appropriate health care providers and services in remote areas."
- o "DHAT program has the ability to expand access to care, fill the gaps, and provide high quality culturally competent care."

• Program needs to be Community- and Area-based.

- o "Recognizes the value of community recruited paraprofessionals and mid-level providers in all aspects of health care in the IHS system."
- o "Identifies the need for behavioral health aides recruited from the community."
- o "Tribe is in full support of expanding health care opportunities under a new policy for these aides and strongly supports the inclusion of the Community Health Aides, DHAT, and Behavioral Health Aides."
- o "Tribe strongly supports expansion of BHA [behavioral health aide] CHAP program due to suicides in the community."

• There needs to be some baseline standards with enough flexibility that each Area can set-up its own program.

- o "The IHS should also consider whether Area-specific certification boards would be more appropriate as it would allow Areas to tailor their CHAP programs to best meet their needs."
- o "National convening and workgroup should be established for CHAP expansion to establish baseline standards with flexibility."
- o "Due to the magnitude of the proposed transformation, IHS should kick off the national dialogue with a 2-3 day national conference to discuss program expansion."
- o "We do not welcome the expansion of Indian Health Services authority over the planning, development, implementation, and/or provision of health care services to our Tribal

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membership. There is a fundamental difference between the concepts of creating a program and creating a service. Programs have an internal logic that controls services they provide."

• Each Area would set-up its own certification board.

- o "We do have concerns about how a national certification board would interact with the boards already in place; like in Alaska. Instead of a national Board, each IHS Area Office should establish their own CHAP certification board."
- o "We favor the decentralized approach to the development of a certification board and recommend a regional approach."
- o "IHS should not adopt a national certification board."
- o "We would like to see one curriculum and certification nationally, rather than on a piecemeal basis that varies State to State. That way therapists could transfer and not be limited by local regulations."

• Do not disrupt programs that are working now; such as those in Alaska.

- o "Do not adopt a national certification board as it will adversely affect programs like Alaska when changes are made at the Federal level."
- o "Alaska has operated DHAT Program for over 10 years with many successes citing health impacts saving dollars."
- o "The IHCIA prohibits IHS from reducing funding provided to Alaska CHAP."

• There needs to be legislative change to fully implement the use of DHATs in CHAPs.

- o "Needs to be clarification on provisions within the IHCIA that permit expansion of the CHAP."
- o "Amend IHCIA as it limits the ability of Tribes outside Alaska to use DHAT services unless such services are authorized under State law."
- o "Limiting language in IHCIA, 25 U.S.C. 1616l(d)(3)(A), must be eliminated."
- o "It is our opinion that you cannot amend the IHCIA without opening it up to other actions. We do not think these positions can be covered by the Federal Tort Claims Act (FTCA)--will providers pay for a bad outcome?"
- o "IHCIA currently prevents Native American Governments from accessing the necessary Federal dollars to pay for services."
- o "Fighting one State battle at a time. Hope on the national level, there will not be State-by-State, or Tribe-by-Tribe challenges. Urbans should also take opportunity of program."

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Next Steps

As part of our ongoing work to deliver quality health care to patients, and in consideration of available resources, the IHS, in partnership and collaboration with Tribes, looks forward to the next steps in this process as follows:

- Establish a national workgroup to develop a draft CHAP Expansion Policy and Implementation Plan comprised of these representatives:
 - o Alaska CHAP
 - o Alaska and Lower 48 Dental Therapist experts
 - o Alaska and Lower 48 Behavioral Health Aide experts
 - Health Education expert
 - o Maternal and Child Health expert
 - o Communicable Disease Control expert
 - o Family Planning expert
 - o IHS Area leadership
 - o Alaska and Lower 48 Medical/Nursing/Behavioral Health/ Dental experts.
- Seek input on the draft CHAP Expansion Policy and Implementation Plan through the Tribal Consultation process.
- Revise and recirculate draft policy and plan as necessary.
- Circulate plan through IHS Areas for clearance.



Issues Related to Medicare Like Rates & Tribal Self-Insurance

NPAIHB Quarterly Board Meeting January 17, 2017

A. Medicare Like Rates (MLR)

- 1. Hospital MLR (Section 506 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. 108-173; adds new subpart D to 42 C.F.R. Part 136).
 - Requires any Medicare-participating inpatient hospital to agree to be a PRC provider; to be bound by the same admission requirements that apply to Medicare generally; and to accept no more than the Medicare-established pay rates for the services provided to PRC-referred patients.
 - Applies only to Medicare-participating hospitals that provide inpatient hospital services, including all departments and provider-based facilities of such hospitals, and to critical access hospitals.
 - Covers all levels of care provided by such hospitals inpatient, outpatient and skilled
 - Includes long-term care hospitals, independent inpatient rehabilitation facilities and inpatient psychiatric facilities, as they all furnish inpatient hospital services.
 - All such providers are subject to the MLR payment rates when providing a service *authorized* under 42 C.F.R. Part 136 (IHS regulations) by a PRC program of the IHS or by a tribe/tribal organization carrying out such a program under ISDEAA.
- 2. Non-Hospital MLR (IHS issued final regulations at 42 C.F.R. Part 136, Subpart I).
 - Became effective May 20, 2016.
 - Applies to payments to providers and suppliers not already covered by the existing "Hospital MLR" regulations.
 - Unlike Hospital MLR, it is not a condition of Medicare participation, which means nonhospital providers do not have to accept payment at MLR in order to participate in Medicare.
 - Health programs operated by tribes or tribal organizations pursuant to a contract or compact under the ISDEAA have the choice of whether or not to participate in the new Non-Hospital MLR regulations. 42 C.F.R. § 136.201(c). Must opt in by adding language to ISDEAA agreement.
 - Rate to be paid depends on whether the PRC program has negotiated a specific rate with the provider.
 - Rates apply only when the tribal PRC program has validly authorized PRC for the services under the PRC regulations set forth at 42 C.F.R. Part 136, Subpart C.

B. Tribal Self-Insurance & PRC

- MLR only applies when the PRC program validly authorizes PRC.
- Consider the Structure and Administration of the Plan.

- Plan Language.
- Consider a Coordination Agreement.
- Section 402 of the IHCIA authorizing tribes to purchase care (a tribal health program).
- Grand Traverse Band of Ottawa & Chippewa v. Blue Cross & Blue Shield of Mich.

C. Developing Issues: Alternate Resources and Access To CHEF

1. Payor of Last Resort Rules

- IHS CHS rule 42 C.F.R. § 136.61.
- PPACA Extension § 2901(b) of Pub. L. 111-148:
 - "Health programs operated by . . . Indian tribes, tribal organizations . . . shall be the
 payer of last resort for services provided by such . . . tribes, or organizations to
 individuals eligible for services through such programs, notwithstanding any Federal,
 State, or local law to the contrary."

2. Tribal Self-Insurance As An Alternate Resource

Recent significant change in IHS longstanding policy (*see* Section 2-3.8I of the IHS Indian Health Manual) of *not* treating tribal self-insurance plans as alternate resources:

- <u>Redding Rancheria v. Burwell, Civ. No. 14-2035 (D.D.C.)</u>: IHS takes the position that tribal self-insurance plans are to be considered alternate resources to PRC.
- IHS Frequently Asked Questions on PRC Rates: "Since Tribal self-insurance plans are not PRC programs, the PRC rates rule does not address the amount these plans will pay for services, but the rule incorporates that plan's responsibility for payment relative to the PRC program under the payor of last resort statute."
- <u>IHS Proposed Regulations On CHEF</u>: IHS proposes not to pay CHEF when patient is eligible for an "alternate resource," which IHS specifically defines to include tribal self-insurance.
- IHS proposed Circular On Purchase of Insurance Under Section 402 of the IHCIA:
 - Would treat tribal self-insurance as a payer before IHS.
 - Could exclude some individuals being eligible to receive PRC if they have insurance purchased under Section 402 (including tribal self-insurance).
 - But, some flexibility on tribal self-insurance and CHEF: If a tribe has a self-insurance plan funded wholly or partially by ISDEAA funding, there is no reinsurance or indemnity, and the plan is "designed to follow PRC eligibility," then the IHS would consider the plan to be eligible for CHEF reimbursements on the same basis that any PRC program is eligible for CHEF.

3. Thoughts on Potential Implications

- IHS's new position is inconsistent with applicable law, and contrary to Congress' goals of implementing its federal trust responsibility and expanding access to federal health care resources for American Indians and Alaska Natives.
- However, if IHS is successful in its arguments, it could undercut some of the legal parameters under which tribes have carefully coordinated their PRC and tribal self-insurance plans to date, and it may become necessary to reconsider those relationships.

NPAIHB QBM THRIVE WE R NATIVE PROJECT RED TALON JANUARY 2017

Agenda

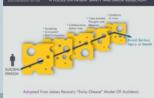
- THRIVE updates
- o Suicide Prevention Signs
- o Zero Suicide Sites
- ${\color{red} \circ}$ WRN collaboration update on Concerning Post Webinar
- o Social Marketing Campaigns
- Project Red Talon and We R Native Updates
- o www.wernative.org
- o Gen I Bootcamps
- o Healthy Native Youth Portal



Suicide Prevention Signs • Dissemination by summer • Signs & Poles if wanted Prevent • 10-11 trigger locks and resource list Suicide · Contact info. to order large #WeNeedYouHere amounts of trigger locks · Contact Colbie or Celena Call for the signs and locks 1-800-273-8255 o ccaughlan@npaihb.org or 503-416-3284 or text "START" to 741741 o cmccray@npaihb.org or 503-

Zero Suicide

- 3 NW Tribes continue to pilot the implementation
- 3 additional Tribes hoping to begin the process
- Workforce Surveys
- Trainings
- Challenges
- Successes



Coming Soon...

Tool to help educators (or any caring adult) respond to concerning posts seen on social media

Developed by NPAIHB and the Social Media and Adolescent Health Research Team (SMAHRT)

https://vimeo.com/170679097



Concerning Posts Webinar

- Partnership with SMHRT
- Introduction to the topic and webinar
- Real life experiences
- Suicide or self-harm posted on social media
- o Responses to posts
- · Goals of the webinar
- Statistics
- $\bullet\,$ Study before the webinar

https://vimeo.com/170679097

- Tools for educators/adults
- Resources
- o QPR
- o Factsheets
- Websites
- o Videos
- Completing IRB
- Available for pilot testing Mar-May 2017
- Who is interested??

(y)

Suicide Prevention Social Marketing Campaign

WE ARE CONNECTED. #WE NEED YOU HERE.



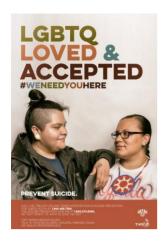


Posters
Blank Flyer
Rack Card
Tip Card
Lanyard
Flash Drives
Radio PSAs
T-shirts
Lived Experience
Videos

LGBTQ, TWO SPIRIT Social Marketing Campaign

LOVED & ACCEPTED #WE NEED YOU HERE





Posters
Rack Card
Tip Card
Radio PSA
Lived Experience
Videos

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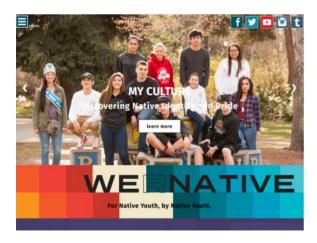
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TALK TO TRUSTED ELDERS. HEALERS, FRIENDS, FAMILY MEMBERS OR HEALTH PROFESSIONALS.	Commin.
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TO CHAT WATEST MESSAGE	
CALL THE SLICIDE PREVENTION LIFELINE AT LBOOL373.8355	#WENEEDYOUHERE
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TO GIVE HELP OR GET HELP!	TWO SPIRIT

Developing the....

