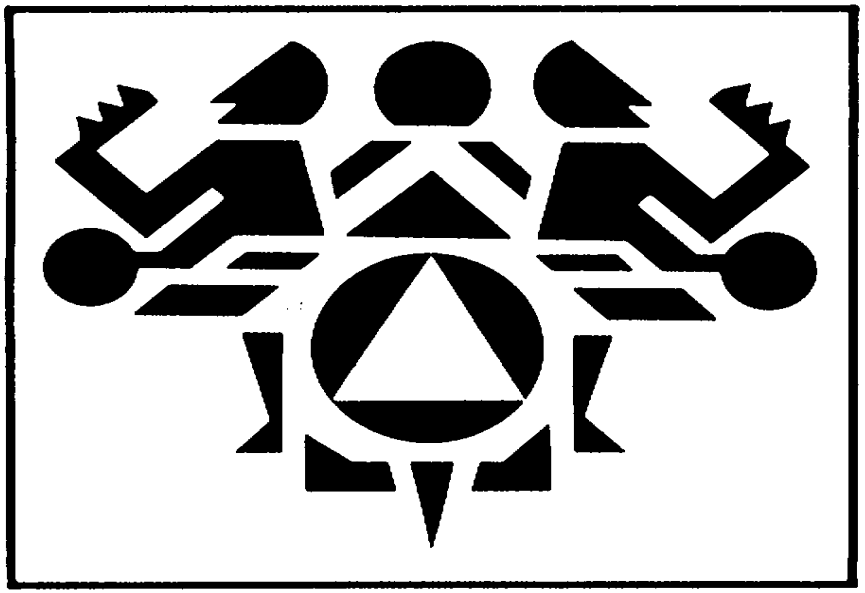
SUMMARY OF MINUTES



QUARTERLY BOARD MEETING

AUGUST 9-11, 2016

12 TRIBES RESORT CASINO

OMAK, WA

AUGUST 2016 Quarterly Board Meeting

12 Tribes Resort Casino, Omak, WA

Summary of Minutes

Issue	Summary	Action	Follow-Up
Tuesday AUGUST 9, 2016			
AREA DIRECTOR REPORT – DEAN SEYLER	❖ **Renew And Strengthen Our Partnership With Tribes** Portland Area Direct Service Tribes Meeting ▪ July 6th & 7th ▪ Review of the Area's services to the Direct Service Tribes ▪ One-On-One Meeting – Action Plans Developed ❖ 13th Annual National Direct Services Tribes Meeting ▪ Rapid City, SD ▪ August 31st – September 1st ▪ Holiday Inn Rapid City-Rushmore Plaza ▪ https://www.ihs.gov/dstnm/ ❖ 2016 IHS National Behavioral Health Conference ▪ August 9th – 11th ▪ Portland, Oregon ▪ https://www.ihs.gov/dbh/2016conference/ ❖ IHS Contract Support Costs Workgroup Meeting ▪ September 15th & 16th ▪ Washington, D.C. ▪ IHS Directors Award Ceremony ▪ Rockville, MD ▪ Date to be determined ▪ https://www.ihs.gov/nda/ ❖ Portland Area Fund Distribution Workgroup Meeting ▪ August 25th ▪ Portland, Oregon **Portland Area User Population FY16 -2nd Draft Presented**		

- Dear Tribal Leader Letters: https://www.ihs.gov/newsroom/triballeaderletters/
- Purchasing Health Care Coverage ( )
  - DTL dated July 18, 2016
  - Written comments by COB August 17th –extended to Oct 31st
  - Two in person consultation
    - Sept 19th – NIHB Annual Consumer Conference – Scottsdale, AZ
    - Oct 9th – NCAI 73rd Annual Convention – Phoenix, AZ
  - Draft circular
- Community Health Aide
  - Proposed expansion in use of community health aides
  - Written comments deadline extended to Oct 27th
  - Telephone consultation – Oct 4th
  - Two in person consultations – same as Purchase Health Care consult
  - IHS Quality Framework
  - Improve health outcomes for patients receiving care
  - Provide a care delivery service all patients trust
  - Upcoming Tribal consultation
  - Written comments by COB September
  - PRC Rates
  - IHS Press Release New Medicare like rates (effective May 20, 2016)
  - https://www.ihs.gov/newsroom/pressreleases/2016pressreleases/ihs-implements-new-regulation-for-tribes-to-negotiate-medicare-like-rates/
  - Dear Tribal Leader letter
  - Tribes who wish to Opt in contact Denise Imholt at 503-414-5555 or at Denise.imholt@ihs.gov
  - If you wish to Opt out no action is necessary
  - Dear Provider Letter (send to all Providers)
  - FY16 CHEF Balance –
  - $37,547,141.00 as of 06/01/2016

- 15 CHEF cases, all reimbursed at 100%
- Total YTD $288,954.00

To Improve the Quality of and Access to Care

- Purchase & Referred Care (PRC) Pool
  - Started in 2001
  - 8 Tribes participate
  - No claims or distributions in FY14 or FY15
  - Contact with Tribes will occur
- FY18 IHS Budget Formulation (Area Meeting)
  - Date – TBD
  - Location – TBD
  - Andy Joseph and Steve Kutz – Tribal Reps to National Mtg
  - CAPT Ann Arnett, Executive Officer – Area Rep
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  - CAPT Ann Arnett, Executive Officer – Area Rep

Renew And Strengthen Our Partnership With Tribes and Urban Indian Health Programs

- **New Staff:**
  - Dr. Cheryl Sixkiller, DDS – Area Dental Consultant
    - Cheryl.sixkiller@ihs.gov
    - 503-414-5555
  - Ms. Kristi Woodard, LICSW – Area Behavioral Health Consultant

- Kristi.Woodard@ihs.gov
- 503-414-5555

- **Current Vacancies:**
  - Chief Contracting Officer
  - Area Diabetes Consultant – Applicants being reviewed
  - ISDEAA Specialist
- **Request for Public Comment - Federal Register**
  - Proposed Information Collection – Environmental Health Assessment of Tribal Child Care Centers
  - ~40 Daycare and Head Start Centers
  - Includes Routine Assessment of Environment as Conducted Annually by EHS, and Environmental Sampling for Lead, PCBs, Environmental Allergens, and Pesticides
  - Follow-up Activities will include Outreach, Training and Technical Assistance
  - https://www.federalregister.gov/articles/2016/07/25/2016-17494/request-for-public-comment-60-day-proposed-information-collection-environmental-health-assessment-of
- **Implementing Section 1632 of the Indian Health Care Improvement Act – Sanitation Deficiencies**
  - The sanitation deficiencies review has been completed and has been reported to Congress as required. .
  - The initial 2017 list includes 91 projects with $65 million of need.

