Health News & Notes

Northwest Portland Area Indian Health Board

Indian Leadership for Indian Health

A Publication of the Northwest Portland Area Indian Health Board

October 2016

A NEW APPROACH TO CHRONIC DISEASE PREVENTION

By Nora Alexander *(Nez Perce)*
WEAVE-NW Project Specialist
Jenine Dankovchik
WEAVE-NW Biostatistician & Program Evaluation Specialist
Nanette "Star" Yandell
WEAVE-NW Project Director & Epidemiologist

A group of Northwest Tribes gathered in Portland, Oregon in early September to discuss their Good Health & Wellness in Indian Country Initiative projects. Topics were diverse and included:

- Food Systems and Policy
- Health System Improvements
- Youth Leadership and Engagement
- Community Health Assessments

The gathering culminated in poster sessions of specific tribal work, while providing an opportunity for collaboration, networking, sharing of strategies, and discussion of lessons learned from the past year.

Good Health & Wellness in Indian Country Initiative is WEAVE-NW

The Centers for Disease Control and Prevention (CDC) is working with American Indian tribes, Alaska Native villages, tribal organizations, and tribal epidemiology centers to prevent chronic disease and reduce health disparities through innovative and culturally relevant approaches for each unique tribal community. The Northwest Tribal Epidemiology Center, based in Portland, was awarded a five year cooperative agreement through this initiative and now calls this project WEAVE-NW symbolizing the weaving and on-going collaboration with Northwest Tribes.

WEAVE-NW has provided $500,000 in direct sub-award funding to 14 tribes in the Northwest region. The remaining 29 federally recognized tribes in the Northwest are offered technical assistance in the form of trainings, data analysis, survey design, program evaluation, and cultural adaptation of resources.

WEAVE-NW Tribal Projects

Tribal departments receiving direct funding include tribal health clinics, planning departments, community health centers, social services, traditional food programs, and environmental protection programs. This diverse alliance of departments reflects the innovative cross-cutting strategies that tribal communities are using to prevent and manage chronic disease.

Food Systems and Policy

To improve food systems, some projects are

continues on page 10

IN THIS ISSUE:

Chronic Pain

ISSUES IMPACTING TRIBAL HEALTH PROGRAMS

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

A number of developments on important issues impacting tribal health programs have occurred over the past few months. This article briefly discusses the following issues: the status of the FY 2017 IHS budget; IHS reform legislation; ongoing tribal consultation sessions for newly-proposed rules and policies; Contract Support Costs appropriations and policy developments; IHS headquarters realignment; VA reimbursement for direct care services; and IHS's recent decision to not appeal a ruling requiring full compensation for ISDEAA leases.

FY 2017 Continuing Resolution and the IHS Budget

Just as fiscal year 2016 was coming to a close, Congress approved a ten-week continuing resolution (CR) which will provide FY 2017 funding for the Indian Health Service and other federal agencies. The CR, signed by the President as Public law 114-223, extends funding through December 9, 2016. The CR will provide IHS funding on a pro rata basis at the FY 2016 levels and under the authority and conditions of the FY 2016 Appropriations. Increases or other changes proposed by the House and/or Senate Appropriations Committees for FY 2017 are not in effect during the CR period and their fate is dependent upon negotiations on an appropriations bill that will extend through the end of FY 2017. Congress is currently out of session because of the elections and will return on November 14. Then they are expected to be in session through mid-December (except for the week of Thanksgiving).

Negotiations in the post-election session (also known as a "lame duck" session) will be difficult, especially if members stand pat on wanting various policy riders included in the funding bills. The Appropriations Committees have reported out their respective appropriations bills, including bills that contain the IHS budget. There are a number of differences between the House and Senate Interior, Environment, and Related Agencies Committee recommendations for the IHS.

The House bill has $84 million more for the IHS than does the Senate version. The difference is due to the different ways in which they propose budgets allocate funding; the House version includes $143 million for "built-in costs" which are spread among the programs while the Senate bill would allocate little funding for this purpose. Built-in

ISSUES IMPACTING TRIBAL HEALTH PROGRAMS

costs include medical and non-medical inflation, pay increases (1.6%), and population growth. (The IHS budget has in recent years been receiving little in the way of funding for built-in costs; the FY 2016 amount was $19 million.) The Senate bill, on the other hand, would provide more funding than does the House for a behavioral health initiative ($25million) and a Native youth initiative ($17 million). The House bill would provide $3 million more for Urban Indian Health and $46 million more for Purchased/Referred Care than would the Senate. These issues will need to be resolved in conference or behind-the-scenes negotiations.

Both bills would provide indefinite funding ("such sums as necessary") for Contract Support Costs, with the estimated FY 2017 need being $800 million.

Congressional Committees Approve IHS Reform Bills, S. 2953, H.R. 5406

In September two bills designed to bring reform to the Indian Health Service were considered in congressional committee markups. The bills were drafted in large part a response to the serious IHS health delivery problems in the Great Plains region, but they will have agency-wide impacts if enacted. The bills are S. 2953, the IHS Accountability Act of2016 (introduced by Senate Committee on Indian Affairs Chairman John Barrasso (R-WY)) and H.R. 5406, the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare (HEALTTH) Act, introduced by Representative Noem (R-SD). Both bills were amended and then approved by the respective committees on September 21, 2016.

The Senate Committee on Indian Affairs approved a substitute amendment to S. 2953 offered by Chairman Barrasso. As amended, the bill would make changes to IHS procedures including employee hiring, removal, demotion, and incentives and beef up whistleblower protections for IHS employees. It would also require an IHS-wide centralized system to credential health professional volunteers and extend liability protection to certain volunteers; require a review of any patient deaths alleged to be the result of substandard care or potential criminal acts; commission GAO reports on IHS staffing and professional housing needs; impose new measures for fiscal accountability; and mandate a negotiated rulemaking process to establish a new IHS tribal consultation policy. Though S. 2953 as amended was approved by a majority of the Committee, Ranking Member Jon Tester (D-MT) opposed the bill, even while acknowledging a "laundry list of problems" with the IHS. He objected specifically to the employee disciplinary provisions in the bill, which would limit the appeal rights of IHS employees, stating

continues on page 4

IMPACTS ON TRIBAL HEALTH PROGRAMS

continued from page 3

that the provisions raised constitutional concerns and would likely discourage health professionals from wanting to work at the IHS. Senator Tester announced that he will distribute a "comprehensive draft bill" of his own on IHS reform in the near future.