Native Veterans Suicide Prevention Social Marketing Campaign

Please fill out the paper survey Put in the box labeled "Veteran Surveys" Fax attn: THRIVE to 503-228-4801 Deadline: Friday January 20, 2017









- 1. Like us on Facebook
- 2. Follow us on <u>Twitter</u>
- 3. Subscribe to our YouTube Channel
- 4. Follow us on Instagram
- 5. Text "HEALTHY" to 97779 to get the latest health curricula and resources for Native youth!
- 6. If you're a young person:
 - Text "NATIVE" to 97779 to receive weekly health tips, contest, and life advice
 - Become a WRN Youth Ambassador
 - Make a positive difference in your community. <u>Apply for up</u> to \$475

Gen-I Social Media Boot Camps

• WeRNative Training

- o Leadership Skills
- Youth Driven Social Marketing Project
- o Health Activism

• Site's Role

- o Schedule 2 full days
- o Recruit 15-20 AI/AN youth
- o Schedule a facility
- o Provide adult chaperones to assist WRN staff

• Topics

- o Cultural identity & resilience
- Substance abuse prevention
- Suicide prevention

• WRN Role

- o Lead or contract a facilitator
- o Contract a professional media company
- o Edit the final social marketing project

• Offering 2-3 in 2017

o Contact Tommy Ghostdog Jr. at tghostdog@npaihb.org

2016 Bootcamps

- · We R Native Youth Ambassadors (Drug/Alcohol Prevention PSA) - https://youtu.be/D7rlAjgb3tI 1:27
- · Olympia Area Youth (Suicide Prevention PSA) https://youtu.be/X7k1h9FPLK0 1:42
- Quileute Youth (Culture/Native Pride PSA) https://youtu.be/gOGCVSFVX1M 1:53
- · Interested? Contact Tommy Ghostdog Jr. at tghostdog@npaihb.org



SAVE-THE-DATE 7th Annual THRIVE Conference June 26-30, 2017 WHO: For American Indian and Alaska Native Youth Limit of 4 youth (13-19yo) per Tribe or Urban Area. Limit of 1-2 Chaperones per group registering. Registration is free! Activities, materials, lunch and snacks Mon-Thurs, will be provided. Travel, parking, looging, breakfast and dinners are not included.

WHERE: Native American Student and Community Center at Portland State University (PSU) in Portland, OR

Opportunities

Native STAND

- Students Together Against Negative Decision Making (STAND)
- o Recruiting 25 Tribes or AI/AN organizations for the final year
- Mandatory training week, June 26-30, 2017 in Portland
 Application deadline is Mar. 1
- · Contact: Michelle Singer
 - Native STAND Project Manager
 - o Oregon Health and Science University
 - o Phone: 503-418-2199 o Email: singerm@ohsu.edu

- PREP in WA State
 - Personal Responsibility Education Program (PREP)
 - Recruiting sites
 - Hoping tribal sites identify curricula from the Healthy Native Youth website (description next slide)
 Letters of Interest due Feb. 10
- Contact: Lauri Turkovsky, EdD
- PREP Grant Coordinator
 WA Dept. of Health
- o Phone: 360.236.3538
- Email: Lauri.Turkovsky@doh.wa.gov

Take Out Your Phones







Training Opportunities

- Applied Suicide Intervention Skills Training (ASIST)
 - - 2 full days, CEUs offered (no fee for specific professions in some states)
- Working Minds Suicide Prevention in the Workplace

 - · You pick a 2 or 4 hour training
- Question Persuade Refer (QPR)

 - 2-3 hours, CEUs offered for a fee
- Request any of the listed trainings by contacting Colbie Caughlan at ccaughlan@npaihb.org or calling 503-416-3284



(40°) **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

Stephanie Craig Rushing, PhD, MPH Director – Project Red Talon & THRIVE

Colbie Caughlan, MPH THRIVE Project Manager

Celena McCray THRIVE Coordinator

Amanda Gaston, MAT Ask Auntie agaston@npaihb.org

David Stephens, RN HCV RN Project Manager

Tommy Ghost Dog PRT Assistant

Jessica Leston, MPH HIV/HCV/STI Clinical Services Director



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2120 L Street, NW, Suite 700 Washington, DC 20037

T 202.822.8282 F 202.296.8834 HOBBSSTRAUS.COM

MEMORANDUM

January 10, 2017

To: Tribal Health Clients

From: Hobbs, Straus, Dean & Walker, LLP

Re: Washington Report – Health Reform

Healthcare reform and efforts to repeal and replace the Affordable Care Act began in earnest last week. On January 3, 2017, Chairman of the Senate Budget Committee Senator Mike Enzi (R-WY) introduced a budget resolution, S. Con. Res. 3, which could begin the process of repealing provisions of the Affordable Care Act (ACA). The budget resolution provides reconciliation instructions to four congressional committees with authority over health care legislation: the Senate Committee on Finance; the Senate Committee on Health, Education, Labor, and Pensions; the House Committee on Energy and Commerce; and the House Committee on Ways and Means. The instructions direct them to come up with recommendations by January 27, 2017, and are intended to begin the process of ACA repeal.

Under the Congressional Budget Act of 1974, these reconciliation instructions pave the way for changes to the ACA being considered under expedited procedures. Only a simple majority is required to pass legislation under budget reconciliation. However, only budget-related matters may be addressed using this process. This means that only budget related aspects of the ACA could be repealed through this process. Efforts to repeal and/or replace other aspects of the ACA that are not budget related, like the Indian Health Care Improvement Act (IHCIA), would need 60 votes in the Senate and could not be repealed through budget reconciliation.

As has been widely reported, House and Senate Republicans announced their intention to use the budget reconciliation process to press for an immediate repeal of budget related provisions of the ACA, and then delay implementation of that repeal while they can craft a replacement. Just this week, however, concerns have been raised by some House and Senate Republicans that they should have a replacement bill ready to be enacted at the same time as a repeal is enacted. Yesterday, five GOP Senators introduced an amendment to the resolution that would delay the deadline for budget reconciliation instructions until March 3, 2017. As a result, it is unclear whether Congress will move to repeal the ACA until a replacement has been worked out.

Regardless of the process and timeline, health reform is under active consideration. This includes efforts to repeal and replace the ACA, as well as efforts to reform Medicaid. As previously reported, there is also active interest in reforming Medicaid and moving it to a block grant program for States. On January 6,

Representative Rokia (R. IN) introduced HR 352, which would eliminate the Medicaid program and move it to a block grant program for States. While the text of that bill is not yet available, a prior version of the bill introduced last year would have eliminated the Medicaid program entirely and replaced it with a block grant that would leave considerable discretion to the States. Unless an exception is made for Indian country, it could mean that full federal funding of Medicaid for services provided to Indians through the Indian health system would be eliminated, and those costs shifted onto the States.

While we do not have concrete legislative proposals to respond to yet, we are actively working with a number of our tribal clients to provide Congressional Staff and House and Senate offices with tribal priority issues, which include:

- 1. Preserving the IHCIA;
- 2. Preserving Indian-specific laws that were enacted as part of the ACA but which are unrelated to the ACA; and
- 3. Ensuring that full federal funding for Medicaid services to American Indians and Alaska Natives provided through the Indian health system is maintained.

We will be setting up meetings in the coming weeks with a number of committee and staff offices on the Hill, and are happy to work with you to do so as well. Please let us know if we can arrange meetings on your behalf. We have also prepared draft letters to send to your congressional representatives, one for those in States that have expanded Medicaid, and for those in States that have not expanded Medicaid (Attached).

For further information, please contact Elliott Milhollin (emilhollin@hobbsstraus.com or 202-822-8282), Geoff Strommer (gstrommer@hobbsstraus.com or 503-242-1745), or Akilah Kinnison (akinnison@hobbsstraus.com or 202-822-8282).





CHRISTINA PETERS

NATIVE DENTAL THERAPY INITIATIVE PROJECT DIRECTOR NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD QUARTERLY BOARD MEETING JANUARY 17, 2017

Our DHAT Pilot Goals

- Expand access to consistent, routine, high quality oral health care in tribal communities;
- Grow the number of AI/AN oral health care providers available to tribal communities;
- Bring culturally competent care into tribal communities;
- Establish cost effective solutions to oral health challenges into tribal communities;
- Bring care where it is needed most.







(40°)



CTCLUSI Dental Clinic

- Fully staffed 3-chair clinic serves primarily tribal members/families
- CTCLUSI also provide services to Coquille Indian Tribe. Coquille serves CTCLUSI members at their Community Health Center
- CTCLUSI has a 5-county service area including Coos, Curry, Lane, Lincoln and Douglas

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Our Students! Naomi Petrie DHAT Class of 2017 DHAT Class of 2018

Coquille Indian Tribe Health Services

- Coquille operates Community Health Clinic for their members/family, community members, and CTCLUSI members in the 5-county service area: Coos, Curry, Douglas, Jackson and Lane
- They currently do not have a dental clinic or dental team but are exploring facility expansion and other options for housing a dental program





Evaluation

- Working with an outside consultant to evaluate:
- the effect of dental therapists on access to care
- o the quality of care
- Patient satisfaction
- Provider satisfaction
- o Clinic productivity/personnel costs
- o Staff turnover



New Pilot Site in Oregon





(40°)

Demonstration in Washington

The Swinomish dental team has celebrated the first anniversary of Daniel's arrival to the clinic





STATINOM	10h	tod	277
Swinom	TOIL	tou	av.

- Dentists working at the top of their Scope
- Daniel Kennedy (DHAT) out in the community
- · A more efficient dental team
- Daniel is a natural fit to the clinic
- Young Swinomish tribal members considering Dental Therapy as their future career



Statewide Dental Therapy Bill

- The Statewide Dental Therapy Bill in Washington:
 - Has been renegotiated to reflect the language in the tribal bill and
 - Creates a work group to establish a pathway for federally certified or tribally licensed DHATs to become licensed by the state.



SB 5079 Tribal DHAT Bill Summary

- Authorizes DHATs in Washingtyon that are
- o Certified by a CHAP Certification board
- Licensed by a Federally Recognized Tribe
- All DHAT services must be performed:
 - In a practice setting within the exterior boundaries of a tribal reservation and operated by an Indian health program or an urban Indian organization
 - On persons who are members of a federally recognized tribe or otherwise eligible for services under Indian health service criteria, pursuant to the Indian health care improvement act, U.S.C. Sec. 1601 et seq.
- Directs HCA to coordinate with CMS for Medicaid Reimbursement

SB 5079 Tribal DHAT Bill

Tribal DHAT Bill SB 5079 will have a hearing THURSDAY JANUARY 19th at 10 AM

There are many ways for you to support this legislation:

- Attend the hearing
- Sign in "PRO" on the legislation (your lobbyist can do this for you if you can't make it to Olympia)
- Testify
- Call your Senator and let them know you support SB 5079
- Sign on to a letter from tribal leaders to show broad tribal support for the passage of the Tribal DHAT bill



How to Stay Informed

- Like our Facebook Page search for @nativedentaltherapy on Facebook to find the Native Dental Therapy Initiative Project FB Page
- Email Pam Johnson <u>pjohnson@npaihb.org</u> to get on the legislative updates email list



Momentum for modern dental teams is growing



ent 1 .	
Thank you!	
QUESTIONS?	



Indian Health Service Rockville MD 20852

JAN 04 2017

Dear Tribal Leader:

I am writing to update you on my June 1, 2016, letter which initiated a Tribal Consultation on the Indian Health Service (IHS) draft policy statement on creating a national IHS Community Health Aide Program (CHAP). After careful review of all comments received, I am pleased to announce that the IHS will begin the process of developing a formal policy and implementation plan to create a national CHAP under the provisions outlined in the Indian Health Care Improvement Act (IHCIA) as amended at 25 U.S.C. § 1616*l*(d).

Partnership and collaboration are part of our ongoing work to deliver quality health care to patients. Increased access to care is a top priority, which is why the Agency will begin the process, along with our Tribal partners, of developing a formal policy and implementation plan to increase the utilization of community health aides across the IHS system.

Community health aides are proven partners, and utilizing them to the fullest extent permissible in hospitals and clinics operated by the IHS and Tribes will increase the availability of health workers in American Indian and Alaska Native communities. Community health aides include workers in health education, communicable disease control, maternal and child health, dental health, behavioral health, family planning, environmental health, and other areas.

IHS received comments on the draft policy statement from Tribes and Tribal organizations during the Tribal Consultation sessions conducted in-person in Arizona on September 19, 2016, and October 9, 2016; over the telephone on October 4, 2016; and through written comments during the comment period ending October 27, 2016.

In the enclosed report, you will see that several themes emerged, which will provide the framework for the development of the formal policy and implementation plan. Generally speaking, all comments were in favor of establishing a national CHAP and/or provided guiding principles for IHS to consider as it moves forward.

The following principles will guide the development of the formal policy and implementation plan:

- (1) The CHAP can improve access to quality care for American Indians and Alaska Natives.
- (2) Any program needs to be Community- and Area-based.
- (3) Some baseline standards with sufficient flexibility will be needed to ensure that each Area can establish its own program.
- (4) Each Area would establish its own certification board.
- (5) The policy will not disrupt programs that are currently established, such as those in Alaska.
- (6) Legislative changes will be needed to fully implement the use of DHATs in CHAPs.

As part of our ongoing work to deliver quality health care to patients, and in consideration of available resources, the IHS will begin to establish a National Workgroup, comprised of Tribal leaders and IHS representatives, to develop a draft CHAP Expansion Policy and implementation Plan, in accordance with section 11 of the IHS Tribal Consultation policy. After the National Workgroup develops a draft, IHS will seek input on the draft CHAP Expansion Policy and Implementation Plan through the Tribal Consultation process.