  In recent years, Portland Area has been able to reach about $1.8 million with IHS and EPA Set-Aside Funding

To Improve the Quality of and Access to Care

- **Federal Healthcare Facility Modernization**
  -
  - Wellpinit Service Unit
    - Improvements to Front Entry, Patient Registration, Primary Care, IT System, and HVAC System.

	❖ Scheduled Construction Contract Award – October 2016 ❖ 6 – Month Construction Performance Period ❖ $500,000 Investment ▪ Yakama Service Unit ❖ Renovating Former Physical Therapy to Six New Primary Care Exam Rooms with IPC Medical Teaming Area. ❖ Scheduled A/E Design Contract Award – August 2016. Construction to Occur in FY 2017. ❖ $300,000 Investment ▪ Warm Springs Service Unit ❖ IHS and Tribe Collaborating to Develop Health Facilities Master Plan, Goal to Complete in FY 2017. ❖ Master Plan will Guide and Prioritize Major Facility Improvements. ❖ **Facility Condition Assessment Program** ▪ DHFE Provides this Service to Tribal Health Facility Programs with Retained Shares At Least Every 5-years. ▪ The Summary Report Provides Overall Facility Condition and is Useful for Prioritizing and Planning Facility Improvement Projects to Assure Reliable Facility Operation and a Quality Environment of Care. ▪ FY 2016 Progress - Conducted Visits to 13 Tribal Health Programs with Plans to Complete Three More by the End of FY.		
EXECUTIVE DIRECTOR UPDATE - JOE FINKBONNER	See attached PPT		
LEGISLATIVE UPDATE – LAURA PLATERO, GOVERNMENT AFFAIRS/POLICY DIRECTOR	**Status of FY2017 IHS Budget** • Congress will likely enact a continuing resolution for FY 2017 in September to fund IHS and other federal agencies. • Senate and House Committees' Interior, Environment and Related Agencies appropriation bills reflect differences (detailed on next slide)		

- Committee reports
  - Senate requests GAO report on Advance Appropriations
  - House questions the distribution of population growth funds; and directs IHS to provide a report on full funding for IHCIA
  - Concurrence on CSC; CSC for domestic
  - violence, zero suicide initiative; and volunteer dentists/credentialing

Contract Support Cost

- President's FY 2017 IHS budget proposes an increase of $82m above FY 2016 level for Contract Support Costs (CSC)
- Senate and House Committees' Interior, Environment and Related Agencies bills continue the FY 2016 enacted policy of appropriating an indefinite amount ("such sums as may be necessary") to separate accounts for IHS and BIA.
  - Not classified as mandatory yet.
- CSC Policy - Several recommended changes to the CSC Policy were made following the March 28-29 CSC Workgroup meeting.
- Dear Tribal Leader sent out on 4/11/16 providing a 60-day comment period on the revised policy and three tribal consultations were held.
- Final draft policy will be reviewed by the CSC workgroup in September (15-16 in DC)

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.
- Telephone consultation on October 4 at 12 noon PST.
- Two in person consultations:
  - NIHB Annual Consumer Conference on September 19 in Scottsdale; and
  - NCAI Annual Convention on October 9 in Phoenix.
- Comments are due on October 27 (extended from July 29, 2016).

Tribal Premium Sponsorship

- On July 18th, 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.
- One telephonic consultation held; two in person scheduled:
  - NIHB Annual Consumer Conference on September 19 in Scottsdale; and
  - NCAI Annual Convention on October 9 in Phoenix.
- Comments due on October 31.

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.
- DTLL issued on July 29, 2016 with Tribal consultations set, as follows:
  - Telephone consultations on August 16 and October 24
  - In person consultations at NIHB ACC on September 19 in Scottsdale, and NCAI Annual Convention on October 9 in Phoenix

Medicare-Like Rates (MLR) to Non-Hospital Providers
- Final rule with comment period issued on March 21, 2016 – 81 Fed. Reg. 14977-84.
- Extends MLR to physicians and other health care professional services and non-hospital based services (non-hospital providers).
- Applies to IHS-operated PRC programs and urban Indian health programs; and only to Tribes/Tribal organizations if they opt-in.
- Rule effect on May 20, 2016 but comments were accepted up to this date.
- The Board submitted comments on the definition of "referral" and on opt-in method.

100% FMAP Update
- On February 26, 2016, CMS issued a letter to State Health Officials re-interpreting the scope of services to be considered "received through" an I/T to qualify for 100% FMAP:
  1. "Received through" now includes any services that an I/T is authorized to provide according to IHS rules, and that are also covered under the approved Medicaid

state plan, including long-term services and supports (LTSS).
2. May also include transportation (emergency and non-emergency) and other related travel expenses if it is a covered service under the Medicaid state plan.
3. I/T's request for service from a non-I/T provider must be in accordance with a "care coordination agreement" and non-I/T provider must be a Medicaid provider.
4. Two billing options presented: (a) non-I/T provider bills Medicaid directly; or (b) I/T handles all billing.
5. Effective upon execution of a written care coordination agreement.

- CMS to issue a FAQ on new policy – still pending.

Other Policies

- 6/9/16 - IHS DTLL on FY 2016 $10m increase for Gen I Initiative Support
- 6/15/16 & 7/20/16 - IHS DTLL requesting Tribal Consultation on the draft Quality Framework policy for Direct Service Tribes.
  - Telephone consultation on 8/15/16 at 11 am PST
  - In person consultations at the Great Plains Tribal Chairman's Health Board Summit on August 30, and NIHB Annual Consumer Conference on September 19
  - Written comments due in 60 days
- 7/22/16 – IHS DTLL on SDPI FY 2016 Community-Directed grant application process

STAC Meeting Update

- Last meeting was June 7-8; next meeting is September 13-14
- Tribal leaders made several requests to Secretary Burwell, including:
  - Transition planning for STAC
  - A National Tribal Behavioral Health Summit
  - Work with White House Council on Native Americans to create a Tribal Action Plan
  - Provide information on Opioid abuse and addiction for Indian country
  - Tribal consultations related to CHAP expansion

MMPC & CMS TTAG Update

- Medicare, Medicaid and Health Reform Policy Committee (MMPC) conference call on

May 4, retreat on June 13-14, 2016, and face-to-face meeting on July 26

- At retreat:
  - Developed action items
  - Identified priority areas
- CMS TTAG conference call on June 8 and face-to-face meeting July 27-29 in DC
  - CMS and IHS representatives provided updates to tribal leaders

Litigation Impacting Indian Health

- Section 2901(b) -- Payer of Last Report
  - *Redding Rancheria v. Burwell*, No. 15-152 (DDC)
  - IHS has argued in this litigation that Section 2901(b) of the Affordable Care Act (ACA), enacted in 2010, invalidated the IHS's longstanding policy exempting tribal self-insured health plans from the payer of last resort rule.
- Section 105(l) under ISDEAA – Lease Compensation
  - *Maniilaq Association v. Burwell,* No. 14-2035 (RMC)
  - Court held that IHS should negotiate proper lease compensation under 105(l) of the ISDEAA.
  - On July 27, Judge issued a Final Order.