Meanwhile, the House Ways and Means Committee considered one specific provision of H.R. 5406, concerning the IHS loan repayment program. The provision would change the tax code by excluding from taxable income the amount of the IHS loan repayment a person receives something that, if not excluded, often bumps the recipient into a higher tax bracket. Participants in the National Health Service Corps (NHSC) loan repayment program already receive this tax benefit, and at the markup Committee Chairman Kevin Brady (R-TX) introduced an amendment which would, in his words, "align" the IHS program proposed in H.R. 5406 with the NHSC program by limiting the IHS exclusion to only those specified health professions eligible for participation in the NHSC program. In practice, the NHSC has a smaller list of medical professions eligible for its loan repayment program than does the IHS. The Committee approved the Brady amendment, and should Congress consider a tax bill in the lame duck session, this provision might make its way into such a bill. Other provisions of H.R. 5406 not considered by the Ways and Means Committee include: a long-term contracting pilot program for IHS hospitals; changes to IHS hiring, removal, demotion, and incentive authority; a requirement that the IHS promulgate regulations to monitor timeliness of care in IHS facilities; a requirement that the IHS consult with tribes to develop a cultural competency program; a requirement that the IHS implement a uniform credentialing system for licensed health professional volunteers; and changes to the Purchased/Referred Care program, including the funding distribution formula.

IHS Seeks Tribal Comments on Proposed Rules and Policies

The IHS extended the comment period and will host additional tribal consultation sessions for three proposed rules and draft policies.

First, the IHS has extended the submission deadline for comments on the draft policy statement to expand the Community Health Aide Program (CHAP), which would expand the use of community health aides, including dental health aide therapists, at IHS facilities nationwide. Comments must be received by 5:00pm on October 27, 2016, and they should refer to "IHS Expansion of CHAP Draft Policy Statement Consultation." The comments may be submitted via email at consultation@ihs.gov.

Second, the IHS has extended the submission deadline for comments on the draft circular addressing the purchase of health care coverage, which is commonly referred to as Tribal Premium Sponsorship. Comments must be received by 5:00pm on October 31, 2016, and may be submitted via email at consultation@ihs.gov. IHS will also hold an in-person consultation session at the National Congress of American Indians 73rd Annual Convention and Marketplace in Phoenix, Arizona, on October 9, 2016.

Third, the IHS announced that it will engage in additional tribal consultations on the proposed rule for the Catastrophic Health Emergency Fund (CHEF), which addresses the extraordinary medical costs associated with treating victims of disasters or severe illnesses within IHS and tribal facilities. The next tribal consultation session will take place in person at the same NCAI Convention mentioned above on Sunday, October 9, 2016, from 1:00 pm - 2:00 pm. The final consultation will take place via conference call on Monday, October 24, 2016 from 1:00 - 2:00 pm (Eastern Time). To join the call, dial 888-790-3108 and enter the passcode 4110567.

Contract Support Cost Developments

After almost a year of intensive negotiations, the new IHS contract support cost (CSC) policy is near completion. On September 15-16, 2016, the IHS CSC Workgroup met in Washington, D.C. to address comments provided during tribal consultation on the draft policy. As usual, the negotiations were tense and at times heated. In the end, however, tribal representatives were able to secure agreement on

IMPACTS ON TRIBAL HEALTH PROGRAMS

important improvements to the policy.

For example, the policy places strict limitations on when, and to what extent, IHS can review tribal health programs for duplication between CSC and the "Secretarial" or program amount. Such IHS reviews can lead to a significant reduction in a Tribe's CSC funding. Tribal representatives on the Workgroup negotiated a grandfather provision under which established contracts and compacts will not undergo duplication analysis unless one of three "triggers" is pulled: (1) the tribe adds new or expanded programs, in which case the new or expanded portion would be scrutinized for duplication; (2) the tribe adds a new type of cost that raises the value of the indirect cost pool by 5% or more, in which case the new cost is evaluated for duplication; or (3) the tribe requests a duplication analysis (which will likely never happen unless one of the other two triggers applies). This structure minimizes the extent to which tribes must undergo a potentially costly duplication review.

IHS also demonstrated some flexibility on how it would negotiate direct CSC, and promised to share data on the agency's fringe rate as well as the CSC distribution reports (formerly known as the "shortfall reports") for 2013, 2014, and 2015.

Many unresolved issues remain, however. In a recent letter to IHS, Andy Joseph Jr., Chairman of NPAIHB and Tribal Co-Chair of the IHS CSC Workgroup, laid out the positive changes to the policy but also several remaining challenges. For example, IHS refuses to pay CSC on several categories of funds that tribes believe should be eligible, such as Catastrophic Health Emergency Fund (CHEF) reimbursements and Methamphetamine and Suicide Prevention Initiative (MSPI) funds. IHS also interprets the law to prohibit duplication of funding categories rather than funding dollars meaning that if the Secretarial amount includes any funding for, say, Information Technology, then the Tribe is entitled to no CSC for IT, whatever the actual cost.

IHS plans to finalize the new CSC policy by the end of October. On the implementation front, the CSC Workgroup continues to review and fine-tune the Annual CSC Calculation (ACC) spreadsheet that IHS uses to estimate CSC needs at the beginning of the fiscal year, update them during the year, and reconcile needs and payments after the close of the year.

IHS Headquarters Realignment

The Indian Health Service is proposing a realignment of its Headquarters staff as part of an effort to improve the operation of the agency. Not all details are yet known, although the IHS is expected to send out a Dear Tribal Leader Letter (DTLL) with additional information, including job descriptions, in the near future. Following that there is to be a 30-day consultation period.