The IHS, in partnership and collaboration with Tribes, looks forward to the next steps in this process.

Sincerely,

/Mary Smith/

Mary Smith Principal Deputy Director

Enclosure: Report on the Tribal Consultation for the Indian Health Service (IHS)
Policy Statement on Creating a National IHS Community Health Aide Program





Indian Health Service Rockville MD 20857

REPORT ON THE TRIBAL CONSULTATION FOR THE INDIAN HEALTH SERVICE POLICY STATEMENT ON CREATING A NATIONAL INDIAN HEALTH SERVICE COMMUNITY HEALTH AIDE PROGRAM

On June 1, 2016, Ms. Mary Smith, Principal Deputy Director, Indian Health Service (IHS or Agency), issued a letter to Tribal Leaders to initiate a Tribal Consultation to seek input on a policy statement describing the intention of the IHS to create a national Community Health Aide Program (CHAP) similar to the Alaska model that could ultimately lead to greater numbers of dental providers (e.g., dental health aide therapists) and other community health aides. A copy of the June 1, 2016, letter to Tribal Leaders is available on the IHS website at: https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2016_Letters/55744-1_DTLL_CHAP_Expansion.pdf.

The Tribal Consultation on the draft policy statement concluded on October 27, 2016. After careful review of all comments received from the Tribal Consultation, the IHS will pursue next steps to begin the process to develop a policy to create a national CHAP under the provisions outlined in the Indian Health Care Improvement Act (IHCIA) as amended at 25 U.S.C. § 16161. Tribal consultation to review the policy will follow.

Background

With rising demands for comprehensive, quality health care, communities are increasingly looking for innovative approaches to health care delivery.

From 1976 through 2010, the IHCIA, at 25 U.S.C. § 1616*l*(a), directed the Secretary of the Department of Health and Human Services (HHS), by and through the IHS, to create and maintain a CHAP in Alaska. Community health aides work in a variety of health program settings, such as health education, communicable disease control, maternal and child health, and family planning. They provide a broad range of services, from taking patient histories to performing certain treatment procedures.

Community Health Aides (CHAs) employed by CHAPs are paraprofessionals who work as nursing aides, community health workers, and psychiatric aides. In 2007, the Alaska CHAP added a Dental Health Aide Program called "Dental Health Aide Therapists (DHATs)," a specialized category of community health aides who are trained and certified to perform various dental procedures, including some irreversible procedures authorized under Federal law. (See 25 U.S.C §§ 1616*l*(b)(7)).

While the 2010 amendments to the IHCIA, at 25 U.S.C. § 1616*l*(d), authorize the Agency to create a national CHAP, the statute explicitly excludes the use of DHATs. However, the IHCIA at 25 U.S.C. §§ 1616*l*(d)(2) and (3), provides a waiver to the prohibition when a Tribe elects to utilize DHAT services in those States that authorize the use of DHATs or the use of other mid-level dental health providers. From its inception, the CHAP has evolved to improve access to care to meet the health needs of Alaska Natives in rural villages.

On June 1, 2016, Ms. Smith shared with Tribal leaders a draft policy statement that proposes "to see community health aides (including DHATs) utilized to the fullest extent permissible

Page 2 - Report on the Tribal Consultation for the Indian Health Service Policy Statement on Creating a National Indian Health Service Community Health Aide Program

in the IHS and tribally run hospitals and clinics." The policy statement is available on-line at: https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2016_Letters/55744-1_IHSPolicyStatementontheExpansionofCHAP.pdf).

Tribes and Tribal organizations provided comments on this important draft policy statement in writing and through telephone and in-person Tribal Consultation sessions through the October 27, 2016, submission deadline.

- Three consultation sessions were completed:
 - Face-to-Face: National Indian Health Board (NIHB) Consumer Conference in Scottsdale, Arizona, on Monday, September 19, 2016;
 - Over 150 participants
 - o Telephone: October 4, 2016;
 - Approximately 50 participants
 - o Face-to-Face: National Congress of American Indians (NCAI) Consultation in Phoenix, Arizona, on Sunday, October 9, 2016.
 - Approximately 20 participants
- Number of Organizations/Individuals providing comments:
 - o 27 Tribal organizations;
 - o 14 National American Indian/Alaska Native organizations; and
 - o 10 Individual American Indians or Alaska Natives with comments/questions.

The 2010 IHCIA amendments, at 25 U.S.C. §§ 1616l(d)(1) - (3), authorize the HHS Secretary acting through the IHS to establish a national CHAP outside of Alaska with specific statutory requirements that prohibits the reduction of funding for CHAPs in Alaska and prohibits the use of DHATs in CHAPs unless DHAT services are authorized in the state and a Tribe elects to use them.

As stated above, DHATs are a type of dental health therapist created specifically for use in a CHAP. These DHATs are not licensed by any State, but are required to be certified by a Community Health Aide Certification Board. Currently, DHATs are only being certified and utilized in Alaska pursuant to 25 U.S.C. 1616*l*(a) and (b). This Federal certification is confirmation that the DHAT provider has successfully completed the curriculum established by the Board so that he/she may provide services in a tribally or federally managed CHAP.

CHAPs, including those utilizing DHATs, must comply with Federal training, certification, and scope of practice requirements. See 25 U.S.C. § 1616*l*(b), which includes the IHS creation of a national Community Health Aide Certification Board and a training curriculum before sending CHAs and/or DHATs into field locations to practice. While Congress has not prohibited the use of DHATs in those States that have authorized the use of DHAT or mid-level Dental Health Provider

Page 3 - Report on the Tribal Consultation for the Indian Health Service Policy Statement on Creating a National Indian Health Service Community Health Aide Program

services, a Federal law must be enacted to authorize the use of DHAT services in those States that do not permit DHAT services. The IHS will develop a policy and implementation plan using the guiding principles received from the Tribal Consultation process.

Summary of Comments Received

Generally speaking, all comments were in favor of establishing a national CHAP and/or provided guiding principles for IHS to consider as it moves forward. Several themes emerged:

• The CHAP can improve access to quality care for American Indians and Alaska Natives.

- o "One of the greatest areas of need in our Tribal communities is access to reliable, high quality, affordable dental care. Inclusion of DHATs in the CHAP is a necessary element for Tribes to support such a policy."
- o "We welcome the assistance of the IHS to address a critical need in Indian Country to access skilled and culturally appropriate health care providers and services in remote areas."
- o "DHAT program has the ability to expand access to care, fill the gaps, and provide high quality culturally competent care."

• Program needs to be Community- and Area-based.

- o "Recognizes the value of community recruited paraprofessionals and mid-level providers in all aspects of health care in the IHS system."
- o "Identifies the need for behavioral health aides recruited from the community."
- o "Tribe is in full support of expanding health care opportunities under a new policy for these aides and strongly supports the inclusion of the Community Health Aides, DHAT, and Behavioral Health Aides."
- o "Tribe strongly supports expansion of BHA [behavioral health aide] CHAP program due to suicides in the community."

• There needs to be some baseline standards with enough flexibility that each Area can set-up its own program.

- o "The IHS should also consider whether Area-specific certification boards would be more appropriate as it would allow Areas to tailor their CHAP programs to best meet their needs."
- o "National convening and workgroup should be established for CHAP expansion to establish baseline standards with flexibility."
- o "Due to the magnitude of the proposed transformation, IHS should kick off the national dialogue with a 2-3 day national conference to discuss program expansion."
- o "We do not welcome the expansion of Indian Health Services authority over the planning, development, implementation, and/or provision of health care services to our Tribal

Page 4 - Report on the Tribal Consultation for the Indian Health Service Policy Statement on Creating a National Indian Health Service Community Health Aide Program

membership. There is a fundamental difference between the concepts of creating a program and creating a service. Programs have an internal logic that controls services they provide."

• Each Area would set-up its own certification board.

- o "We do have concerns about how a national certification board would interact with the boards already in place; like in Alaska. Instead of a national Board, each IHS Area Office should establish their own CHAP certification board."
- o "We favor the decentralized approach to the development of a certification board and recommend a regional approach."
- o "IHS should not adopt a national certification board."
- o "We would like to see one curriculum and certification nationally, rather than on a piecemeal basis that varies State to State. That way therapists could transfer and not be limited by local regulations."

• Do not disrupt programs that are working now; such as those in Alaska.

- o "Do not adopt a national certification board as it will adversely affect programs like Alaska when changes are made at the Federal level."
- o "Alaska has operated DHAT Program for over 10 years with many successes citing health impacts saving dollars."
- o "The IHCIA prohibits IHS from reducing funding provided to Alaska CHAP."

• There needs to be legislative change to fully implement the use of DHATs in CHAPs.

- o "Needs to be clarification on provisions within the IHCIA that permit expansion of the CHAP."
- o "Amend IHCIA as it limits the ability of Tribes outside Alaska to use DHAT services unless such services are authorized under State law."
- o "Limiting language in IHCIA, 25 U.S.C. 1616l(d)(3)(A), must be eliminated."
- o "It is our opinion that you cannot amend the IHCIA without opening it up to other actions. We do not think these positions can be covered by the Federal Tort Claims Act (FTCA)--will providers pay for a bad outcome?"
- o "IHCIA currently prevents Native American Governments from accessing the necessary Federal dollars to pay for services."
- o "Fighting one State battle at a time. Hope on the national level, there will not be State-by-State, or Tribe-by-Tribe challenges. Urbans should also take opportunity of program."

Page 5 - Report on the Tribal Consultation for the Indian Health Service Policy Statement on Creating a National Indian Health Service Community Health Aide Program

Next Steps

As part of our ongoing work to deliver quality health care to patients, and in consideration of available resources, the IHS, in partnership and collaboration with Tribes, looks forward to the next steps in this process as follows:

- Establish a national workgroup to develop a draft CHAP Expansion Policy and Implementation Plan comprised of these representatives:
 - o Alaska CHAP
 - o Alaska and Lower 48 Dental Therapist experts
 - o Alaska and Lower 48 Behavioral Health Aide experts
 - Health Education expert
 - o Maternal and Child Health expert
 - o Communicable Disease Control expert
 - o Family Planning expert
 - o IHS Area leadership
 - o Alaska and Lower 48 Medical/Nursing/Behavioral Health/ Dental experts.
- Seek input on the draft CHAP Expansion Policy and Implementation Plan through the Tribal Consultation process.
- Revise and recirculate draft policy and plan as necessary.
- Circulate plan through IHS Areas for clearance.

A New Vision for Public Health in **Washington State**

Rebuilding Core Services & Modernizing the System





Northwest Portland Area Indian Health Board Quarterly Meeting January 18, 2017



WSALPHO

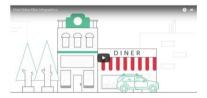




http://publichealthisessential.org/

Website & Video





Washington's Governmental Public Health System

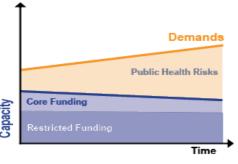


The Problem

- 1. Changing nature of preventable disease
- 2. Increasing demand for core public health services
- 3. Diminished and inequitable funding for core public health services



Increasing Demand + Diminished Core Funding = Increased Risk



Source: BERK Consulting, 2016.

The Solution

Rebuilding Core Services & Modernizing the System



FOUNDATIONAL
PUBLIC HEALTH IN
WASHINGTON STATE
Ensuring all residents can depend
on a core set of services which only
governmental public health can provide

PROGRAMS
A basic set of programs that are
accessible in every community
accessible in overy community
accessible in the late.

Capabilities
Capabilities
Individual in
MEETING LOCAL NEEDS
In addition to these core program
and capabilities, there are other
services implemented to other
services implemented to other
services implemented to other

2017 & Beyond

- Legislative Proposal policy bill & budget request
- **System-wide Assessment** evaluate current FPHS capacity and update cost, current spending and funding need estimates
- Service Delivery implement and evaluate pilot projects; further develop ideas and models; identify which FPHS fit best at local, zone, state level
- Accountability tracking the investments, spending, capacity, performance, impacts
- Funding Allocation funding to follow the work
- Process for Routine Updates definitions, costs, services delivery, accountability, allocation

Why I/T/Us are Part of our Governmental Public Health System

- Respecting sovereignty: Tribal governments provide public health functions and services to their communities; Tribal FPHS framework must be tribal-driven
- State and local health departments have no jurisdiction on Tribal lands
- I/T/U, state and local partnerships will be enhanced where shared services are needed
- 2017 LEGISLATION includes defining the governmental public health system in Washington as: DOH, SBOH, LHJS and their boards and the sovereign Tribal Nations of Washington.