Indian Legislative Issues 114th Congress

- The Comprehensive Addiction and Recovery Act of 2016 (S. 524)
- The Indian Health Service Accountability Act of 2016 (S. 2953)
- The Helping Ensure Accountability, Leadership and Trust in Tribal Healthcare Act (H.R. 5406)
- Department of Interior Tribal Self-Governance Act of 2015 (S. 286)
- Advance Appropriations (H.R. 395)
- Tribal Programs Exemption from Sequestration (S. 1497/H.R. 3063)
- Employer Mandate (S. 1771/H.R. 3080)
- Family Stability and Family Kinship Act of 2015 (S. 1964)
- Native American Suicide Prevention Act of 2015 (H.R. 3166)
- Ongoing:
  - IHCIA Technical Amendments (S. 2114)

	– SDPI Permanent Reauthorization – Contract Support Costs mandatory funding and reconciliation language • **S. 524** – The Comprehensive Addiction and Recovery Act of 2016 (CARA) – Signed into law by President Obama on July 22, 2016. – Addresses various issues through prevention and treatment of opioid abuse. – The House and Senate disagreed about funding. – No funds appropriated for emergency mandatory funding to address the opioid crisis. – Contains several competitive grant programs that tribes would be eligible for but there is no tribal-specific allocation of funds. • House ($500m) and Senate ($261m) appropriation bills recommended discretionary opioid funding. • **S. 2953** -- The Indian Health Service Accountability Act of 2016 – Introduced by Sen. Barrasso (R-WY) and Sen. John Thune (R-SD). The Act will improve transparency and accountability at the IHS by: • Expanding removal and discipline authorities for problem employees at the agency; • Providing the Secretary of HHS with direct hiring and other authorities to avoid long delays in the hiring process; • Requiring Tribal consultation prior to hiring area directors, hospital CEOs and other key leadership positions; • Commissioning GAO reports on staffing and professional housing needs; • Improving protections for employees who report violations of patient safety requirements; • Mandating that the Secretary of HHS provide timely IHS spending reports to Congress; and • Ensuring the Inspector General of HHS investigates all patient deaths in which the IHS is alleged to be involved – Referred to Senate Committee on Indian Affairs on 5/19/16. • **S. 5406** – The Helping Ensure Accountability, Leadership and Trust in Tribal Healthcare		

Act
- Introduced by Sen. Kristi Noem (R-SD) on 6/8/16; co-sponsors include Senators Ashford (D-NE), Smith (R-NE), Fortenberry (R-NE), Cramer (R-ND), McCollum (D-MN), and Cole (R-OK).
- Addresses issues similar to S. 2953 on hiring, removal and demotion but also focuses on more substantive reforms including a long-term contracting pilot program and reforms on the PRC funding formula.
- Referred to House Committees on Natural Resources, Energy and Commerce, and Ways and Means on 6/8/16; and to House Natural Resources Subcommittee on Indian, Insular and Alaska Native Affairs on 6/13/16.
- Subcommittee hearing held on 7/12/16.

- **S. 286** – Department of Interior Tribal Self-Governance Act of 2015
  - Introduced by Sen. John Barrasso (R-WY) on 1/28/15; co-sponsors include Senators Tester (D-MT) , Murkowski (R-AK), Crapo (R-ID), Schatz (D-HI), Franken (D-MN)
  - Amends Title IV of of ISDEAA to make it consistent with Title VI, the Self-Governance Program for HHS
  - Creates the same administrative efficiencies for DOI that have been in place for HHS programs.
  - S. 286 passed Senate on 7/7/15 by Unanimous Consent with an amendment
  - Referred to House Natural Resources Subcommittee On Indian, Insular and Alaska Native Affairs on 8/4/15
- **H.R. 395** – Indian Health Service Advance Appropriations Act of 2015
  - Introduced by Rep. Young (R-AK) on 1/14/15; co-sponsors include Senators Kirkpatrick (D-AZ), Huffman (D-CA), Lujan (D-NM)
  - Amends IHCIA to authorize Advance Appropriations for the Indian Health Service and Indian Health Service Facility Accounts
  - Referred to House Natural Resources Subcommittee on Indian, Insular and Alaska Native Affairs on 3/2/15
- Senate and House Bills Exempting Tribal Programs From Sequestration

- **S. 1497**
  - Introduced by Sen. Tester (D-MT) and Sen. Udall (D-NM) on 6/3/15
  - S. 1497 would exempt IHS, BIA, HUD and other Indian programs from sequestration required under the Budget Control Act of 2011
- **H.R. 3063**
  - Companion bill to S. 1497
  - Introduced by Rep. Young (R-AK) on 7/14/15; co-sponsors include Representatives Grisham (D-NM), Cole (R-OK), Ruiz (D-CA), McCollum (D-MN)
- Both bills referred to Budget Committees
- Senate and House Bills Exempting Tribes from the ACA Employer Shared Responsibility Mandate
  - S. 1771-Tribal Employment and Jobs Protection Act introduced by Sen. Daines (R-MT) on 7/15/15; co-sponsors Senators Thune (R-SD), Crapo (R-ID), Rounds (R-SD), McCain (R-AZ), Risch (R-ID)
  - H.R. 3080 introduced by Rep. Noem (R-SD) on 7/15/15; 27 bi-partisan co-sponsors
  - Senate bill referred to Finance; House bill reported favorably out of House Ways and Mean on 6/15/16.
- **S. 1964** Family Stability and Family Kinship Act of 2015
  - Introduced by Sen. Wyden (D-OR) on 8/5/15; co-sponsors Sen. Bennett, Brown (D-OH), Cantwell (D-WA), Casey (D-PA), Gillibrand (D-NY), Menendez (D-NJ), Schumer (D-NY), Stabenow (D-MI), Warner (D-VA)
  - Reforms the federal finance system supporting state and child welfare services
  - Funds preventive services and kinship placements for children at risk of foster placement
  - Current law creates incentives to place Indian children outside of families in order to receive federal funding
  - Encourages child welfare system to forego alternatives to prevent breakup of families like parent training, mental health counseling, trauma recovery, etc.
  - Referred to Finance Committee on 8/5/15