In a recent conference call IHS Principal Deputy Director Mary Smith spoke about this initiative, and made the point that she considers its proposal a "realignment" rather than a "reorganization". She said that the realignment would not reduce the authority of the IHS Areas, including their procurement authority, and that it will have no impact on what tribes/tribal organizations are receiving under the Indian Self-Determination and Education Assistance Act.

Under the proposal the number of Deputy Directors will be reduced from six to one. The other Deputy Director positions will be deemed to be Associate Directors. There will also be a Chief Operating Officer. A chart which shows this arrangement and which programs are included under each Associate Director will be posted on the IHS website.

The IHS is planning to have the realignment in place by the end of 2016, and while she acknowledged that a new Administration would have the authority to change it, Principal Deputy Director Smith characterized it as a sensible realignment which will improve the IHS.

Reimbursement from the Veterans Administration for Direct Care Services

Many tribes and tribal organizations have entered into agreements with the Veterans Administration (VA) to provide for the VA to reimburse tribal programs for

continues on page 11

CURING HEPATITIS C

By David Stephens, *BSN, RN*
HCV Clinical Services Manager, NPAIHB

Jessica Leston, *MPH HIV/STI/HCV*
Clinical Programs Director, NPAIHB

Hepatitis C virus (HCV) is a chronic infection that can cause liver damage and liver cancer. About 20,000 persons die from HCV each year. Hepatitis C is a preventable and curable disease. So why are so many people dying?

Most HCV falls on baby boomers – those born from 1945 to 1965 – many of whom have unknowingly been living with the infection for many years. Persons infected with HCV usually have no symptoms and do not know they are infected. Baby boomers may have been infected during medical procedures decades ago when injection and blood transfusions were not as safe as today. These infections from many years ago are now showing up as long term liver damage. Damage that can be stopped and even reversed with diagnosis and treatment.

HCV testing is recommended for all adults born from 1945 through 1965, regardless of risk factors

For more testing recommendations and ways HCV can be transmitted please visit: cdc.gov/hepatitis/hcv/cfaq.htm

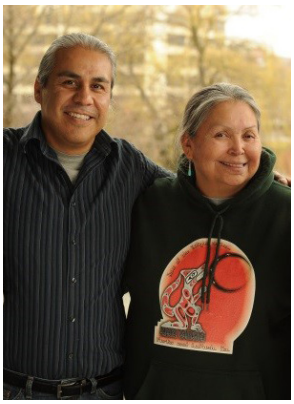
In order to better understand HCV among NW Tribes, Project Red Talon performed Electronic Health Record (EHR) audits to determine caseload and awareness of HCV disease in the Portland Area. The project identified persons in EHRs with a probable HCV diagnosis, age, antibody and RNA test results, genotype, and liver function and platelet test results (to determine stage of liver disease).

635 unique patients were found with an HCV diagnosis, and 382 (60%) were born between 1945 and 1965. This represents only a small fraction of the total number of baby boomers in the Portland area that have been screened 2444/6812 (35.8%), despite the CDC recommendation that all people born between 1945 and 1965 get tested for hepatitis C.

New Cures. HCV has historically been difficult to treat, with highly toxic drug regimens and low efficacy (cure) rates. In recent years, however, medical options have vastly improved: current treatments have almost no side effects, are oral-only, and have cure rates of over 90%.

Current treatments have almost no side effects, and have cure rates of over 90%.

Curing a patient of HCV greatly reduces the risk of liver cancer and liver failure. New drug regimens have made early detection and treatment of HCV critical, although the main barrier to treatment has been cost. The New medications have been among the most expensive in history, although private and public insurance companies are beginning to cover the two to three month oral regimen and help cure this chronic disease.



It has been estimated that the HCV caseload in Indian Country is 120,000 patients. The best estimates of how many patients are being treated does not come close to meeting clinical need and preventing HCV-related deaths, although by treating at the primary care level, we can begin to eradicate this disease.

Case Study: Treating Chronic Hepatitis C at the Lummi Tribal Health Center

Early in 2016 the Lummi Tribal Health Center began developing a program to treat chronic HCV infection at our primary care clinic. Rates of new HCV infection were found to be 40 times higher than the neighboring non-native community, which unfortunately parallels national data for AI/AN people. The high incidence of new HCV infection is largely secondary to high numbers of persons who inject drugs within AI/AN

CURING HEPATITIS C

communities. On an individual level, untreated HCV can cause significant long-term health problems including cirrhosis and liver failure. From a public health perspective, rates of new infection will continue to rise unless a considerable number of people with chronic HCV who continued to inject drugs are treated. We therefore adopted a treatment-as-prevention approach in developing our program.

For many decades, treating hepatitis C was the work of specialists. However, in the last five years, the introduction of new direct acting antiviral (DAA) medications have allowed primary care providers to begin treating hepatitis C. These medications have been shown to cure hepatitis C at rates above 95%, and have safety profiles equal to or better than many other medications routinely prescribed in primary care. As we looked closely at developing our program, it became fairly clear that we already had a significant amount of institutional knowledge to support this effort given decades of experience treating other chronic diseases such as diabetes.

…we already had a significant amount of institutional knowledge to support this effort given decades of experience treating other chronic diseases such as diabetes.

The experience in case management, managing patient registries, ensuring close follow up for routine labs, and monitoring medication compliance were skill sets already in place, which could be redirected to a different disease state.

The primary barrier to implementing our program was provider knowledge and comfort in prescribing the new DAA medications. We elected to send one of our physicians to the University of New Mexico, which is an opportunity offered to all IHS, tribal and urban providers, for a two-day HCV training.

"we are proving that hepatitis C is treatable in our communities, by our own providers."