Tribal Participation History	
The state of the s	
2014 FPHS Policy Workgroup	
Tribal Leader Representation	
Co-chaired by Tribal Leader	
2015 – Tribal Consultation	
 Secretary 'ask' to determine I/T/U interest in pursuing Tribal- 	
specific FPHS	
 Positive response to move forward 	
2015-2016 - Presentations at Tribal meetings	
– AIHC, NPAIHB, Other	
2016 FPHS Tribal Technical Workgroup Formed	
	10
DRAFT Foundational Public Health Services (FPHS)	
Tribal Technical Workgroup	
modi recimical vvoingi oup	
Workgroup Goal	
Assure I/T/Us are a key component of the overall WA State governmen	tal
public health system by considering & evaluating FPHS concepts and	LP-
framework and assessing & identifying Tribal-prioritized foundational phealth services and funding opportunities	JUDIIC
•	
Workgroup Objectives Through continuous I/T/U engagement:	
Identify current I/T/U public health services, gaps, and desired role in or	verall
system	
Develop foundational services and definitions	
 Identify current FPHS expenditures and funding sources Estimate potential FPHS funding gaps 	
Convene decision makers to determine funding sources	
Create strategies for funding advocacy	
	11
Tribal Technical Workgroup Roste	r
Revised: 12-12-16	•
Name Tribe / Organization Role Adrien Dominquez adriand@uhi.org Seattle Indian Health Board (SIHB), Urban Indian Health Institute (UIHI) Scientific Director	
Andrew Shogren Andrew.shogren@quileutenation.org Quileuten Barbara Hoffman@suquamish.nsn.us Suquamish Community Health	tor
Nurse Barbara Juarez Barbara@indianhealthboard.org Northwest Indian Health Board Executive Director	
(NWIHB) Crystal Tetrick Crystal.tetrick@kingcounty.gov WSLPHO / Public Health – Seattle- Maternal Child Heal	ith I
King County Director Jim Steinruck isteinruck @tulaliptribes-nsn.gov Tulalip Health Administrato	
Marilyn Scott marilyns@upperskagit.com Upper Skagit AlHC Past Chair Steve Kutz Skutz.health@cowlitz.org Cowlitz AlHC Chair	
Susan Turner Susan.tumer kitsappublichealth.org WSALPHO / Kitsap Health Officer Victoria Warren-Mears warrenmears naihb.org Northwest Portland Area Indian Epi Center Director	\dashv
Health Board (NPAIHB) – Epi Center	
Project Management Team: Jan Olmstead, Public Health Projects Consultant, American Indian Health Commission; jan.Olmstead@gmail	Lcom
Sheryl Lowe, Tribal Liaison, WA Department of Health; Sheryl Lowe@doh.wa.gov Marie Flake, FPHS Manager, WA Department of Health; marie.flake@doh.wa.gov	
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Washington State Department of Social and Health Services
Transforming Lives
Washington State LTSS System, History and Vision
Bea Rector, Director, Home and Community Services Aging and Long Term Support Administration Washington State Department of Social and Health Services For Northwest Portland Area Indian Health Board Quarterly Meeting January 18, 2017
PO Box 45050, Olympia, WA 98504 www.dohs.wa.gov

Washington State Department of Social and Health Services
DSHS Aging and Long-Term Support Administration (ALTSA)
Vision
Seniors and people with disabilities living in good health, independence, dignity, and control over decisions that affect their lives
Mission
To Transform Lives by promoting choice, independence and safety through innovative services
We Value
The Pursuit of Excellence, Collaboration, Honesty, Respect, Open Communication, Diversity, Accountability, and Compassion

ALTSA Serves approximately 74,000 individuals per year



	Washington State Department of Social and Health Services
	Focus of Home and Community Services
,	Financial eligibility for Medicaid LTSS programs, also determines state/federal
	programs such as cash and food benefits for LTSS recipients
	authorization for new clients, including those choosing in-home services
٠	Case management for Medicaid clients in licensed residential care settings APS investigation of abuse, abandonment, neglect, and self-neglect of vulnerable
	adults in the community, and the provision of protective services
	Assist individuals to relocate from institutional to community based settings Develop housing, resources and system capacity to serve clients in community
	settings Develop local partnerships and work directly with local agencies to improve
	service delivery to clients, including 7.01 planning with tribes and tribal organizations
	4
	Washington State Department of Social and Health Services
	Focus on Adult Protective Services
	Investigates and prioritizes allegations of abuse, abandonment,
	neglect, self-neglect or financial exploitation of vulnerable adults in their own homes.
	aren own nomes.
	Offers protective services to alleged victims in situations where
	allegations were substantiated.
	Educates, networks and coordinates with other community entities
	to serve vulnerable adults
	Authority: RCW 74.34
	Washington State Department of Social and Health Services
	Focus of Area Agencies on Aging (AAA)
•	Focus of Area Agencies on Aging (AAA) Specialized Senior Information & Assistance/Community Living Connections
	Specialized Senior Information & Assistance/Community Living Connections
	Specialized Senior Information & Assistance/Community Living Connections Local contracting and quality assurance oversight of community service providers
	Specialized Senior Information & Assistance/Community Living Connections Local contracting and quality assurance oversight of community service providers Case management and nursing services for in-home clients
	Specialized Senior Information & Assistance/Community Living Connections Local contracting and quality assurance oversight of community service providers Case management and nursing services for in-home clients Family Caregiver Support and Kinship Caregiver Services

Focus on Money Follows the Person Tribal Initiative

Create sustainable, culturally competent mechanisms to support American Indians/Alaska Natives (AI/ANs) currently residing in institutions and at risk of institutional placement to either return home or avoid placement through access to the most culturally relevant living environments, as identified by the individual.

- Increased accessibility to Medicaid LTSS to eligible individual tribal members who need them;
- Identification of tribal infrastructure needs to enable T/TOs to provide services directly and/or contract to provide services;
- Development of accessible reimbursement mechanisms for service delivery;
- Identification of opportunities to obtain higher federal medical assistance percentages (FMAP) and/or encounter rates as defined in the federal register.

Washington State Department of Social and Health Service:

Rebalancing Washington State



Washington State Department of Social and Health Services

Washington State has worked hard to "rebalance" and serve Medicaid clients where they want to be served

TOTAL = 36,649

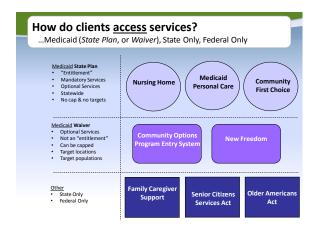
TOTAL = 36,649

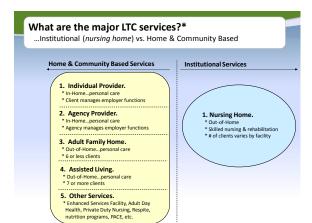
Clients Served in Home and Community

Same Clients Served in Nursing Homes

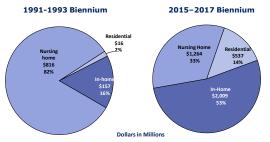
Same Clients Served in Nursing Homes

Source CRES ATTA Care Metrics and tasks.



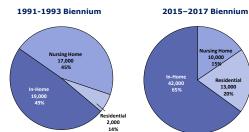


Rebalancing in Washington State: Funding

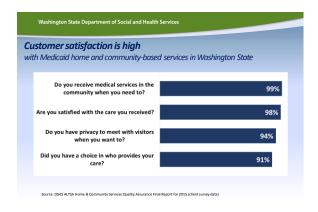


12

Rebalancing in Washington State: Caseload



Community and Nursing Home Utilization By American Indians/Alaska Natives in Washington 104 Gender: Female Community First Choice (CFC) 367 : Male 88 Total : 192 CFC & COPES 803 Medicaid Personal 16 Age : 20-30 6 : 31-40 New Freedom 7 : 41-50 9 PACE 6 : 51-60 32 Residential Support : 61-70 42 Waiver : 71-80 47 Roads to : 81-90 35 Community Living : 91-100 13 Total 1,231 : 100+ 1



Expanding home and community-based services resulted in taxpayer savings

State and Federal Costs
Avoided Since FY1999
by increasing home and community options, and actively reducing the need for nursing home care

\$2.7 Billion
Cumulative savings over 15 years

Source Dayle Meetings in the first party and take the first party and the first part



Targeting Services Can Address Diverse Needs and Keep Services Affordable for Taxpayers

"The Right Support at the Right Time"

- Long-term care is now six percent of Washington State's operating budget
- · Long-term care spending increases an average of 12% every biennium
- · The state's aging population will nearly double between 2015-2035

Continued success is contingent on continued innovation

Washington State Department of Social and Health Services

HCBS: Improving Outcomes and Controlling Costs

- Provide wellness education and training through existing 1915(c) waiver
- Offer skills acquisition training and assistive devices to clients through new state plan option (1915 (k) Community First Choice)
- Improve worker skills and interventions for clients who are high-risk
- Engage in Health Homes to improve outcomes for high risk individuals and share in Medicare savings
- Provide supports and services to unpaid caregivers to reduce stress and delay need for Medicaid



Washington State Department of Social and Health Services

Bea Rector

Director, Home and Community Services

State of Washington
Department of Social and Health Services
Aging and Long-Term Support Administration
Home and Community Services

Bea.Rector@dshs.wa.gov

360.725.2272

https://www.dshs.wa.gov/adult-care

Washington State Department of Social and Health Services
Transforming Lives
ALTSA Residential Care Services
The Section of Control

Aging and Long-Term Support Administration Residential Care Services (RCS)

Mission: To protect the rights, security, and well-being of individuals living in licensed or certified residential settings.

- RCS is responsible for the licensing/certifying and oversight of:
 - Adult Family Homes
 Assisted Living Facilities

 - Nursing Homes

 - Intermediate Care Facilities for Individuals with Intellectual Disabilities
 - Supported Living
 - Enhanced Services Facilities.



The Continuum of Care

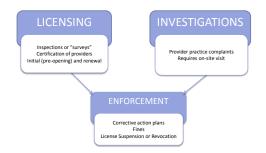
<u>Leadership and partnership:</u>
RCS and residential providers and caregivers are working to improve the quality of life and quality of care for our residents through respectful communications and professional relationships.

The development and delivery of strategic services and innovative funding: New Home and Community-Based Service rules and requirements with a focus on

person-centered planning and providing full access to the benefits of community

 $\underline{\textbf{Making the connections and understanding the transformation of services}}$ We are all working together to ensure quality options for our residents, their families and friends, and our communities.

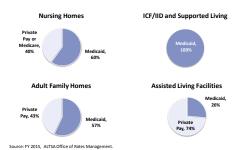
Residential Care Services: Current Key Elements



25

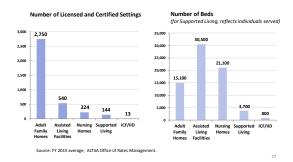
Washington State Department of Social and Health Services

Who is the "market" for the settings we license?



Washington State Department of Social and Health Services

How many settings do we license or certify?



9

Licensed and Certified Settings

by Size and Type of Oversight

Setting	Size (number of residents)	Statutory Oversight	Frequency of Inspection/ Certification
Skilled Nursing Facilities ("Nursing Homes")	90 average	Federal and state	Every 15 months (12 month average)
Assisted Living Facilities	60 average	State	Every 18 months (15 month average)
ICF/IID (Intermediate Care Facilities for Individuals with Intellectual Disabilities)	16 maximum	Federal and state	Every 15 months (12 month average)
Adult Family Homes	6 maximum	State	Every 18 months (15 month average)
Supported Living	2-3 typical	State	At least every 24 months

Washington State Department of Social and Health Services

Tribal Owned or Operated Facilities

Tulalip Tribes Boarding Home – Assisted Living Facility Colville Tribal Convalescent Center – Nursing Home





Washington State Department of Social and Health Service

Everyone has a role in the safety of residents



Investigations are targeted to two kinds of safety issues

Abuse and Neglect

Adult Protective Services

Example 1:

An elderly neighbor with dementia appears neglected, and you also worry his "friend" is defrauding him.

Example 2:

A woman living in facility is being mentally and physically abused by a specific staff member.

Provider Practice Complaints

Residential Care Services

Example 1:

A resident has an unexplained 40 lb. weight loss over the past 3 months. The facility is not doing anything about the weight loss.

Example 2:

Residents are being put to bed at 6:30 pm each day, not by choice.