	• **H.R. 3166** Native American Suicide Prevention Act of 2015 – Introduced by Rep. Grijalva (D-AZ) on 7/22/15; co-sponsors are Reps. Ruiz (D-CA), Huffman (D-CA), Young (R-AK), Moore (D-WI), McCollum (D-MN), Grisham (D-NM), Salmon (R-AZ), Napolitano (D-CA) and Cole (R-OK). – Amends the Public Health Service Act to require a state or state-designed entity to seek Tribal consultation as a condition of receiving a grant or cooperate agreement for development/implementation of a statewide youth suicide and early intervention and prevention strategy. – Referred to Energy & Commerce, Subcommittee on Health on 7/24/15.		
ALZHEIMER'S ASSOCIATION - BOB LEROY, EXECUTIVE DIRECTOR, ALZHEIMER'S ASSOCIATION WASHINGTON STATE CHAPTER, & MICHAEL SPLAINE, SENIOR ADVISOR AND CONSULTANT TO ALZHEIMER'S ASSOCIATION	See attached PPT		
REGION X NATIVE AMERICAN CONTACT – RHONDA MARTINESZ-MCFARLAND, MSN-ED, FNP-BC, ARNP	GAVE ORAL INTRODUCTION AND PRESENTATION		
BILLABLE PEER DELIVERED SUPPORT SERVICE - LONI GRENINGER, TRIBAL ADMINISTRATOR DIVISION OF BEHAVIORAL	See attached PPT		

HEALTH & RECOVERY, DEPARTMENT OF SOCIAL & HEALTH SERVICES			
Wednesday AUGUST 10, 2016			
WEAVE PROJECT – EPICENTER SURVEY – NANETTE YANDELL, WEAVE PROJECT DIRECTOR	See attached PPT		
FOOD SOVEREIGNTY - VALERIE SEGREST, TRADITIONAL FOODS PROGRAM MANAGER FOR MUCKLESHOOT	**Presentation done in Prezi, please visit** http://prezi.com/o0so50ckc4pt/?utm_campaign=share&utm_medium=copy&rc=ex0share		
SALISH CANCER CENTER - DR. EIKO KLIMANT, CLINICAL DIRECTOR	See attached PPT		
COLVILLE'S NARCH PROGRAM – HAUS MAREMSUME	See attached PPT		
Tribal Updates	1. Cow Creek - Sharon Stanphill, Health & Wellness Director 2. Jamestown S'Klallam – Brent Simcosky, Director of Health Services 3. Klamath - Sandy Walker, Tribal Council		
NPAIHB WELLNESS AND TEAM HANDS – BIRDIE WERMY, EPICENTER NATIONAL EVALUATION SPECIALIST	See attached PPT		

CHAP/DHAT - PAM JOHNSON, ORAL HEALTH PROJECT SPECIALIST	See attached PPT		
Thursday August 11, 2016			
CHAIRMAN'S REPORT, ANDY JOSEPH, JR	See Attached Report		
FINANCE REPORT – Eugene Mostofi			
	MOTION: BY GREG ABRAHAMSON, SPOKANE, 2ND SHAWNA GAVIN, UMATILLA	**MOTION**	
COMMITTEE REPORTS			
	ELDERS COMMITTEE – Patti Kinswa-Gieser (A copy of the report is attached)		
	VETERANS – No meeting		
	PUBLIC HEALTH - Victoria Warren-Mears (A copy of the report is attached)		
	BEHAVIORAL HEALTH – Nanette Yandell (A copy of the report is attached)		
	PERSONNEL – Cassie Sellars-Reck (A copy of the report is attached)		
	YOUTH – Devonte Casey (A copy of the report is attached)		
MINUTES	April 2016 Minute approval, **MOTION: BY LELAND BILL, YAKIMA, AND 2ND BRENT SIMCOSKY, JAMESTOWN**	**MOTION**	
LEGISLATIVE/RESOLUTION COMMITTEE	**Laura Platero:** (A copy of the report is attached)		
	RESOLUTION: Resolution No.:16-04-01 Northwest NARCH 9 Program **MOTION: RATIFIED BY BOARD**	**MOTION**	
	RESOLUTION: 16-04-02 Portland Area Fetal Alcohol Spectrum Disorders Funding **MOTION: CASSIE SELLARS-RECK, COWLITZ, 2ND SHAWNA GAVIN, UMATILLA**	**MOTION**	
RECOGNITION EMPLOYEE OF THE YEAR	**Birdie Wermy**		
	April 2016, Yakama will host if hotel is complete.		
ADJOURN: MOTION: BY SHAWNA GAVIN, UMATILLA, 2ND BY LELAND BILL, YAKAMA			

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
AUGUST 2016 QUARTERLY BOARD MEETING
12 Tribes Resort Casino, Omak, WA

MINUTES

TUESDAY, AUGUST 9, 2016

Call to Order: Andy Joseph, Chairman,

Invocation: Barb Aripa, Tribal Elder
Welcoming: Michael Marchand, Colville Chairman
Posting of Flags: Omak 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 – **Absent**	NW Band of Shoshone – **Absent**
Colville Tribe – **Present**	Port Gamble Tribe – **Present**
Grand Ronde Tribe – **Present**	Puyallup Tribe – **Absent**
Siletz Tribe – **Present**	Quileute Tribe – **Absent**
Umatilla Tribe – **Present**	Quinault Nation – **Absent**
Warm Springs Tribe – **Present**	Samish Nation – **Absent**
Coos, Lower Umpqua & Siuslaw Tribes – **Present**	Sauk Suiattle Tribe – **Absent**
Coquille Tribe – **Present**	Shoalwater Bay Tribe – **Absent**
Cow Creek Tribe – **Present**	Shoshone-Bannock Tribe – **Present**
Cowlitz Tribe – **Present**	Skokomish Tribe – **Present**
Hoh Tribe – **Absent**	Snoqualmie Tribe – **Absent**
Jamestown S'Klallam Tribe – **Present**	Spokane Tribe – **Present**
Kalispel Tribe – **Present**	Squaxin Island Tribe – **Present**
Klamath Tribe – **Present**	Stillaguamish Tribe – **Absent**
Kootenai Tribe – **Present**	Suquamish Tribe – **Absent**
Lower Elwha Tribe – **Absent**	Swinomish Tribe – **Absent**
Lummi Nation – **Present**	Tulalip Tribe – **Present**
Makah Tribe – **Present**	Upper Skagit Tribe – **Present**
Muckleshoot Tribe – **Present**	Yakama Nation – **Present**
Nez Perce Tribe – **Present**	

There were 25 delegates present, a quorum is established.

AREA DIRECTOR REPORT - DEAN SEYLER PAO DIRECTOR:

All rightie. So, good morning, everyone. It's good to be back here. We had our Governing Board meeting for the Colville Service Unit here last year, so it was good to be able to hear and we went over sort of the Omak Clinic facility, and I think you guys are going to take a look at that. There's a lot of great quality health care that happens at that facility. As small as it is, but high quality, large amounts of quality of health care that occurs there. I wanted to share with the group here that we had our Portland Area Direct Service Tribes meeting back on July 6 and 7. It is kind of a biannual event, so the next time I am going to move it out to one of the Direct Service Tribe locations. And I already promised that we will be going to Ft. Hall for our next one. So, that will be in 2018. That will give me time to get the requisitions through the process. (Laughter) Unfortunately, just because of the costs involved for folks to travel and they take all of that into consideration, the regulations have gotten to the point where anything above a certain threshold that's above my authority, I have to go forward to Headquarters, and even that is going to trigger it to go through the department for approval. So, I just didn't have time to get all of that through the process and in time to get over there. But, the next one will be at Ft. Hall So, the feedback I received from the folks that were there was that it was a good meeting. They found it informative. That's my intent, is to have a meeting that we share information that the services that the Area office, and the Service Units, at their respective location, that they provide to the Tribe. So, I also had a one-on-one session with each of the Tribes, and out of that I will be sending out a corrective action plan to each of the Tribal councils as to the issues and concerns that were raised to me and to report back on a regular basis until each of those items are addressed and completed. I did that last time, and we got a lot of action taken care of, so, for the five Direct Service Tribes, look for that to be coming your way soon.