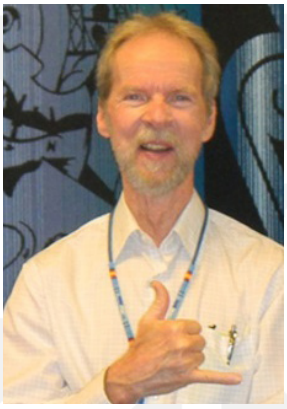
Additionally, two providers completed the University of Washington Hepatitis C Online course (http://www.hepatitisc.uw.edu/) which is free to the public and provides continuing education for clinicians. This course was comprehensive and tailored to providers of all types, including RN's and pharmacists. We continually reference HCVGuidelines.org which provides the most up-to-date treatment protocols for HCV, and is managed by the AASLD (American Association for the Study of Liver Disease) and IDSA (Infectious Disease Society of America). In addition to these resources, we now participate in Project ECHO (Extension of Community Healthcare Outcomes) with the University of New Mexico (UNM). Project ECHO is a bi-monthly 1 hour web-based conference call for didactics and the opportunity to present patient cases to UNM specialists for treatment recommendations. In the State of Washington, participation with Project ECHO is required for Medicaid coverage of the DAAs.

A secondary barrier to implementing our program was accessing the DAAs given their high cost and complex prior-authorization process. Fortunately, in the State of Washington, Medicaid will approve payment for nearly every patient with chronic HCV (as of June 2016). This includes patients who are actively injecting drugs and/or using alcohol.

Medicaid will approve payment for nearly every patient with chronic HCV (as of June 2016). This includes patients who are actively injecting drugs and/or using alcohol.

continues on page 9

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

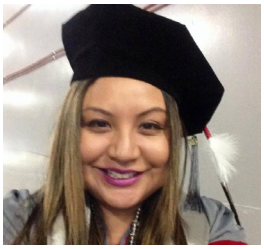


By Dr. Tom Becker
NW NARCH & Cancer Project Director

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

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

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



Dr. Crystal Lee, *(Navajo)*
NW NARCH Fellow
Ph.D in Public Health

How did I learn about the NW NARCH Fellowship?
I learned about the NW NARCH Fellowship at the attendance of the American Public Health Association American Indian, Alaska Native, Native Hawaiian Caucus networking session, where the information was provided. I put the NW NARCH flyer in my bag and found it a year later. When I found it, I emailed Dr. Tom Becker asking him if I was eligible for any financial assistance, and in a couple of weeks I was awarded!

Why did I choose my specific degree?
I chose this specific degree because as a child I was always interested in health and healing due to both my maternal and paternal grandfathers being Navajo medicine men. I knew I wanted to become a doctor to help my people. However, I did not know about public health until I graduated from my undergraduate degree program. Then, I got a job working for National Institutes of Health under their Diabetes Prevention Program Outcomes Study as a clinical data collector and fell in love with public health, which is essentially population health and preventative medicine. I knew I could help a lot of people with this degree and continued my education in the public health discipline.

After graduating, what are my career goals and/or educational goals?
My career goals are to become a successful Native researcher, educator, and leader to ultimately contribute to the scientific field of health and healing for Native people. To jumpstart my career, I got accepted to a Post-Doctoral Fellowship program at UCLA David Geffen School of Medicine under their Semel Institute & Department of Psychiatry, Global Center for Children & Families, Center for HIV Prevention & Treatment Services. I am doing HIV combination prevention research and I am the first Native to be selected for this academic appointment.

How did the NW NARCH fellowship help in furthering my education?
The NW NARCH helped me by providing financial assistance so I can focus on my dissertation. The dissertation journey was already stressful enough and the NW NARCH helped to alleviate some of that stress. I am grateful for the NW NARCH because it is programs like these that help us Native students successfully continue and complete our academic journey.

What would you share with others who are seeking

continues on page 9

(NW NARCH) FELLOW HIGHLIGHTS

financial assistance?
I would tell students to be pro-active to identify and apply for any scholarships/fellowships they may qualify for. Do not be scared of rejection and APPLY! In addition, identify your scholarship point persons and thank them for helping you. Your gratitude can go a long way.

Jacob Phipps, *(Muscogee Creek Nation)*
NW NARCH Fellow
M.S. Environmental Science & Engineering; OHSU,
B.S. Chemistry; South Dakota School of Mines and Engineering

How did I learn about the NW NARCH Fellowship?
I heard about the NW NARCH Fellowship through my contacts with OHSU.

Why did I choose my specific degree?
I chose to get my masters in environmental science & engineering because I wanted to apply my background in chemistry to something I was passionate about. I love being in nature so I decided to learn more about it and the way in which we as humans perturb it.

After graduating, what are my career goals and/or educational goals?
My career goal is to own a remediation firm specifically geared for federally recognized Tribes. I currently work for Indian Health Service, which is helping me connect with Tribes as well as understand how a federal agency's conducts business.

How did the NW NARCH fellowship help in furthering my education?
For me, the NW NARCH fellowship helped me in many different ways. For one, it gave me the financial aid I needed to pay for my housing and food. The fellowship also acted as a mentorship program as I sought advice from the director and other staff members.

What would you share with others who are seeking financial assistance?
I would tell others that financial assistance is out there for those who really want it. I would suggest putting time into your letter of intent and to make it catchy/flashy, something people will remember and want to re-read.

CURING HEP C

continued from pg. 7

Other private insurance companies will also cover the DAA's. The prior authorization period has taken between 6-8 weeks and we are counseling patients about this at their initial visit.

As of today, we have nearly completed treatment with our first patient and have initiated treatment with a handful of others. Our goal is to treat over 50 patients in 2017. Many other tribal clinics around the country have also started treating hepatitis C, and are beginning to see the possibilities. From our experience thus far, treating hepatitis C is no more complicated than treating other chronic diseases like diabetes. While it may seem like a daunting task at first, with proper training and cooperation with specialists, we are proving that hepatitis C is treatable in our communities, by our own providers.

Justin Iwasaki, *MD, MPH Executive Medical Director, Lummi Nation*
David Stephens, *BSN, RN HCV Clinical Services Manager, Northwest Portland Area Indian Health Board*
Jessica Rienstra, *LPN Hepatitis C Project Coordinator, Lummi Tribal Health Center*
Ron Battle, *MD Primary Care Physician, Lummi Tribal Health Center*
Jessica Leston, *MPH HIV/STI/HCV Clinical Programs Director, Northwest Portland Area Indian Health Board*

For more information about treating HCV in your community, please contact Jessica Leston, 907-244-3888 or jleston@npaihb.org

WEAVE - NW

continued from cover page

focused on creating policies, protocols, and campaigns to improve access to affordable, healthy food, and encourage a balanced diet. Some tribes are centering on traditional foods, food sovereignty, and native medicines to address the current chronic disease in their community and to build on their community's strengths.