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Washington State Department of Social and Health Service

Provider Online Complaint Reporting

Owners, caregivers, social workers, nurses, physicians and other employees of RCS-licensed and/or certified facilities or agencies are mandated reporters and must report if they have reasonable cause to believe abandonment, abuse, financial exploitation, or neglect has occurred to a vulnerable adult.



www.dshs.wa.gov/altsa/residential-care-services/residentialcare-services-online-incident-reporting

Report Concerns Involving Vulnerable Adults

All reports will be screened by Adult Protective Services and/or Residential Care Services. *If the person is in immediate danger, call 911*. You do not need proof to report suspected abuse and you do not need to give your name.

https://www.dshs.wa.gov/altsa/home-and-communityservices/report-concerns-involving-vulnerable-adults



33

Action Plan for RCS Continuous Quality Improvement



- 1. New performance metrics with improved data and reporting.
- 2. Continued Lean practices to promote process improvements.
- 3. Pilot mobile technology for field staff to speed up workflow and timeliness.
- 4. Focused recruitment and retention of qualified nurses and other staff.
- 5. Partner with providers to think creatively about quality and service delivery.

34

Washington State Department of Social and Health Services

Candace Goehring

Director, Residential Care Services

State of Washington
Department of Social and Health Services
Aging and Long-Term Support Administration
Home and Community Services

Goehrcs@dshs.wa.gov

360.725.2401

https://www.dshs.wa.gov/adult-care





Northwest Portland Area Indian Health Board

Hosted by: Chehalis Tribe Great Wolf Lodge Grand Mound WA

Colleen F. Cawston, MPA Chief Executive Officer January 18, 2017



Colville Service Unit Update



- · Renew and Strengthen our Partnerships with Tribes
- Improve the Indian Health Service
- Be Transparent, Accountable, Fair and Inclusive
- · Improve Quality & Access to Care for Patients



Colville Service Unit



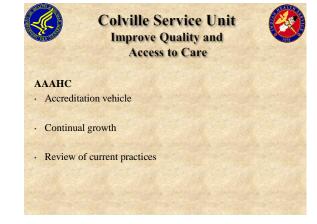
Renew & Strengthen our Partnerships with Tribes

Collaboration

- · Lake Roosevelt Community Health Centers
- · Tribal Health Diabetes/Language
- · Environmental Trust
- · Human Resources



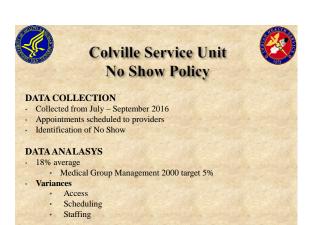


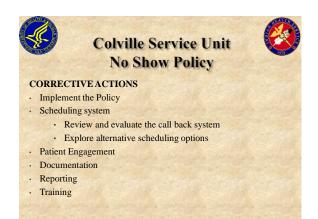


Colville Service Unit Improve Quality and Access to Care Three studies presented to Governing Board Time out procedures Anticoagulation No Show for appointments

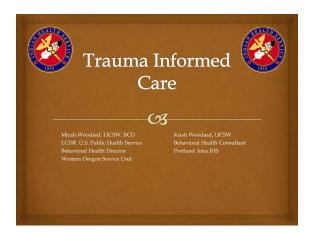
	Colville Service Unit No Show Policy	
PURPOSE		
Track our	r No Show Rate (NSR)	
Develop	strategies to improve	
• Impleme	nt strategies	
Review a	nd update	







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.	



What is Trauma?

-03

- Trauma refers to intense and overwhelming experiences that involve serious loss, threat or harm to a person's physical and/or emotional well being.
- These experiences may occur at any time in a person's life. They may involve a single traumatic event or may be repeated over many years.
- These trauma experiences often overwhelm the persons coping resources. This often leads the person to find a way of coping that may work in the short run but may cause serious harm in the long run.

 [SAMISA]

Trauma Informed

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○ A trauma-informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. (SAMHSA TIP 57)



	T (
Trauma	Intormed



 It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. $_{\mbox{\scriptsize (SAMHSA\,TIP\,57)}}$

Trauma Informed Care

 TIC is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p.82). (SAMHSA TIP 57)

Trauma Informed Care & **Indian Country**

The Indian Country Childhood Trauma Center (ICCTC) further defines trauma to address the specific conditions and experiences of American Indians and Alaska Natives (AI/ANs) as a "unique individual experience associated with a traumatic event or enduring conditions, which can involve an actual death or other loss, serious injury, or threat to a child's well-being, often related to the cultural trauma, historical trauma, and intergenerational trauma that has accumulated in AI/AN communities through centuries of exposure to racism, warfare, violence, and catastrophic disease."

23	Several distinct forms of	trauma hav	e been i	dentified	in Inc	dian	Countr	y.
	· · C h lm							

- Cultural Trauma
 Historical Trauma
 Intergenerational Trauma
 Current Trauma

(NICWA)

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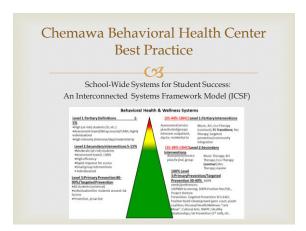


Introduction

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- Number of youth seen in primary care who present with mental health related problems has nearly tripled over the last 20 years
- ☼ Over one in five children have a mental health disorder severe enough to disrupt their daily functioning, and of those identified, nearly 70 percent will not receive any services.
- © Over 25,000 schools across 50 states are implementing School-Wide Positive Behavior Intervention and Supports, a multi-tiered prevention based framework.

"Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization." (SAMHSA)



Big Ideas... **Read How Positive Behavioral Intervention and Supports (PBIS) (Multi-tiered Systems of Support (MTSS)) enhance mental health in schools within an Interconnected Systems Framework (ISF) that is Trauma-Informed. **Pramework (ISF) that is Trauma-Informed.** **How can School-Based Health Centers integrate an Interconnected Systems Framework that is Trauma-Informed.** **How can client/community centric design thinking significantly impact outcomes (Trauma Informed, 0 Suicide, Child Adolescent Needs Strengths (CANS), Systems of Care/Wrap Around, Quality Management, etc.)

	Resources
	<u>US</u>
CS	http://www.integration.samhsa.gov/pbhci-learning-community/Trauma- Informed Care in an Integrated World for CIHS 8 27-12 all edits.pdf
cs	$\underline{http://www.integration.samhsa.gov/about-us/CIHS_TIC_Webinar_PDF.pdf}$
CS	http://www.integration.samhsa.gov/about-us/CIHS_TIC_Webinar_PDF.pdf
CS	$\frac{http://www.nicwa.org/mental_health/SystemsOfCare/documents/Traumal formedCareFactSheet_April2014_000.pdf}{} \\$

Questions/Discussion
Contact Information
LCDR Micah Woodard micah.woodard@ihs.gov (503) 304-7626
Kristi Woodard, LICSW <u>kristi.woodard@ihs.gov</u> (503) 414-5596

Elders Committee

Tuesday January 17, 2017 Great Wolf Lodge- Grand Mound, WA

	N. Imu		5) 6000
	Name and Title	Organization	Phone/FAX/E-mail
1	Party K. Carternan	Countité Tribe	Date Gaiser @gmail - Co
2	Anhy Joseph J	Colville	Path Gaiser Ogmail - Cor only is osept a colvillatorbes, con delason @ Che Hahis
3	DAN GLEASON	CHÉ Halis	d glasson @ CheHalis TRIBE.ORS
4	Bob De Los Angeles	SNOGUALMIE TRIBE	bobbe@SNOQUALMIETRIBEIL
5	Janice Clements	asour Strings	Ex y 194 - 5531196
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Elder Committee Meeting Minutes

January 17, 2017

Great Wolf Lodge

Grand Mound, WA

Members: Patty Kinswa – Gaiser, Cowlitz Tribe, Janice Clements-Warm Springs
Tribe, Bob De Los Angeles-Snoqualmie Tribe, Andy Joseph-Colville Tribe,
Dan Gleason, Chair, Chehalis Tribe.

NPAIHB Staff: Clarice Charging

Dan asked Andy to open the meeting with a prayer. Elders welcomed Clarice back to the committee.

Dan asked for a motion to approve October 2016 minutes. Patty motioned.

Bob seconded. Opposed 0. Motion approved.

Updates:

Cowlitz: Patti is teaching cultural education for the tribe. Elder apartments are at capacity. The tribe is currently advertising for their Housing Director position. Cowlitz Casino is slated to open April 2017.

Snoqualmie: Tribe implemented \$250.00 vouchers for elders to spend as needed and they are not required to submit receipts back to the tribe. Their new tribal C-store will open this spring. As part of the next phase for their casino the tribe is building a parking garage.

Chehalis: Tribe re-opened their buffet and parking garage several weeks ago. Will be busy planning activities this spring for their elders.

Colville: Wood Program for elders has been busy helping provide heating assistance as this year has seen heavy snowfall. Tribe is working with other tribes to quietly re-bury Kennewick Man when returned to them.

Warm Springs: Youth are studying tribal language and effects of climate change at their local schools in Warm Springs. Tribe is expecting huge crowds and are making plans for the August 2017 solar eclipse. Elder Day will be held in May.

Legislative/Resolution Committee

Tuesday January 17, 2017 Great Wolf Lodge- Grand Mound, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	BREAT SIMOR	Jamestowk	
2	Gerald Hill	Klauath	gerald. L. Hille ghant.
3	CHEMI RASPA	SWINAMEN	Crasar Commonish.nsn.us
4	Christina Reters	NPAIHB	
5	Tin 8 Balt	Shoshove Bannocle	that a shtribes com
6	Leslie Wosnig	Suguamish Tribe	******
7	Kim Thompse	Shoahwate Bay	Kzillyetta Shoahwater bay nov
8	Cherice Kenneds	C.T. Grunf Kinde	/
9	Joe MALOUAN	NDAIHO	
10	Nickolaus lasis	Lumm:	nickslauste Lummi ming
11	Audy Joseph J	Colville	andy. Joseph e colville tr. be, com
13	Latra Platen	MPATHO	
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Legislative Committee Report January 17, 2017

Attendees: Brent Simosky, Jamestown S'Klallam; Gerald Hill, Klamath; Cheryl Rasar, Swinomish; Tino Batt, Shoshone Bannock; Leslie Wosnig, Suquamish Tribe; Kim Thompson, Shoalwater Bay; Cheryl Kennedy, Grande Ronde; Nicholas Lewis, Lummi; Andy Joseph, Jr., Colville

Staff: Joe Finkbonner, Laura Platero, Christina Peters

Four resolutions were considered and acted upon:

1. Approval of Background Check Policy.

This resolution requests Board approval of the Background Check Policy and incorporates the policy into the Program Operations Manual of the Northwest Portland Area Indian Health Board.

<u>Action</u>: Motion by Shoshone Bannock; second by Shoalwater Bay; and unanimous vote to pass the resolution to the Board for consideration.

2. Support submission of grant for CDC funding for Northwest Tribal Comprehensive Cancer Project.

This resolution requests Board approval to submit a grant application to the CDC to request funding for Comprehensive Cancer Control Project.

<u>Action</u>: Motion by Swinomish; second by Shoalwater Bay; and unanimous vote to pass the resolution to the Board for consideration.

3. Authorizations Related to National Indian Health Policy Education Foundation

This resolution requests authorization for the Board to act as the fiduciary agent for the Myra Munson's national Indian health policy foundation and provides approval for the opening of a new bank account in order to maintain a separation of funds while it serves as the fiduciary agent of the funds of the foundation. The resolution also resolves that the authorized signers of checks drawn on that account will be the Treasurer of the Northwest Portland Area Indian Health Board, the Executive Director, and the Administrative Officer; and the Purchase Order associated with the foundation require two of these officers' signatures, and checks on the account require two of these officers' signatures.

<u>Action</u>: Motion by Suquamish; second by Shoalwater Bay; and unanimous vote to pass the resolution to the Board for consideration.

4. Pathways into Health – Northwest Native American Center of Excellence #17-02-01.

This resolution supports the application of Oregon Health & Science University to HRSA for the Pathways into Health: Northwest Native American Center of Excellence proposal.

<u>Actions</u>: It was approved by the Executive Committee on December 7, 2016 and requires ratification by the full Board. In addition, there was a motion by Jamestown S'Klallam; second by Lummi; and unanimous vote to pass the resolution to the Board for consideration.

Christina Peters talked about IHS's Dear Tribal Leader Letter issued on January 4, 2017 announcing IHS decision to move forward with nationalization of CHAP. She shared a draft letter from the Board to IHS thanking them for nationalization of CHAP.