The thirteenth annual National Direct Service Tribes meeting is coming up in Rapid City, that Greg and Ann, that they've been involved with there. I am not sure if Janice and Greg are going to talk about that later today, but that's on August 31 and 1st at the Holiday Inn there in Rapid City. And, I will try to put in the links here to links here to the locations on your iPads, so hopefully you are able to click on those and get to it.

The IHS Contract Support Workgroup meeting has been called into session for next month. There, I think the intent there is to go over the final product that was pushed out for the Tribes to have comment on and to have a final document signed off by Ms. Smith and identify locations, again, it can be in the DC metro area someplace. So, watch for that. I think, Andy, you're on that, and [inaudible 20:53].

The IHS Service Unit awards ceremony, I have had quite a few folks both from the federal sides and the Tribal sides that I had forwarded on up to the Headquarters for consideration. I believe quite a few of them had been accepted. That's been pushed back. I'm not exactly sure what the date is, but as soon as I get a date for that, I will be sharing that with everybody.

As I mentioned at the last Quarterly Board meeting, I was going to call into session the ordinary Fund Distribution workgroup, and I've done that. I've already contacted the members. We have a date set for August 25. Captain Ann Arnett, the Executive Officer, will be the federal facilitator for that, and giving two challenges to the workgroup to work on. The first one is to take a look at our current methodology as to the distribution of new funds that they already received. That methodology that is in place right now was established years ago, prior to the Affordable Care Act, and so what I'm going to ask the group to do is take a look at that, is that still a viable methodology, or does it need to be tweaked a little bit and, whatever the workgroup comes up with and recommends, I will bring forward to the Quarterly Board meeting and share that with you, with everybody here for any changes to be made. The second thing is, I've been involved with probably six CHISDA expansion requests over the last five years. Mostly in the Portland area, but also here recently, I have a Tribe in the California area that wanted to expand their CHSDA into Oregon, and then, of course, one of our Portland area Tribes looked to expand into the Phoenix area. While borders should really not impact how we deliver health care or the ability to, it does, unfortunately. So, time and time again, what I find from the Tribal leaders when I consult with them is, you know, why doesn't IHS come up with a permanent fix? Why is IHS this Band-Aid approach CHSDA expansion requests from the Tribes? And, so, on my latest letter, my recommendation regarding the California Tribe that is requesting into Oregon, my closing sentence in my letter was that we need to find, we need to set up a National CHSDA, one that a Tribe can determine where they're going to cover their Tribal members. So, you can have like a Colville member could be going to school down in Florida, and if they choose that to cover them once they would be eligible for PRC, then so be it. So, what I am going to charge the Workgroup to do is to come up with a proposal that I can push forward, realizing that this is going to be a year down the road before I think we really see anything, because it's going to impact all 567 Tribes in the United States, but it's got to start someplace. So, the Portland Area has always been known for putting forth innovative ideas and setting the pace for the rest of the agency, so, whatever that Workgroup comes up with, I'll definitely bring here and share with you all before I bring it back there to Headquarters.

This came out last week, it's the, I don't know if I'm told final. There's multiple versions come out. We're still, the last word I got was that there were still a couple of Tribes that we're waiting for some data on to be sent to the National Data warehouse and once that comes up, then Mary Brickell will be generating the final version of the numbers. If you take a… it's hard to see and hopefully you can see it on your iPad, but I also sent it out to the Tribal Chairs and to the Tribal Health directors, the hard copy of this, and I'm not sure if there's one in the handouts or not, but there's actually a dip in the total number from last year of approximately 400 user pop. That came out August 4. So, look… if you don't have it, please let me know.

I'm going to share with you some letters, and I've noticed there are hard copies out in the hall and there's also the link I put into the slide, to the IHS website, the DTLL different letters. There are multiple dear Tribal leader letters that are looking for input. And, the first one, of course, is

purchasing health care coverage. That one has been extended. I know that I had a few folks call me about that, that they were worried that they weren't going to make the deadline with their input. So, Liz Smith went ahead and extended it until October 31. As you know, there are two in-person consultations coming up. Now, they're both in Arizona, but they're in two places where most of us go to. So, hopefully, if you want to have some input and hear firsthand directly from them as to what their proposal is, you can be at one of those locations. And, there is a draft circular, and that is attached to Dear Tribal Leader letter if you go to that link. And, then the community health aide, the proposal and expansion of the community health aides, that, too, has been extended until the 27th of October.

Cassie Sellars-Recks: I've e-mail your office and called with no response. I didn't know what that is so, I feel like we are asking to be commenting on something that we don't know what it is. I can't make an educated comment nor can Tribal leaders if you're asking us to comment on something we don't know what it is, we don't know the educational requirements, and we don't know the parameters around monitoring safety and activities and those kinds of things. To comment to say if it's a good thing or a bad thing. So I need more information to know what kind of comment to give to say I support it or no it's not your putting a band aid on the real issue that is we need to get health care workers for the Indian communities and quit doing a lower class system. So that needs to come out and certainly you guys have that information, correct?

Dean Seyler: There is a frame work of this looking at the what happen up in Alaska and the DHAT program and what's starting to happen down in the lower 48 with the DHAT expansion. How that type of expansion of duties that can be pushed out to other Areas to meet the needs of so Tribes and Federal Service Units are experience a shortage in. My understanding is and intent is that they are laying this out here as a broad frame work and asking for input, ideas such as that or for frame work and ideas such as that and that they cover it all.
Cassie Sellars-Recks: But we need to know what they do up in Alaska certainly they have a job description and educational requirements and those kinda of things to know that yes, we can support that. None of that information has come out so I feel like the cart has been set in front of the horse. We'll say that we need this but we don't know what they do. So we need to know what they do. I asked Joe and I don't know if it's on the agenda for this meeting to get and explanation. Before I can support what a DHAT was I needed to know what they did, who trained them, what do they do? Otherwise, having our health care put down to not insuring quality which certainly got IHS in trouble currently. So I need to know the quality measurements and standards are for what they do. Is it more than a CHR? Is it different? If it's different how are they trained? Do they go through and extensive training like UW like the DHAT did? We need to know that information before I and other people can send a comment to say that's what we want, to advocate for down here in the lower 48.