Several community gardens have been planted, revitalized, harvested and shared during the 2016 growing season. Providing increased access to healthy food choices and teaching one another about preparation of fresh produce has had a positive impact across communities. For example, two sub-awardee tribes have set-up 'food shares' to help distribute their produce. Community members sign-up to receive a box or bag of produce from the garden and it is delivered to them weekly. Included in these 'food shares' are recipes and information about the garden.

Health System Improvements

Health care delivery improvements can ensure that patients don't fall through the cracks in the system. Increasing access to preventative care is key to combat chronic disease. Multiple projects are focused on improving their health systems by identifying patients who may be at greater risk for cardiovascular disease, diabetes, and obesity. Clinic directors and staff are working closely across tribal programs linking behavioral health, family services, registered dieticians, and community health representatives to develop and implement improved cardiovascular disease (CVD) case management and chronic disease population management systems. Linking services will ensure that those at high risk of chronic diseases like CVD or type II diabetes can access all of their community resources to best manage or prevent these conditions.

Youth Leadership and Engagement

Youth are the future. Investing in the youth is important to our tribal communities and exemplifies the dedication needed to protect tradition and continue the great strides forward. Youth driven projects include implementing a culturally adapted Youth Risk Behavior Surveillance System (YRBSS) that will result in youth identified priority areas for 2017 projects. This strategy will help youth develop leadership skills and empower them to be health advocates for their community. Other projects are focused on developing curricula that train youth in environmental science, traditional foods, gardening, and policy development.

Community Health Assessments

Community Health Assessments have been completed for two of our sub-awardee tribes. With community input, these assessments will be used to develop community health action plans to guide the work moving forward. This past year has included focus groups, community forums, and trainings on interview techniques to make sure the voices of the communities are included in these assessments.

Tobacco Prevention

A full-time Tobacco Project Specialist is available through WEAVE-NW to help develop and expand the reach of culturally adapted commercial tobacco education campaigns and provide trainings, technical assistance, and resources.

Future Direction of WEAVE-NW

The WEAVE-NW project will continue to provide monthly webinars, regional trainings, and technical assistance in the areas of:

- data analysis
- survey design
- evaluation
- assessments
- strategic planning
- policy development
- youth engagement
- health education materials

In August 2017 WEAVE-NW will be seeking applications to fund additional sub-awardees. We are looking forward to hearing what other great ideas our Northwest Tribes have to address chronic disease through policy, system change, or environment change. If you are interested in learning more, or would like to be on our listserv for our monthly webinars, please email us at weave@npaihb.org.

IMPACTS ON TRIBAL HEALTH PROGRAMS

continued from page 5

direct care services provided to eligible veterans. The VA also has a national reimbursement Memorandum of Agreement (MOA) with the IHS, which was recently renewed through December 2017. The MOA mirrors the agreements the VA has with the individual tribal health programs. According to a member of the VA who presented at the recent National Indian Health Board's (NIHB) annual Consumer Conference, the VA has to date reimbursed over $45 million, covering more than 7,200 eligible American Indian and Alaska Native veterans since 2013. Non-native veterans are not covered by the reimbursement agreements except in Alaska, and the VA is not currently reimbursing for PRC.

Many of the existing reimbursement agreements are set to expire over the upcoming months, so tribes and tribal organizations may want to consider renewing the agreements for an additional term. Whether the VA will be open to that, and for what period of an extension, could depend on the outcome of a tribal consultation that the VA is currently conducting. The VA held an in-person tribal consultation session on September 28, 2016 in Washington, D.C. to gain tribal input into the VA's idea of combining all of the VA's multiple reimbursement programs including the IHS and tribal programs into one community care program. The VA is considering this step in order to help streamline its procedures and establish a standard reimbursement rate. A copy of the VA's Dear Tribal Leader Letter and a fact sheet about the community care program can be obtained from the VA at www.va.gov/tribalgovernment/.

Many tribes have already voiced opposition this idea and want their reimbursement agreements to be renewed without revisions when they expire. The VA indicated during the NIHB conference that it may be open to extending those for at least one additional year through December 2018 but would like to hear from tribes about that through the consultation. Written comments can be submitted to the VA at tribalgovernmentconsultation@va.gov before November 5, 2016.

IHS Declines to Appeal Ruling Requiring Full Compensation for ISDEAA Lease

The IHS chose not to appeal a July 27, 2016 final judgment ordering the agency to enter into a fully-compensated lease under Section 105(l) of the Indian Self-Determination and Education Assistance Act (ISDEAA) with the Maniilaq Association for a clinic facility in Kivalina, Alaska, as well as an earlier ruling finding that the IHS is bound by regulations defining full lease compensation under Section 105(l). The IHS had argued that the lease compensation elements set out in the regulations were not binding, and that the agency retained the discretion to set the lease compensation amount at whatever level it deemed appropriate. On March 22, 2016, Judge John D. Bates of the United States District Court for the District of Columbia ruled that ambiguities in the statute and regulations must be resolved in favor of tribes and tribal organizations like Maniilaq Association, and as a result Judge Bates ruled that Maniilaq was entitled to the full amount of lease compensation as determined under the regulatory criteria. The case is Maniilaq Association v. Burwell, No. 15-152 (D.D.C. Mar. 22, 2016).