Youth Committee

Tuesday January 17, 2017 Great Wolf Lodge- Grand Mound, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Leland Bill	YN Tribal Council	(509) 386-3437
2	Sabido-Hodges Chanty	Cowlitz Health 3 Youth Boa	nd Charity. Sabido@gmail
3	Namosto Yender	MPAITIB	n
4	Mark Johnston	Coquille Tudian	5417560904 mank JoHNSTON@ Coquiller
5	Shapen Strykil	Coquille Tarlian Con creek	0
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Youth Committee

Tuesday January 17, 2017 Great Wolf Lodge Grand Mound, WA NPAIHB Quarterly Board Meeting

<u>Attendees</u>

Yakama Nation- Leland Bill, Tribal Council Member Coquille Indian Tribe- Mark Johnston Cowlitz Health & Youth Board- Charity Sabido-Hodges Cowcreek Health & Wellness Center- Sharon Stanphil NPAIHB- Nanette Star

Discussion

- Introductions
- Previous Youth Committee meeting
 - Identifying what focus to have for a youth track at: 1) All QBMs; 2)
 Summer QBMs
- Review of survey questions for delegates with feedback
- Resources for youth in communities and review of resource sheet.
 - Suggestions to get this on NPAIHB website for easy access
 - o Document brought to each QBM as a resource
- Ideas for future QBM logistics and 2018 Summer:
 - o Invite Tribal Youth Council (Future Tribal Leaders)
 - Share the work going on in their communities
 - Break out into separate room for further discussion

Action Items

o Information sent out to delegates regarding what youth to invite and how, for the July Joint QBM with CRIHB and NPAIHB

Public Health Committee

Tuesday January 17, 2017 Great Wolf Lodge- Grand Mound, WA

	Name and Title	Organization	Phone/FAX/E-mail
		Organization	Fhone/FAA/E-man
1	Uctoria Warren-Mears	MPAIHB	
2		412	360 854.7039
3	Marilga M. Scott	Upper Skagit	marilyne e upperskagit es
4	Jolene Winger, PPC	Quileute Tribe	374-40536
	Kelle Little THD	Coquille India Triba	591-888-9494
5	Julie Johnson	Oregon Health Authority	503, 396-1148
6	Λ Ω		
7	Carrie Campson	1 Jellowhawk Inbal Health Ctr.	544-969-1111, Carriesampsona,
8	CHUCK FREEMONT	WEDBUSH SECURITIES	
0	Kaven Hanson	Kooknai Tribe of Idal	6 208-267-5223
9	Julie Reed	SugaralmanaTrila	Julie peed e snognalmietribe.
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11	JAN OLM STAD	AIHC	
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Public Health Committee

Meeting Minutes January 17, 2017

In attendance:

Marilyn Scott – Upper Skagit
Jolene Winger – Quileute Tribe
Kelle Little – Coquille Indian Tribe
Julie Johnson – Oregon Health Authority
Carrie Sampson – Umatilla
Karen Hansen – Kootenai Tribe of Idaho
Julie Reed – Snoqualmie Tribe
Jan Olmstead – AIHC
Staff: Victoria Warren-Mears

Data Repository Overview:

Victoria reviewed the progress on the NW Tribal Data Repository. The staff of the board have been working on getting a data repository for about 4 years. Currently we have a dedicated, secured server for the data repository, which was recently purchased. About a month ago we purchased the software to allow data storage and retrieval. This will allow us to steward data for our projects and data for tribes in the Northwest, should that be desired by a specific tribe. Having this repository allows us to retain control of data through an IRB process, which will include obtaining approval for any secondary research from each tribe involved in the data.

The data repository will allow us to meet federal requirements for data sharing on larger grants, but also retain tribal based control of the data.

We will be able to steward data for tribes if desired, such as community health assessment data, BRFSS data and others as requested.

Public Health Data Review:

Currently the EpiCenter has completed state level health profiles using the data that has been linkage corrected. They were published for each state, and are available on our web site.

We are working to determine ways to get data to the tribes more quickly. Each tribe should have received an updated Cancer Profile from us in the late fall. We send this information to the delegates, the tribal health director, and specific tribal program people. From that point on the data is yours to use as you wish and distribute as appropriate.

We have access to the Epi Data Mart, which is a regional data set derived from the National Data Warehouse. We do not have access to behavioral health data. The tribal epidemiology centers are talking with Dr. Beverly Cotton to try to gain access to this data in the Epi Data Mart.

We have a large number of linkage matched and corrected data sets from the states.

Public Health Accreditation:

Carrie Sampson requested a revitalization of support for public health accreditation support and sharing at the Board meetings. This request was supported by Kelle Little.

Several suggestions were made for action:

- Develop an opportunity for sharing among tribes who are seeking public health accreditation
- Develop resource and knowledge sharing
- Develop a monthly call for interested tribes on Public Health Accreditation to encourage cross tribal support and information sharing, including CHA, CHP, and strategic planning.

Carrie and Kelle indicated a willingness to support this initiative. Victoria will discuss with Bridget Canniff revitalizing the EpiCenter's support around this initiative.

Behavioral Health Committee

Tuesday January 17, 2017 Great Wolf Lodge- Grand Mound, WA

		l .	
	Name and Title	Organization	Phone/FAX/E-mail
1	VICKI LOWE	AHC	(360)477-452/ @outlook co
2	Michael Stickler	NARA Northwest	503-310-6707 mstickler@ Nova 10
3	Caroline M. Crun	CONFITTIBLE OF WS: HERITHIE HUMAN SERVICE	641-615-0148 Caroline. Cruze wstribes. 045 541-460-8649
4	Darry Scott	Confitribu of W.S. Reparton Health	darry 1. scott @ wst. ibes. org
5	Chanda K Yats	Klamath Tubal Hay	th Chanda yutes. @plan. part
6	LETA CAMPbell	COA frobe	2 Complete colatite
7	Susan Sheoships	CONFTRIBES OF Umatilla RES.	ssssheoships agmailige
8	Kevin Collins	Stillaguenish:	15 COllins foltilla quamicha
9 	Jim Steinveck	Tukakip	(800)-716-7610 Steins well to the try to 509-789-71012-
10 مال	Lisa Guernan	Kalispel	lanzonana carnasheelth. con
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NPAIHB Behavioral Health Committee - Meeting Minutes

Chehalis, WA - January 2017

Introductions

• Update on NARA's Youth Treatment Center

- o Michael Stickler from NARA and Caroline Cruz from Warm Springs gave updates on the youth treatment center.
- Still set to open in April 2017, and will serve youth and families 13-17 years old
- Will be open to all NW Tribes to access
- o Participants asked to have the intake form resent to committee members which will go out in the committee follow-up email.
- Caroline Cruz described how this center came to fruition and how the OR Indian Council on Addictions worked tirelessly to get treatment facility funding from the State.
- This treatment center will treat co-occurring conditions or diagnoses.
- o Lisa Guzman described how the Healing Lodge recently switched to a cooccurring model under Rebecca Crocker.
- Request: the committee would like the NPAIHB to make a list of treatment centers that can be accessed by tribes and each center would have a description of services offered, treatment models used, patient eligibility requirements and age ranges, number of beds, what accreditations the facility has, and what diagnoses are accepted i.e. is cooccurring accepted?
- Presentation Idea: Can some of the treatment facilities come and present on what they offer, how patients are eligible, who to contact, and what insurances are taken? Possible presenters include NARA, Healing Lodge, Northwest Treatment Center, etc.
- A question about juvenile drug court came up do any tribes have drug court?
 - o Tulalip has a recovery court
 - CTCLUSI has Peace Court (restoration court?)
 - Stillaguamish is putting together a Wellness Court now and will be touring Tulalips recovery court soon.
 - Warm Springs does not have a drug court but does offer diversion
 - A member brought up the possibility of gaming tribes taking cost of incarceration out of the individuals per cap versus out of their families or the Tribes as a whole – this may deter teens from re-offending or not following through with consequences from tribal (or even) county court.

- o <u>Request:</u> Identify contact at Tulalip's and CTCLUSI's courts and send it out to the committee members so they can follow-up with these contacts and learn more about the system.
- Discussion about Marijuana and the NW Tribes came up
 - O Are any tribes trying to decriminalize the offense? Some of our tribal members are losing everything because of their possession of or use of marijuana and being caught with it. Are there any Tribes that feel marijuana should be brought down from a level 1 controlled substance to make the punishment less severe? To discuss the pros and cons of this please contact Leta Campbell with CDA.
 - Also what are tribes doing in regards to marijuana overall? Who is trying to grow hemp or distribute marijuana only for specific cancer cases? Who hopes to do research with marijuana and cancer treatment?
 - O A committee member suggested that attendees review information coming out of Schick Shadel hospital in Seattle. They have found that alcohol and marijuana are the toughest substances to combat, not alcohol and heroin, not alcohol and cocaine. Interesting. . . .
 - o Request: Can the NPAIHB provide a presentation on marijuana in the Tribes and the findings of any studies around cancer treatment and the use of marijuana? Also, what are the effects of marijuana short and long-term on kids and teens? Does it affect the lungs and possibly lead to lung cancer like tobacco does?
- <u>Request:</u> Can the NPAIHB help assist with the large problem many rural tribes face around recruiting and sustaining professional staff at their clinics? Licensed behavioral health staff are not applying for the open positions at many rural tribes. Can we learn more about psychiatric consultations? Chandra Yates from Klamath is looking into this method of having an off-site psychiatrist consult with staff on site about patients. This may help ease the need a little but does any other Tribe have this issue or is any other tribe finding other solutions to lack of professional applicants?
- <u>Presentation Request:</u> Tribes with integrated care models would present on their journey to their systems change, successes, challenges, tips for other tribes trying to streamline and di-silo clinical processes. Example – possibly Tulalip or Stillaguamish to present on their roads to health systems integration.
- List of trainings being offered to the NW Tribes online was handed out in hopes
 that the Tribes will access these trainings offered by the NW Addiction
 Technology Transfer Center Network (ATTC). These courses are offered at no
 cost to NW Tribes. The list will be emailed along with committee meeting
 minutes.

Veterans Committee Meeting	
January 17, 2017	
Attendees: Theresa R. Lehman (Jamestown), Nikki Finkbonner (Lummi), Chris Sanford (NPAIHB staff)	
CHES SELECTE (MPAIND STUTY)	- Contraction of the Contraction
Jamestown Discussion Topics:	
 Al Fletcher (Jamestown's Tribal Veterans representative) is a retired Veteran who is looking for opportunities to help other Vets. Please contact Theresa (lehman1949@hotmail.com) if you'd like to get in 	
touch with him • Port Angeles now has a Veterans clinic and they refer care out to Bremerton or Seattle if needed	
 The Jamestown Tribe is currently building a memorial wall for Veterans 	
 Two Jamestown WWII Veterans (Lyle Prince and George Adams) recently passed away, however the Tribe was able to honor them both before they died 	wastania .
Lummi Discussion Topics:	
 David Jefferson (Lummi Veterans program manager) is transporting Veterans to Mt. Vernon for care, or even as far as Seattle if necessary Veterans are now able to obtain services at the Lummi Tribal clinic — 	
details to follow from Nikki who is the Lummi Tribe's Family Services director	

Questions?	
NPAIHB staff contact Info:	
Chris Sanford – <u>csanford@npaihb.org</u>	
or	
Don Head – <u>dhead@npaihb.org</u>	

Personnel Committee

Tuesday January 17, 2017 Great Wolf Lodge- Grand Mound, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Anden Wagner	NPATHS	awasneve npaihb.on
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Northwest Portland Area Indian Health Board **Quarterly Board Meeting Personnel Committee Meeting Minutes**

January 17, 2017

Start Time: 12:00 pm

Members Present: Shawna Gavin

Members Absent: Bonnie Sanchez, Cassandra Sellards-Reck

Staff Present: Andra Wagner

- Personnel update was read by Andra Wagner
 - o 0 new hires
 - o 0 promotions/transfers
 - o 1 intern
 - 1 resignation
- One open position On-Call Office Assistant
- Preventing Harassment and Discrimination Training was given to all staff on Nov 7th, 2016.
- Background checks were conducted for all current staff and one intern. Background checks will be conducted for all new hires, interns and volunteers.
- Revision to the Program Operations Manual Annual Review policy was proposed to update the manual to the current annual review process

Proposed Revision of Program Operations Manual Section C: Annual Performance Evaluation

CURRENT POLICY

ANNUAL PERFORMANCE EVALUATION

A performance evaluation of regular employees will be completed by the immediate supervisor annually on or within thirty (30) days of the anniversary of the employee's date of hire for the current position.

The Personnel Evaluation form is to be used for all evaluations. Scoring will use the system on that form in order that all employees are rated consistently. Supervisors will measure performance against the rating criteria.