Dean Seyler: Well let me work with Headquarters to gather all the information they have to be released. I'll work with Joe to have it placed on the Health Board's website.

Tim Gilbert: I just want say something on that, there was a webinar about a month ago, I think the Health Board put it on and it went through some of those concern of what a DHAT….kinda explained the ANTCH program pretty informative. But, what they are asking for is for Tribes to submit a letter to IHS for a formal Tribal consultation. INAUBILE: Equivalent to that model well-grounded up in Alaska. I think it's kinda early and they are introducing the concept. But what they really need is for Tribe to formally ask for consultation so they can go through the process of hearing

Dean Seyler: That's my understanding this is the frame work and once they get the input form Tribes.

Cassie Sellar-Reck: This was in my e-mail and in my questions. I have a job and I'm not able to go to the webinar. I don't know what it is to say that I think that we need it. I don't want to go to consultation or say support it if I see or think or my Tribe assesses it and says there not quality around it.

Dean Seyler: I understand. And just to speak of quality. Issue going on in the Great Plains is well known. I issues going on there the Agency as a whole as rallied around the Great Plains Area to assist them, to help them. But I assure you based on what I've seen throughout the rest of the Agency that is not the norm of Indian Health Services and it's absolutely not the norm of the five of six Federal sites in the Portland Area. All Federal sites are accredited, we were just reaccredited for another three years and we provide quality health care. I feel all Tribes deliver quality health care here in the Portland Area and I've expressed that multiple at the national level, Area Directors, and the Director of IHS. Portland Area we're on the right path and I believe in continuous quality care improvement. Are we going to find errors or area that are not up to where they should be? Sure, because of the human factors involved. But, we are nowhere near what's going on in the Great Plains.

Eric Metcalf: and I have two questions because you mentioned accreditation; do you know how many Tribes that offer direct care in the Northwest that are accredited? And my second question, that our Council had is are the Community Health Aid program that I've participated on in Alaska where I worked back in 2000. What I saw was a great program all the way to the community level to the CHR level and a couple levels in between. I thought it was a wonderful model up in Alaska and ANTHC, my question on the community health aid is will there be money attached to it to get it started in the lower 48?

Dean Seyler: That's a good question to be asked of us and of course we all know how the process goes asking for money from Congress. We have to wait and see who gets in the White house and see what happens there.

I think Dr. Rudd can share with you the number of Tribes that are accredited.
Dr. Rudd: Of course all six of our Federal Service Units and we are aware of 13 Tribes here in the Northwest that are also accredited by AAACO

Brent Simosky: Dean real quick, States are already doing different things. The state of Washington already has a list of Community Aid positions for Washington State Plan that's all paid at the Medicare encounter rate, you don't get the whole encounter rate but you get a percentage based on what the position is. Nothings been said, it's still all in development. I know Steve's involved with the American Indian Health Commission on that Cassie. But, it's still in the infancy stages and the States like it because in pays a 100% FMAP.
Dean Seyler: And there are the two pilot projects in Oregon that the Health Board, Joe and crew are working with. There's a question over there

Laura Platero: Tomorrow Pamela Johnson who work on our Oral Health Project will be presenting on CHAP she'll be presenting at 2:45. The Board has cohosted two webinars on the CHAP program on what framework and what the program could look like in collaboration with NIHB and the Alaska Native Tribal Health Consortium. Sop with this extend comment period October 31st there is more time to provide information to Tribal leaders.
Dean Seyler: IHS Quality Framework is tied into again what's going on in the Great Plains. Pull in information that's going on at all the different 12 Areas at Headquarters to have at their fingertips and being able to report back to Congress at any given time. But, that too is on this website and you can click on that and come to a letter where they talk about the outcomes and upcoming consultations. So the framework focus on the federally operated facilities Tribes are welcomed to participate but are not required. To align all these priorities that's to strengthen organizational capacity to improve quality and care system, to meet and maintain accreditation for IHS Direct Service facilities. Align service processes, improve patient experience, and insure patient's safety, and improve processes and strengthen communication for early identification for risks. So that's the intent on the Framework of the quality improvement initiative that's going on.

IHS issued a Press release on the new PRC Medicare like rates, which became effective May 20, 2016. We're implementing that new regulations that give IHS, Tribes and Urban Indian Health programs the ability to cap payment rates at Medicare Like rates to position any other non-hospital provider who proved services to PRC program Purchased and Referred program. One thing to note here are Tribal facilities can opt out of this, if you do not want to follow this and you want to establish your own rate to your providers Tribal programs who run their own PRC programs that's totally your choice, you are not required to follow this. The Principle Deputy Director did issue a Dear Tribal Leader letter with the option for the Tribes back on May 24th .To opt in or opt out. We ask that Tribes that wishes to opt in all we ask is that you contact Denise Imholt as you know you've worked with her on your contracts her number is listed there or her email address is listed there and let her know.

Latest update on CHEF balance which is another reason why I want to take a look at our PRC program, as you can see we have a pretty healthy balance yet at Headquarters, which is unheard of and this is maybe our third year in a row. Is Terry here, yes, third year in a row we are experiencing and expecting to end the fiscal year with a balance. Last there still a balance of 15 are working through some of the requests that came through and are expecting to reimburse all. As you can see there year to date as of June 1st we've had 15 CHEF cases, all have been reimbursed at 100%, I attribute that to the Tribes who have put forth the request with solid documentation. That was something we weren't experiencing in years gone by that I have focused on in over several years are staffs ability to work with the Tribes to ensure that the packet comes up that it doesn't get set aside as incomplete that they actually work with the different PRC programs to have a full package to put forth and those get through the system quickly. So year to date so far $288,954 has come back to the Area to the Tribes for you guys to put back into your PRC programs.

Audience: INAUBILBE Question

Dean Seyler: Of course our role in the Portland area is that there are three sites that run the PRC program Colville, Wellpinit, and Western Oregon so we'll implement it in those three locations. For the Tribes themselves have the option of working with Peggy Ollgaard in our office is excellent person to work with.

Audience: Is this more FYI in your office, INAUBILBE Question

Dean Seyler: The Purchase and Referred Care pool I wanted to enter into a discussion with eight Tribes. A lot of those eight Tribes, two of them are Federal Service Units. Years ago Mrs. Doni Wilder prior Area Director had worked with the Health Board to set up this Portland Area CHEF account and they called it or back then the called it the CSH pool and there were a lot more Tribes involved then there are now. But, everyone agreed to a certain percentage and I don't have that information with me. Who promised to hold out of their PRC funds at the beginning of the fiscal year and it goes into this pool. So the intend was if they had a case that met that threshold but didn't quite met the Area had developed threshold but didn't quite make the National one the Headquarters' one that this was an alternate site that they can go into and get some reimbursement or at least a partial reimbursement. Well ever since the expansion of Medicaid and how the PRC funds are able to stretch more no one has been filing any claims for that. So we have two years of funds FY14, FY 15 that if it hasn't already been pushed out it will be pretty soon. But right now there is about half million dollars sitting in that account that I want to get pushed back out to the Tribes. But what I want to do is ask the Tribes do you want to continue this? Or would you rather have your money? Keep your money at the end of the year to use for your own contracts or care that you want to manage there in your facility. The two Federal sites, actually four Federal sites Colville, Wellpinit, Yakama, and Warm Springs. Yakama and Warm Springs are controlled by the Tribe so I've talked with them. I've already set

in motion stop pulling monies out of Colville and Wellpinit and go out to. As far as the other Tribes I'll be in contact with you.