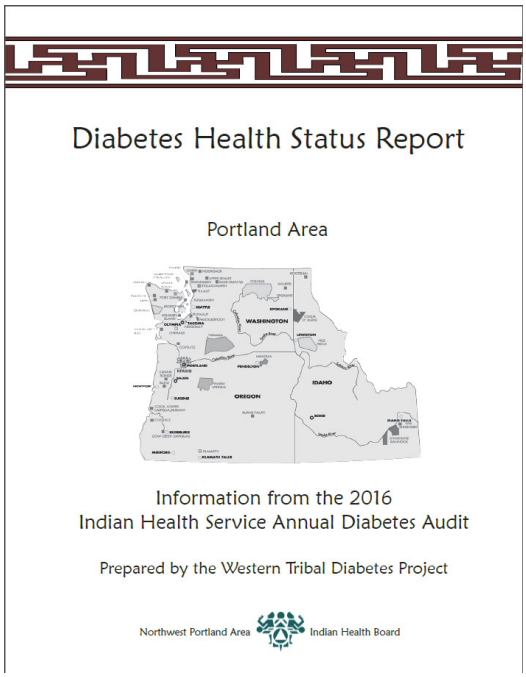
As a district court decision, Judge Bates's ruling in the Maniilaq case is persuasive but not binding legal precedent on other federal courts. The reasoning of Judge Bates's opinion, however, applies broadly to any Section 105(l) lease request for any facility used by an Indian tribe or tribal organization for the administration and delivery of services under the ISDEAA, provided that the tribe or tribal organization holds title to, a leasehold interest in, or a trust interest in the facility. This would include facilities owned by, leased by, or held in trust for a tribe or tribal organization that utilizes the facility to carry out health care programs under an ISDEAA contract or compact with the IHS. While it remains to be seen how the IHS will implement its leasing obligations under Section 105(l) in light of the Maniilaq ruling, the case is likely to have a lasting impact on federal funding for tribal health care facilities.

DIABETES HEALTH STATUS REPORT FOR NORTHWEST PROGRAMS COMPLETED

By Don Head
WTD Project Specialist

The Western Tribal Diabetes Project (WTDP) is pleased to announce the completion of the 2016 Diabetes Care and Outcome Audit Health Status Report for the Special Diabetes Program for Indians (SDPI) grantees in the Portland Area. This report was mailed on October 12 – 13, 2016 to the diabetes programs. It was also sent to the Tribal Health Directors and NPAIHB Delegates of the tribes those programs serve.

SDPI grantees are required to submit an Audit for their program to the Division of Diabetes Treatment and Prevention (DDTP) annually. The Audit adheres closely to the Standards of Care for Patients with type 2 diabetes and includes data on those indicators. Programs create a text file within their electronic health record, and upload that file to WebAudit, an online data tool provided by the DDTP. The WebAudit was created specifically for this purpose, but in recent years has included an option to create an "interim" audit, so that SDPI grantees can create the WebAudit reports throughout the year. In addition to the Audit Report, the WebAudit also has the Renal Preservation Report, the Cardiovascular Disease Report, a Means Report, and Key Measures Reports for 2015 and 2016. Programs can also access their data from previous years in which they submitted the Audit, going back to 2008. New to the Audit this year is a section on comorbidities. The section shows the percentage of patients with diabetes that also suffer from other health issues. These include depression, tobacco use, severe obesity (BMI 40+), hypertension, cardiovascular disease, and chronic kidney disease.



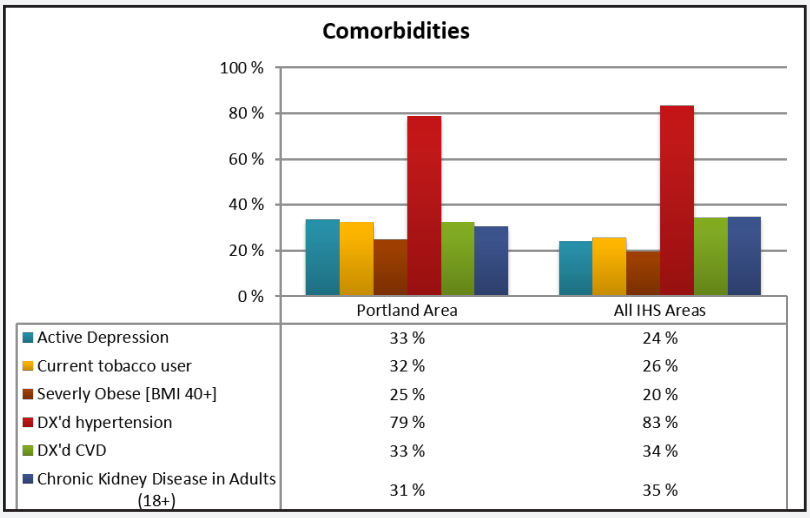
The Health Status Report (HSR) was created by the WTDP to visually represent the data within these reports in graph form. With access to multiple years of data, the WTDP saw an opportunity to show the SPDI grantees how their patient population is doing with respect to the Standards of Care over time. Beginning in 2005, the WTDP has sent each program that submits data to the DDTP the HSR. The HSR helps programs identify any data gaps in their reporting and also demonstrates the efficacy of the SPDI itself.

The HSR for 2016 is comprised of two distinct sections, a trends report and a comparison report. The trends report compares each program's audit indicators to previous years' results. The years that are trended are 2003 or 2004 (based on the initial year of data that WTDP has access to), and the most recent four years (2013-2016). In a few cases, the indicators have changed so much over the years that trending them out would not make sense logically. In these cases, these indicators have been dropped from the report. Those indicators that can be compared throughout the years, however, have been included.

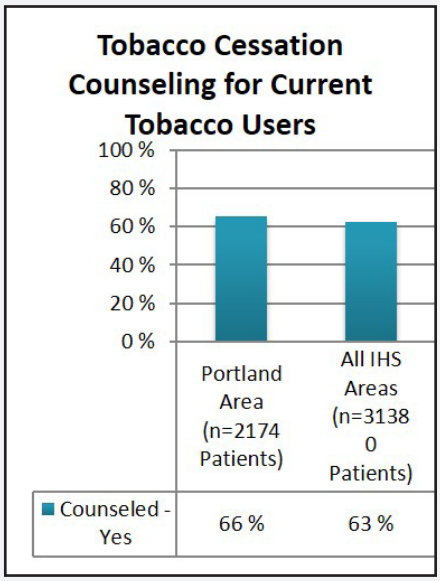
The other section, the comparison report, compares each program's Audit indicators for 2016 to the results of all the reporting programs in the Portland Area. In the cases of some of the indicators, notes have been included from the Standards of Care for Patients with type 2 diabetes, to provide more information about the indicator, or to explain why the indicator is important to patient health.