Before preparing the evaluation, supervisors should meet informally with other individuals who assign work to the individual being supervised to ensure that all performance issues are identified in the evaluation.

After the supervisor has prepared and presented the written evaluation to the employee being evaluated and they have each signed it, the Executive Director will review and sign it to complete the process.

PROPOSED REVISION

ANNUAL PERFORMANCE MANAGEMENT REVIEW

An annual performance management review of regular employees must be completed by the immediate supervisor(s) on, or within thirty (30) days of, the anniversary of the employee's date of hire for the current position.

All performance reviews will utilize the on-line Performance Management Review system "ReviewSnap" in order that the efforts of all employees are assessed consistently. Supervisors will measure performance against the rating criteria entered into that system. Those criteria will include performance measures relevant to the position as well as to the requirements of funding agreements that support the position and to the NPAIHB Strategic Plan.

Before completing the evaluation, supervisors should meet informally with other individuals who assign work to the individual whose work is being reviewed to ensure that all performance criteria are fully considered in the review process.

After the supervisor and the employee have completed each part of their review process, have met to discuss it, and signed the review, the Executive Director and Human Resources Coordinator will review and sign it to complete the process.



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 Indians Confederated Tribes of Umatilla Confederated Tribes of Warm Springs Cow Creek Band of Umpqua Cowlitz Indian Tribe Hoh Tribe Jamestown S'Klallam Tribe Kalispel Tribe Klamath Tribe Kootenai Tribe Lower Elwha Klallam Tribe Lummi Nation Makah Tribe Muckleshoot Tribe Nez Perce Tribe Nisqually Tribe Nooksack Tribe NW Band of Shoshone Nation Port Gamble S'Klallam Tribe Puyallup Tribe Quileute Tribe Quinault Indian Nation Samish Indian Nation Sauk-Suiattle Tribe Shoalwater Bay Tribe Shoshone-Bannock Tribes Skokomish Tribe Snoqualmie Tribe Spokane Tribe Squaxin Island Tribe Stillaguamish Tribe Suquamish Tribe Swinomish Tribe

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Tulalip Tribe

Upper Skagit Tribe

Yakama Indian Nation

Resolution # 17-02-01

Title: Pathways into Health – Northwest Native American Center of Excellence

WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS, the Northwest Portland Area Indian Health Board is a "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

WHEREAS, NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the primary goal of the NPAIHB is to improve the health and quality of life of its member Tribes; and

WHEREAS, the Oregon Health & Science University (OHSU) is the only public health and research university in the state of Oregon; and

WHEREAS, OHSU strives for excellence in education, research and scholarship, clinical practice and community service as part of its multifaceted public mission; and

WHEREAS, OHSU strives to lead and advocate for programs that improve health for all, and extend OHSU's education, research and healthcare missions through community service, partnerships and outreach; and

WHEREAS, OHSU School of Medicine seeks to enhance human health through programs of excellence in education, research, health care and public service to the larger community including underserved populations; and

WHEREAS, OHSU Department of Family Medicine aims to be a supportive and collaborative organization that transforms primary care and inspires future leaders by demonstrating the best in Family Medicine by serving our patients and communities through excellence in clinical care, education, research, and leadership in Family Medicine; and

WHEREAS, OHSU Family Medicine Assistant professor Erik Brodt, MD is proposing the Pathways Into Health: Northwest Native American Center of Excellence (OHSU-NNACOE) funded by HRSA; and

WHEREAS, OHSU-NNACOE will recruit, train, and retain Native American health professional students and faculty; and

WHEREAS, OHSU-NNACOE will raise awareness of Native American health issues; and

WHEREAS, OHSU-NNACOE will further tribal-academic partnerships in education and research.

THEREFORE, BE IT RESOLVED that:

The Northwest Portland Area Indian Health Board supports the application of Oregon Health & Science University to HRSA for the Pathways Into Health: Northwest Native American Center of Excellence proposal.

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PREASONNE, BE IT RESEARCHED

CERTIFICATION

NO. 17-02-01

The foregoing resolution was duly a Northwest Portland Area Indian Hestablished;for,	
	Andrew C. Joseph Dr
	Chairman
December 7,2016	Dregny J. Abrhams Secretary



Rurns-Painte 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 Indians Confederated Tribes of Umatilla Confederated Tribes of Warm Springs Coquille Tribe Cow Creek Band of Umpqua Cowlitz Indian Tribe Hoh Tribe Jamestown S'Klallam Tribe Kalispel Tribe Klamath Tribe Kootenai Tribe Lower Elwha Klallam Tribe Lummi Nation Makah Tribe Muckleshoot Tribe Nez Perce Tribe Nisqually Tribe Nooksack Tribe NW Band of Shoshone Nation Port Gamble S'Klallam Tribe Puyallup Tribe Quileute Tribe Quinault Indian Nation Samish Indian Nation Sauk-Sujattle Tribe Shoalwater Bay Tribe Shoshone-Bannock Tribes Skokomish Tribe Snoqualmie Tribe Spokane Tribe Squaxin Island Tribe

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its member Tribes; and

Stillaguamish Tribe Suquamish Tribe

Swinomish Tribe

Tulalip Tribe Upper Skagit Tribe Yakama Indian Nation

RESOLUTION# 17-02-02

Authorizations Related to National Indian Health Policy Education Foundation

WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS, the Northwest Portland Area Indian Health Board is a "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

WHEREAS, the Northwest Portland Area Indian Health Board is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the primary goal of the NPAIHB is to improve the health and quality of life of its member Tribes; and

WHEREAS, the NPAIHB has long been a leader in improving policy related to health concerns of American Indian/Alaska Native (AI/AN) populations; and

WHEREAS, a long-time advocate and colleague in Indian health policy, Myra Munson, upon her retirement, wished to make a substantial one-time financial gift for the development of a national Indian health policy education foundation; and

WHEREAS, Myra Munson was seeking a fiduciary agent for the national Indian health policy education foundation; and

WHEREAS, Myra Munson has provided the financial gift to the NPAIHB for this purpose; and

RESOLUTION# 17-02-02 Authorizations Related to National Indian Health Policy Education Foundation

WHEREAS, the NPAIHB desires to open a bank account for the purpose of clearly separating the accounting of the funds of the aforementioned foundation and the NPAIHB's operations or project

costs.

NOW THEREFORE BE IT RESOLVED, the Northwest Portland Area Indian Health Board agrees to act as the fiduciary agent for the Myra Munson national Indian health policy foundation and approves the opening of a new bank account in order to maintain a separation of funds while it serves as the fiduciary agent of the funds of the aforementioned foundation.

BE IT FURTHER RESOLVED, authorized signers of checks drawn on that account will be the Treasurer of the Northwest Portland Area Indian Health Board, the Executive Director, and the Administrative Officer; and the Purchase Order associated with the foundation require two of these officers' signatures, and checks on the account require two of these officers' signatures.

Control Market Control (1997)

CERTIFICATION

NO. 17-02-02

Northwest Portland Area Indian	y adopted at the regular session of the Health Board. A quorum beingagainst,abstain on
	Andrew C. Joseph Dr
·	Chairman
June 19, 2017	Ling Abokan



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 Indians Confederated Tribes of Umatilla Confederated Tribes of Warm Springs Coquille Tribe Cow Creek Band of Umpqua Cowlitz Indian Tribe Hoh Tribe Jamestown S'Klallam Tribe Kalispel Tribe Klamath Tribe Kootenai Tribe Lower Elwha Klallam Tribe Lummi Nation Makah Tribe Muckleshoot Tribe Nez Perce Tribe Nisqually Tribe Nooksack Tribe NW Band of Shoshone Nation Port Gamble S'Klallam Tribe Puyallup Tribe Quileute Tribe **Ouinault Indian Nation** Samish Indian Nation Sauk-Suiattle Tribe Shoalwater Bay Tribe Shoshone-Bannock Tribes Skokomish Tribe Snoqualmie Tribe Spokane Tribe Squaxin Island Tribe Stillaguamish Tribe Suquamish Tribe Swinomish Tribe Tulalip Tribe

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Upper Skagit Tribe

Yakama Indian Nation

Resolution # 17-02-03

"Support submission of grant for CDC funding for Northwest Tribal Comprehensive Cancer Project"

WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS, the Northwest Portland Area Indian Health Board is a "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

WHEREAS, the Northwest Portland Area Indian Health Board is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the primary goal of the NPAIHB is to improve the health and quality of life of its member Tribes; and

WHEREAS, cancer is the second leading cause of death for AI/AN in the Northwest; and

WHEREAS, AI/AN age adjusted cancer mortality rates are the second highest among all races in the Northwest; and

WHEREAS, cancer is a priority for the NPAIHB identified in the board strategic plan; and

WHEREAS, the Centers for Disease and Control and Prevention have issued a request for applications for CDC-RFA-DP17-1701 and is titled: Cancer Prevention and Control Programs for State, Territorial, and Tribal Organizations; and

WHEREAS, the Northwest Tribal Comprehensive Cancer Project has the experience and capacity to carry out activities of the proposed comprehensive cancer project: support cancer coalition efforts; plan and implement strategies; build on partnerships; promote capacity building at the tribal level; and support the development and implementation of community based intervention strategies through policy, systems and environment to address cancer, and develop action plans for cancer prevention and control; and

Resolution # 17-02-03

"Support submission of grant for CDC funding for Northwest Tribal Comprehensive Cancer Project"

WHEREAS, the Northwest Portland Area Indian Health Board supports the Northwest Tribal Comprehensive Cancer Project to continue building on our 5-year comprehensive cancer control program.

NOW, THERFORE BE IT RESOLVED that the NPAIHB approves a submission of a grant application to the CDC to request funding for Comprehensive Cancer Control

CERTIFICATION

NO. 17-02-03

Northwest Portland Area Indian I	adopted at the regular session of the Health Board. A quorum being
established; 9 for, 6 for, 19, 2017.	_against,abstain on
	Andrew C. Joseph Dr
	Chairman
Date 19-2017	Lieg Abrilandon Secretary.



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Upper Skagit Tribe Yakama Indian Nation

Resolution # 17-02-04

Approval of Background Check Policy

WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS, the Northwest Portland Area Indian Health Board is a "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

WHEREAS, the Northwest Portland Area Indian Health Board is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the primary goal of the NPAIHB is to improve the health and quality of life of its member Tribes; and

WHEREAS, the Northwest Portland Area Indian Health Board's policies and procedures are subject to the requirements of the Indian Child Protection and Family Violence Prevention Act (ICPA), 25 U.S.C. §§ 3201 - 3210; and

WHEREAS, ICPA requires that a criminal background check be conducted for all potential hires, existing employees, assignees, interns, contractors and volunteers who have regular contact with children; and

WHEREAS, the Northwest Portland Area Indian Health Board seeks to comply with ICPA and provide protection and safety for children.

NOW THEREFORE BE IT RESOLVED that the Northwest Portland Area Indian Health Board approves the Background Check Policy and it is incorporated into the Program Operations Manual of the Northwest Portland Area Indian Health Board.

WHEREAS, the Northwest Portland Area Indian Health Board is dedicated to assist

ACT (ICPA), 25 U.S.G. \$9 3201 - 3210, and

CERTIFICATION

NO. 17-02-04

· ·	adopted at the regular session of the
Northwest Portland Area Indian H established; for, for, 2017.	eann Board. A quorum beingagainst,abstain on
	Andrew C. Joseph In
	Chairman
January 19,2017 Date	Liney J. Abrikanis Secretary.

PROGRAM OPERATIONS MANUAL

SECTION J: BACKGROUND CHECK POLICY

Policy

Once an individual has (A) received a conditional offer of employment from NPAIHB and (B) passed the background check requirement set forth in Section K, Child Background and Character Investigation Policy, which requires background checks for certain criminal history pursuant to Federal law, NPAIHB may thereafter make a good faith determination about whether there is any other criminal history in the individual's criminal record that may disqualify the individual from performing in the job position for which the individual received the conditional offer of employment.

As one example, but not limited hereto, NPAIHB may in its discretion determine not to place an individual in a job position involving access to or responsibility for NPAIHB financial resources or signatory authority for the NPAIHB when the individual has a criminal history of fraud, theft or other financial crimes.

Consideration of Background Check Findings

NPAIHB will consider the following:

- A. The nature and seriousness of the crime;
- B. The relationship of the crime to the work to be performed in the position;
- C. The extent to which the position might offer an opportunity to engage in further criminal activity;
- D. The nature and extent of the individual's past criminal activity;
- E. The individual's age at the time of the crime;
- F. The amount of time that has elapsed since the crime; and
- G. Any evidence of the person's rehabilitation.