The FY18 IHS Budget Formulation meeting there's going to be an Area meeting to establish Captain Arnett do you have update? No date yet. So as soon as the information gets rolled out from Headquarters we'll send it out. You'll get a letter from us indicating when that will happen. Still Andy and Steve are the two Tribal reps at the National meetings. I understand this past years when well, Andy do you have any input on that?

Andy Joseph: We had a meeting a couple weeks ago in Denver and we are setting up our calendars and it's all going to be pretty similar to this year's our All Tribes meeting I think it's going to be in October. I always tell everyone to bring in their request take a look at your data to what you have to bring forward so we can justify our Area needs. There also going to look at by Area type of budget this year which might need an extra day on the All Tribes meeting to do Area specific budget. And it get submit that way into Congress and OBM and they distribute out the funding that we wanted it might get us more money. It might also be another when it goes to OBM to like Congress and stuff their going to be able to see what more specific to say a Congressman's looking at it they they might say well I want to make sure the Portland Area this. You figure in bigger increase in Purchased and Referred Care and different line items that really help us help our Area. This is going to be a different way of looking at the budget; we'll when the All Tribes meeting comes up and the outcomes. It will be an important meeting to attend. Dean Seyler: As FYI Indian Health Services is switching accounting software to where it will allow Headquarters to drill down into for example Colville Service Unit's budget and take a look at the budget what they are spending it on, what their balance is, they are doing that throughout Indian Health Service for the Federal sites. This is just FYI and it's going to start next fiscal year. We are testing right now and we don't anticipate any glitches in any of the T1, T2 Tribes as far as distribution of funds. Just FYI

New Staff at the Area Office Dr. Cheryl Sixkiller, she is a Doctor of Dentistry she is our Area Dental consultant the prior one was Dr. Woody Crow and I'm sure some of you remember Woody it's been several years since he retired. We hired Dr. Sixkiller she a member of the actually a few Tribes, Seneca, ?, and Cherokee Nation and I was just talking to her about that and she's being told that she needs to pick one or the other both Tribes are telling her they no longer accept dual enrollment. What is new to report is that she's full-time I reported last time that we selected her and she needed to finish up her patient care duties at the Warm Springs Service Unit and so we kinda worked through that transition. She is permanently full-time in Portland. She's already had interactions with the Health Board and it will be a positive addition to the Area for this service. Mrs. Kristi Woodard is our new licensed clinical provider Area Behavioral Consultant. Before that was Michelle Sobell that your staff worked with. Kristi came to us from the VA she is a member of the Confederated Tribes of Colville, so we are looking forward for her involvement and work with the Tribes.

Our current vacancies are our Chief Contracting Officer, Martha Young many of you remember her or worked with her when you dealt with on your Title 1 contracts, we have actively been trying to fill that position. Captain Ardant has been the Supervisor of that program and I know she had multiple interviews, most we had to say "thank you have a good day" type of thing. Because we really didn't feel that they were apt or met the level of need for the Tribes. I'm not sure where we are at with this now. So we are waiting for a new roster. So if you know anyone who fits that category, Indian preference is preferred but it's getting to the point where non-Indians and that's okay.

The Area Diabetes Consultant and Dr. Rudd is currently working on that, in fact I think he's going to be doing interviews so I would anticipate in the next few month you'll see a notice coming out as to who that is. I believe he has three or four, Dr. Rudd? Dr. Rudd responded with four applications and I have interviews this Thursday. So you'll have to give us a few months. And the Indian Self-Determination Act Specialist, that was Wes Simons many of you worked with him also, works in Terry shop and we kinda reevaluating, in fact I think we came up with a new PD announcement where this person focus on 100% of their time on Contract Support Cost that is a full time job in our office. To sit there and calculate and work through that worksheets for each of the Tribes both the Title I and Title V Tribes and full number of 23 T1 contracts and 25 Title 5 contracts. So you can image one person working Contract Support numbers on those is very time consuming.

Audience: INAUBILBE Question

Dean Seyler: So working with our Urban Indian Health Programs again here is the website. There is a request for public comment on the Federal Register and this Program is being ran out of the Office of Environmental Health and Engineering and intent behind it is to be able to have the service to provide to the Tribes to come into your Tribal Daycares and do an assessment, do a review, and provide this information back to the Tribes so they can use that information to either make changes in their programs or to seek grant money and many other funding or to correct any actions that are identified or need to be addressed during the assessments that are environmentally environment issues. So take a look at that please and provide any feedback. The IHS engineers from the Division of Sanitation and Facilities Construction have been completed and reviewed the assessments there were some sanitation deficiencies listed and reported to Congress. This year Portland has listed 91 sanitation deficiencies and proposed projects and all though funding levels depend on a variety of factors and those factors that include budget formulation process one of the things that goes on during our Area meetings for example for the upcoming FY18 and put these into the mix and ask for additional funding and I think most Area's as I recall and was involved directly on the budget calls everyone support that because it has a high impact. And of course the final budget is passed by Congress with IHS and EPA we get a lot of funds here in the Portland Area through the EPA that gets added to the process throughout the Portland Area. Project listings by the other 11 Areas so funding is

prioritized by need based on triage depending on where that higher level of need is at. So you can see there the initial 2017 list has a $65 million level of need, now there not $65 million dollars for the entire agency.

Dean to Rich Truitt: Rich do you know what it is for IHS on a whole? Rich responds: its well over $500 million in need, Dean: Do you know what's been appropriated? INAUBILBE response. In recent years we've been able to reach about $1.8 million with both our funds and EPA and what they set aside.

Greg Abrahamson: Dean on that or a question to Rich is it only goes to our need not growth, because everyone of our Tribes is experiencing growth on the reservation. What do we need to do to change that to go more towards expansion and growth and anticipate 100% growth over the upcoming years then we're not always putting a band-aid?