DIABETES HEALTH STATUS REPORT FOR NORTHWEST PROGRAMS COMPLETED

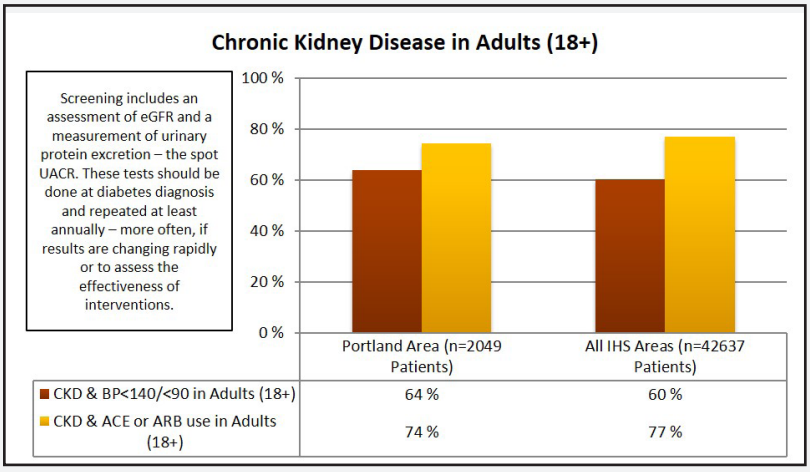
The WTPD also has created a HSR for the Portland Area, which shows the trends of the reporting SPDI grantees in the Portland Area, and compares the Portland Area's results to all of IHS programs nationwide. You can view and download this report on the NPAIHB website.



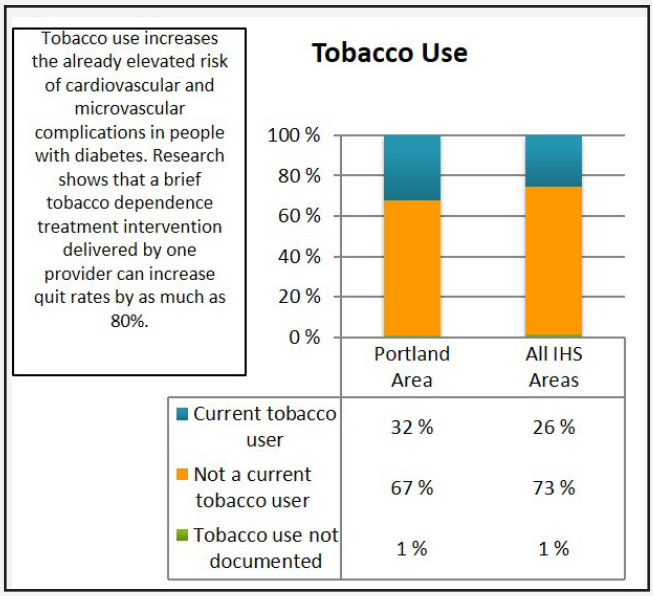
	Portland Area	All IHS Areas
Active Depression	33 %	24 %
Current tobacco user	32 %	26 %
Severly Obese [BMI 40+]	25 %	20 %
DX'd hypertension	79 %	83 %
DX'd CVD	33 %	34 %
Chronic Kidney Disease in Adults (18+)	31 %	35 %



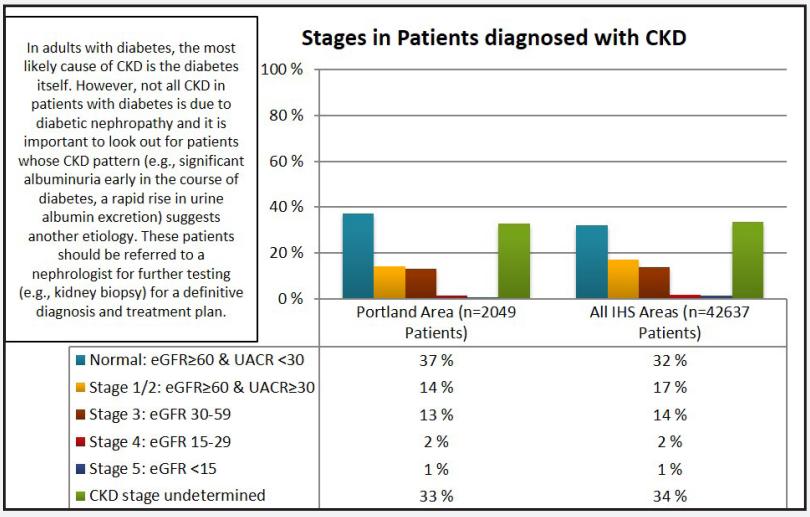
	Portland Area (n=2174 Patients)	All IHS Areas (n=31380 Patients)
Counseled - Yes	66 %	63 %



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



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



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

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

WWW.HEALTHYNATIVEYOUTH.ORG

The NW Tribal EpiCenter is pleased to share a new resource for AI/AN health educators: www.HealthyNativeYouth.org

The site was designed to support the dissemination of health curricula to tribal health educators and teachers, and empower AI/AN communities to select and implement evidence-based programs.

The portal allows visitors to filter and compare curricula on several dimensions, including student's age, delivery setting, duration, cost, and evidence of effectiveness, to determine best-fit for their community or setting. The portal currently includes Native It's Your Game (Native IYG), Native STAND, Native VOICES, Safe in the Village, We R Native and mCircle of Life. Visitors are invited to upload their own culturally-relevant programs for inclusion on the website.

Please help spread the word by sharing the site with your colleagues and tribal schools. You can also follow the site on Facebook to receive news and resources supporting AI/AN adolescent health: www.facebook.com/HealthyNativeYouth

We are eternally grateful to the workgroup members who contributed to the site's design, and to the Indian Health Service's HIV Program for supporting this work!

Please let us know if we can do anything to support your community's use of this exciting new resource.