In making these post-offer considerations, NPAIHB will not:

- A. Consider any "arrest history" that did not lead to conviction or juvenile adjudication, unless the related crime or act that would be a crime if committed by an adult is unresolved, or related criminal charges or juvenile adjudication are still pending against the applicant (NPAIHB may consider arrest records less than 1 year old that have not resulted in acquittal or have not been dismissed); and
- B. Consider any "conviction history" that was judicially voided or expunged, or that was resolved through the completion of a diversion or deferral-of-judgment program for offenses not involving physical harm or attempted physical harm to a person.

Determination and Rescission of Conditional Offers

NPAIHB may choose to rescind a conditional offer of employment based on the considerations above if NPAIHB determines in good faith that doing so is warranted as being <u>job-related and consistent</u> with business necessity.

Before rescinding the offer, NPAIHB will provide the individual with an opportunity to explain why the conditional offer of employment should not be rescinded. The individual will receive a written summary of all derogatory information and be informed of the process for explaining, denying or refuting the unfavorable information. The actual background investigative report shall not be released to

PROGRAM OPERATIONS MANUAL

the individual who is the subject to the background investigation, but such individual may, to the extent permissible by law, obtain a copy of the reports from the originating agency (Federal, State or Tribal) and challenge the accuracy and completeness of the information maintained by that agency.

Should NPAIHB decide to proceed with rescinding the conditional offer of employment, NPAIHB will promptly notify the individual in writing. The written notification will at a minimum state that the conditional offer of employment has been withdrawn and identify the specific item of criminal history on which the rescission is based and the source of that criminal history.

Confidentiality

NPAIHB will maintain and keep confidential any criminal history that it obtains, consistent with the requirements set forth in Section K, *Child Background and Character Investigation Policy*, unless disclosure is required or permitted by law.

SECTION K: CHILD PROTECTION BACKGROUND CHECK POLICY

Policy

NPAIHB will not hire or employ persons, nor allow persons to volunteer, that are subject to this policy who do not meet the minimum standards of character set forth below, except as otherwise provided in this policy or by applicable law. The procedures set forth in this policy for conducting background investigations and adjudications will be used to determine suitability for employment.

1.1 Definitions

The following definitions apply to this policy:

- 1.1.1 Child means a person who is not married and has not attained 18 years of age.
- 1.1.2 **Crimes Against Persons** means a crime that has as an element the use, attempted use, or threatened use of physical force or other abuse of a person and includes, but is not limited to, homicide; assault; kidnapping; false imprisonment; reckless endangerment; robbery; rape; sexual assault, molestation, exploitation, contact, or prostitution; and other sexual assaults. In determining whether a crime falls within this category, the applicable federal, state, or Tribal law under which the individual was convicted or pleaded guilty or nolo contendere (i.e. "no contest") shall be controlling.
- 1.1.3 **Crimes of Violence** means a crime that has as an element the use, attempted use, or threatened use of physical force against the person or property of another, or any other crime that is a felony and that, by its nature, involves substantial risk that physical force against the person or property of another may be used in the course of committing a crime. In determining whether a crime falls within this category, reference may be made to the applicable federal, state, or Tribal law under which the individual was convicted or pleaded guilty or nolo contendere (i.e., "no contest").
- 1.1.4 **Employ / Employed / Employment** mean the hiring or holding of a position covered by this policy under Section 1.2 by an individual, as defined in Section 1.1.5, provided, however, that the use of one of these terms in this policy does not imply or indicate that a person is or is not an "employee" of NPAIHB.

PROGRAM OPERATIONS MANUAL

- 1.1.5 **Individual** means a person who applies for or holds a position with NPAIHB and includes, but is not limited to, the following:
 - (a) Employees of NPAIHB regardless of classification, including but not limited to regular, part-time, temporary and probationary employees.
 - (b) Persons who perform services for or under the supervision of NPAIHB.
 - (c) Persons who contract with NPAIHB to perform services in NPAIHB offices or in a location that includes regular contact with or control over a child as defined under Section 1.1.7.
 - (d) Persons who volunteer to perform services for NPAIHB in NPAIHB offices or in a location that includes regular contact with or control over a child as defined under Section 1.1.7.
- 1.1.6 Offenses Against Children means any felonious or misdemeanor crime under federal, state, or Tribal law committed against a victim who has not attained 18 years of age. In determining whether a crime falls within this category, the applicable federal, state, or Tribal law under which the individual was convicted or pleaded guilty or nolo contendere (i.e., "no contest") shall be controlling.
- 1.1.7 **Regular Contact With or Control Over a Child** means either responsibility for a child within the scope of the individual's duties and responsibilities or contact with a child on a recurring and foreseeable basis.

1.2 Applicability

1.2.1 Covered Individuals/Positions.

This policy and its procedures apply to all individuals as defined under Section 1.1.5 who apply for or hold the following positions:

(a) Positions that require, as determined by the applicable NPAIHB job description or as otherwise classified by NPAIHB, regular contact with or control over children as defined under Section 1.1.7.

1.3 Recruitment

1.3.1 Vacancy Announcements

All job vacancy announcements for positions covered by this policy shall contain an express statement that individuals must meet minimum standards of character and that a background investigation will be conducted.

- 1.3.2 Applications
 - (a) All individuals who apply for positions covered by this policy must fill out an application form.
 - (b) The job application will state that the performance of a background investigation and determination that the individual meets the eligibility criteria of this policy are conditions of employment.
 - (d) The job application form must state that the application is being signed under penalty of perjury and acknowledge that knowingly falsifying or concealing a

PROGRAM OPERATIONS MANUAL

material fact is a felony that may result in fines up to \$10,000 or five years imprisonment, or both.

1.4 Minimum Standards of Character

The minimum standards of character are a benchmark of moral, ethical, and emotional strengths established by character traits and past conduct to ensure that the individual is competent to complete his or her job without harm to children.

1.4.1 Required Standards

No individual will be placed in or will be allowed to continue to hold a position covered by this policy if he or she has been found guilty of, or entered a plea of nolo contendere (i.e., "no contest") or guilty to, any felonious offense or any two or more misdemeanor offenses under federal, state or Tribal law involving –

- (a) crimes of violence;
- (b) sexual assault, molestation, exploitation, contact or prostitution;
- (c) crimes against persons; or
- (d) offenses committed against children;

Provided, however, that all such convictions or pleas of nolo contendere or guilty will be considered in making a determination about suitability for employment unless a pardon, expungement, set aside or other court order reaches the plea of guilty, plea of nolo contendere, or the finding of guilt.

1.4.2 Meeting the Minimum Standards of Character

The minimum standards of character will be considered met only after the individual has been the subject of a satisfactory background investigation under Section 1.5 and adjudged suitable for employment under Sections 1.6 and 1.7.

1.4.3 Other Standards

An individual may be denied or dismissed from employment or from volunteering for any position involving Child Care Services if the individual has been convicted of a sex crime, an offense involving a child victim, a drug felony, or any other crime that bears on the fitness to have responsibility for safety and well-being of children, as provided in Section 1.4.1 (requiring denial of or dismissal from employment).

1.5 Background Investigations

1.5.1 Background Investigation Required

Every individual who applies for or holds a position with NPAIHB must submit to a background investigation as a condition of employment with NPAIHB.

1.5.2 Responsible Entity

NPAIHB may conduct its own background investigation or may request that a Federal or State agency conduct the background investigation on NPAIHB's behalf and provide NPAIHB with the results of the investigation.

PROGRAM OPERATIONS MANUAL

1.5.3 Notification and Acknowledgement

Before a background check is conducted, NPAIHB will obtain the individual's signature on a statement that the individual was notified of NPAIHB's requirement for a background investigation as a condition of employment under Section 1.5.1, the individual's right to receive a copy of the criminal history report and to challenge the accuracy of the information contained in the report, as provided in Section 1.6.3(c). Such a statement may be part of the application form under Section 1.3.2.

1.5.4 Steps for Conducting Background Investigations

The background check shall include the following steps and information:

- (a) Inquiries to State and Tribal law enforcement agencies for the previous five years for all places that an individual lists as current and former residences on the individual's application;
- (b) Consideration of the individual's fitness for employment and trustworthiness through inquiries with the individual's references and places of employment and education as listed on the individual's application for at least the previous five years; and
- (c) A determination of whether the individual meets the minimum standards of character set forth in Sections 1.4.1 and 1.4.2.

1.6 Adjudication

Adjudication is the process NPAIHB uses to determine suitability for employment (to assess the degree of risk the individual brings to the position and certify that the individual's past conduct does not interfere with performance of duties or pose an immediate or long-term risk for any child) and efficiency of service (to verify that the individual is able to perform the duties and responsibilities of the position and will not inhibit other employees from performing their functions).

1.6.1 General Requirements

- (a) Adjudication requires consistency in evaluation to ensure fair judgments are reached.
- (b) Each case will be judged on its own merits.
- (c) All available information, favorable and unfavorable, will be considered and assessed in terms of accuracy, completeness, relevance, seriousness, overall significance, and how similar cases have been handled in the past.

1.6.2 Adjudicating Official

NPAIHB will appoint an Adjudicating Official to conduct the adjudications under this policy. The Adjudicating Official must first have been the subject of a favorable background investigation, must be well-qualified and trained, and must be thoroughly familiar with all laws, regulations, and criteria involved in making a determination for eligibility.

1.6.3 Adjudication Process

PROGRAM OPERATIONS MANUAL

- (a) Review Background Investigation. The Adjudicating Official will review the background investigation conducted under Section 1.5 to determine character, reputation, and trustworthiness of the individual. At minimum, the review will include:
 - (1) Each security investigation form and employment application and a comparison of the information provided.
 - (2) The results of written record searches requested of local law enforcement agencies, former employers, former supervisors, employment references, and schools.
 - (3) Any other information obtained through the background investigation. This includes character and personal reference checks of the individual.
- (b) Consider Circumstances. The Adjudicating Official must consider the information under Section 1.6.3(a) in light of the following:
 - (1) The nature and seriousness of the conduct in question;
 - (2) The recentness and circumstances surrounding the conduct in question;
 - (3) The age of the individual at the time of the incident;
 - (4) Societal conditions that may have contributed to the nature of the conduct;
 - (5) The probability that the individual will continue the type of behavior in question; and
 - (6) The individual's commitment to rehabilitation and a change in the behavior in question.
- (c) Opportunity for review. Before the adjudication is final, the individual will be given an opportunity to explain, deny or refute unfavorable or incorrect information gathered in an investigation.
 - (1) The individual will receive a written summary of all derogatory information and be informed of the process for explaining, denying or refuting unfavorable information.
 - (2) The actual background investigative report shall not be released to the individual who is the subject to the background investigation, but such individual may, to the extent permissible by law, obtain a copy of the reports from the originating agency (Federal, State or Tribal) and challenge the accuracy and completeness of the information maintained by that agency.
- (d) Final Determination. The Adjudicating Official will make a final determination regarding whether the individual meets the minimum standards of character set forth in Section 1.4. The Adjudicating Official's decision is final, and is not subject to the grievance procedures set out in NPAIHB's Program Operations Manual.

1.6.4 Investigation Information

- (a) The results of an investigation cannot be used for any purpose other than to determine suitability for holding a position that is subject to this policy.
- (b) Investigative reports will be maintained confidentially and in securely locked files.
- (c) Investigative reports shall be seen only by those officials who, in performing their official duties, need to know the information contained in the report.

PROGRAM OPERATIONS MANUAL

(d) NPAIHB will comply with the applicable privacy requirements of any Federal, State or Tribal agency providing background investigations.

1.7 Outcome

Once the background investigation has been conducted under Section 1.5 and the adjudication process is complete under Section 1.6, the Adjudicating Officer's final determination under Section 1.6.3(d) will be applied as follows:

- (a) **Suitable for Employment**. The individual will be deemed suitable for employment when it has been adjudicated under Section 1.6 that the individual meets the minimum standards of character set forth in Section 1.4. Suitability for employment will not necessarily result in the individual being hired or retained.
- (b) **Employment Must be Denied**. NPAIHB must deny employment to or dismiss the individual when it has been adjudicated under Section 1.6 that the individual fails to meet the minimum standards of character set forth in Section 1.4.1.

1.8 Pending or Unresolved Charges

If an individual who is applying for or holds a position with NPAIHB is charged with an offense covered by this policy under Section 1.4.1, but the charge is pending or no disposition has been made by a court, NPAIHB may, in its discretion, do any of the following:

- (a) Deny employment until the charge is resolved;
- (b) Deny the individual any on-the-job contact with children until the charge is resolved;
- (c) Reassign the individual to other duties that do not involve regular contact with children;
- (d) Suspend the individual until the charge is resolved.