Stephanie Craig Rushing, PhD, MPH
Northwest Portland Area Indian Health Board
Healthy Native Youth: A one-stop-shop for educators who want to expand learning opportunities for AI/AN youth: healthynativeyouth.org
We R Native: A multimedia health resource for Native youth, by Native youth: WeRNative.org | Text NATIVE to 24587

NPAIHB GATHERINGS/ANNOUNCEMENTS

NPAIHB's team HANDS (HealthyActiveNativesDoingSomething) completed Hood to Coast 2016!

Predicted time: *32:05:17*
Finishing time: *31:42:55*
Conditions: *95+ degree weather, no sleep, cold nights, dust storms, rolling hills, etc., etc.*
Course Volunteers: *Nancy Scott, Nancy Bennett, and Jacob Phipps*
Van Drivers: *Mike Feroglia and Tommy GhostDog*
Dinner Hosts: *Laura Platero, Ryan Sealy and her sister*
After Party Hosts: *Tom Weiser and family, and Anthony Aguirre (Antoinette's dad)*
NPAIHB staff: *The rest of the staff! We couldn't have done any of this without your donations!*

Native Fitness XIII (13)

This year marked the 13th year for the Western Tribal Diabetes Project coordinating the Native Fitness Event. The Event is hosted at the Nike World Headquarters in Beaverton Oregon, and continues to be a huge success. On August 30 and 31st, 180 participants from 80 different tribal programs converged on the Tiger Woods Center to participate in this interactive event. The event featured 20 breakout sessions, power chair circuit, living lean, sports speed system, mixed martial arts, fitness for kids, salsa hip hop natural running, power hour, and a nutrition and healthy cooking demonstration class.

Also included on the agenda were presentations on motivational interviewing and historical trauma in Native communities, an update from the N7 Nike program, Western Tribal Diabetes Project data/tracking and audit issues, and an opportunity for programs across the country to network and share successes and challenges in our SDPI programs. The evaluations from Native Fitness were excellent, and we are planning for next year.

INDIAN DAY / DANCING IN THE SQUARE POWWOW

Thank you to our Sponsors!

Bob's Red Mill
Columbia Printing & Clean Room, inc.
Coquille Indian Tribe
Grand Ronde Tribes
Health Share of Oregon
Hoh
Jamestown S'Klallam Tribe
NARA
Nez Perce Tribe
National Indian Child Welfare Association
Oregon Health & Science University
Port Gamble S'Klallam Tribe
Quileute Tribe
Snoqualmie Tribe
Suquamish Tribe
Swinomish Tribe
Yakama Nation Land Enterprise

SAVE-THE-DATE
7th Annual THRIVE Conference
June 26 - 30, 2017

Registration will open the first week in April 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!

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

WHY: Build protective factors and increase your skills and self-esteem, connect with other young Natives, learn about healthy behaviors (suicide prevention, healthy relationships, etc.) and how to strengthen your nation through culture, prevention, connections, and empowerment!

WHAT: This conference is made up of four workshop tracks and each youth will need to rank their preference for which workshop they want to be in when they are registered. Tracks *may* include: art, physical activity & nutrition, digital storytelling, beats lyrics leaders (song writing and production), We Are Native youth ambassador leadership (additional application required), and a science and medical track sponsored by the Oregon Health and Science University.

#WeNeedYouHere

Contact Information:
Northwest Portland Area Indian Health Board's project THRIVE
Celena McCray, project coordinator
Ph. 503-228-4185 x 270
Email. cmccray@npaihb.org
Website. http://www.npaihb.org/epicenter/project/thrive

THRIVE

Native CARS ATLAS
Native Children Always Ride Safe

save the date

January 10-12 2017

Ready to do a child safety project in your tribe?

Join us in Portland, OR for the Native CARS Atlas launch at NPAIHB January 10-12, 2017.

We will provide training, technical assistance, and limited funding to get you going on a project of your choice, such as:

- ✔ Start a car seat distribution program
- ✔ Develop a motor vehicle law that protects child passengers
- ✔ Build a community coalition around child passenger safety
- ✔ Assess child passenger safety needs in your tribe
- ✔ Learn how to collect or use data to strengthen child passenger safety
- ✔ Develop media to promote child safety seat use
- ✔ Customize a child passenger restraint education program

We will guide you through nativecars.org, an online resource developed by Northwest tribes and the Native Children Always Ride Safe (CARS) team at the NPAIHB.

Limited travel scholarships and mini-grants available for child passenger safety efforts

Contact the Native CARS team at: nativecars@npaihb.org or call 503-416-3264

UPCOMING EVENTS

OCTOBER

October 25-27
SGAC/TSGAC Self Governance 4th Quarter Advisory Committee Meeting
Washington, DC

NOVEMBER

November 1-2
2016 AIHC for Washington State's Tribal leaders Health Summit
Puyallup Tribe's Emeral Queen Conference Center, WA

November 2-4
13th Annual National Native American "Fatherhood is Leadership" Conference
Tempe, AZ

November 7-9
Tribal Interior Budget Council
Washington, DC

November 8-10
GONA Facilitator Training
Las Vegas, NV

November 10-12
American Indian Science & Engineering Society Annual Conference
Minneapolis, MN

November 18
Oregon Oral Health Coalition's 11th Aunnual Fall Conference
Portland, OR

UPCOMING EVENTS

DECEMBER

December 7-10
Native Wellness Institutie Native Youth Leadership Academy
San Diego, CA

JANUARY

January 24-26
SGAC/TSGAC Self Governance 1st Quarter Advisory Committee Meeting
Washington, DC

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

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

NORTHWEST
PORTLAND
AREA
INDIAN
HEALTH
BOARD

2121 SW Broadway • Suite 300 • Portland, OR 97201

Return Service Requested

NON-PROFIT ORG.
U.S. POSTAGE
PAID
PORTLAND, OR
PERMIT NO. 1543

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
OCTOBER 2016 RESOLUTIONS

RESOLUTION #16-04-01
NW NARCh 9 Program

RESOLUTION #16-04-02
Portland Area Fetal Alcohol Spectrum Disorders Funding