Rich Truitt: INAUBILBE

Marilyn Scott: is there coordination going on between Indian Health Services and EPA in regards to the priority and the needs? Because the Tribes work directly with EPA and HUD there seems to be a disconnect between the agencies and now looking at this the list and the identification of deficiencies that we have in our communities but I'm just wondering is there and opportunity or any coordination going on between those agencies?
Rich Truitt: It's a complicated answer and I'll try to simplify as quickly as I can, but the coordination is done new and improved housing for the most part it's done at the Tribal level and it use to be that HUD, EPA and IHS work together as Federal agencies trying to coordinate those activities. HUD through NAHSDA delegated that authority and responsibility to each Tribal housing entity and so now the coordination is done at the Tribal level for new and improved housing. EPA and IHS still collaborate on the plans to serve existing homes to address deficiencies, and I would invite for example Marilyn if you have particular issues or others on how did this happen we'd be happy to talk. We have a number of very successful coordination efforts, one with Yakama currently….INAUBILBE

Greg Abrahamson: You don't guarantee funding with that?

Rich Truitt: INAUBILBE

Marilyn Scott: I think there needs to be a connection in the development of FY18 Budget formulation. Rich talked about the coordination between HUD and the federal agencies but we as Tribes and this goes to our own Tribal growth what we're faced with, Tribes are faced with number of Elders and many of our Tribes have young adults so our housing needs are increasing and we're trying to fix the current housing deficiencies and sanitation issues. We're also planning, and Chairman Marchand was talking about their planning and the growth that they

are looking at so it takes a lot of time for Tribes, Tribal Governments to develop plans to meet the needs of our own people. Funding like many of the Tribal leaders have said funding doesn't always come. So there's a connection between the Budget formulation that we submit to Congress and I don't know how we can better coordinate and what we submit to HUD and NAHSDA. But there's not the connection with what we're working with Indian Health Service as it relates to water and sewer the infrastructure I think we need to have some way for our Area Dean Seyler: I'm going to ask Ann Arnett going to be running the next Budget Formulation meeting that that's one of the topics on the agenda for discussion.

I hear you and I understand I know that Rich's office staffed with three different District Engineers and they do work with HUD and Tribal representatives, the Region X office and like I said and the delegation from HUD has been push down to the Tribal Housing Authority's . Correct me if I' wrong Rich but the District Engineers meet with Housing Authority?

Rich Truitt: Yes, they do meet a least once a year, INAUBILBE meet multiple times a year INAUBILBE

Cassie Sellar-Reck: maybe there needs to be a study or needs assessment so they understand how big the need is because you can sit and talk about it but if you don't really understand the need within the communities across the way. We have elders who can get sewage from IHS but can't get homes or help getting a home. You can put something on there but we can't fund it we'll be able to dig you a hole to poop so their disjointed their not matching up to meet the needs of the people.

Dean Seyler: Certainly we'll do what we can with the Housing Authority to put that forth my understanding is the list has been generated is just what you talked about assessment, the needs of the Area plus the needs of the other 11 Area's then are push into one total.
This is just FYI, I'm not going to go over every part of it you can take a look later. This is specific to the Federal Facilities within our Office of Environmental Engineering I just wanted to share with you where we are at with three of the Service Units: Wellpinit, Yakama and Warm Springs and those projects are moving along well.

The Division of Health Facilities and Engineering is the Facility Assessment Program. Jay Song many of you may know him he travels out to the facilities he completes on-site facilities assessments and repairs and prepares the reports. So far we have 13 the final reports and findings will be provided to the Tribal programs unless otherwise noted. Right now according to the list I have here looks like all the Tribes have been notified, is that correct Rich?
Rich Truitt: 13 of the surveys have been completed and reports have been distributed….
INAUBILBE….

Dean Seyler: On thing I forgot to mention was back on slide 1 is the 2016 IHS National Behavioral Health Conference today, today is the pre-conference it's being held at the Marriot Downtown Portland on the waterfront. They have 500 hundred people signed up for that conference that attends that. So I'm not staying here for the rest of the meeting. So I'll be leaving soon to go catch my flight back. I'll be at that conference starting tomorrow through the opening and spend the day with them going over different topics. There's the website. Hopefully you've sent staff to that and get some feedback on that. So does anybody have any questions or comment?

Cassie Sellar-Recks: Dean regarding that conference can you not schedule big conferences like that at the same time the Quarterly Board meeting. Because there are people who'd like to attend that and had to make a choice. Since we didn't have the Youth Track here because staff were attending that and couldn't make that possible. The Quarterly Board meeting dates are out in advance so planning can go around that. I don't think that was and ideal date.
Dean Seyler: I did express that early on when they picked this date with this being a national meeting this is not an Area meeting so, they were actually asking if we could move the Quarterly Board meeting to Portland, and I go I don't think so. That's well thought out with the Tribe and stuff. Unfortunately there are a lot of conflicting dmeetings like that but I'll do my best when there national meetings to express dates that conflict with this the Tribes.
Marilyn Scott: I have a question for clarification you talked about the public comment Proposed Information Collection I don't know if I heard you right did you say that was in reference to the Urban Programs, ….. INAUBILBE..

Dean Seyler: No, Tribal Daycare facilities

Marilyn Scott: Indian Health Service is going to be working on those to conduct those assessments?

Dean Seyler: Yes, along with EPA. Again the intent behind those are to provide the Tribes, you the documentation of the assessment of the environmental factors that maybe impacting that operation to give you that documentation to address those concerns and/or take forward to seek funding from another agency.

Ed Fox: I just wanted a change to complain about CSH having a zero increase this year. And then to say that it looked like we might have a significate balance on the CHEF fund at the end of the year is there a method already or do we need to work on the back end and the idea would be thrown it back into CSC and distributed to the Tribes and why wouldn't you do that. That's one idea. I thought they burned it up at the end of last year. What happens to that?
Dean Seyler: No, there was a slight balance. Let me ask Captain Arnett to look into that. Let ask Terry do you know that?

Terry Dean: Rollover…. INAUBILBE..

Thank you!

EXECUTIVE DIRECTOR UPDATE - JOE FINKBONNER:

Personnel

- **Promotions:**
  - Tanya Firemoon, NDTI Coordinator
  - Geo. Ann Baker, Receptionist
  - Candice Jimenez, Project Coordinator
- **Interns:**
  - Maggie Tafua, Temp Native Fitness Assistant
  - Devonte Casey, Temp Youth Track Assistant
  - Kim Kummer, Temp – TOTS2Tweens
  - Traven Joseph, PRT Temp
  -

Past travel and Upcoming travel

LEGISLATIVE UPDATE – LAURA PLATERO, GOVERNMENT AFFAIRS/POLICY DIRECTOR

Status of FY2017 IHS Budget

- Congress will likely enact a continuing resolution for FY 2017 in September to fund IHS and other federal agencies.
- Senate and House Committees' Interior, Environment and Related Agencies appropriation bills reflect differences (detailed on next slide)
- Committee reports
  - Senate requests GAO report on Advance Appropriations
  - House questions the distribution of population growth funds; and directs IHS to provide a report on full funding for IHCIA
  - Concurrence on CSC; CSC for domestic
  - violence, zero suicide initiative; and volunteer dentists/credentialing

Contract Support Cost

- President's FY 2017 IHS budget proposes an increase of $82m above FY 2016 level for Contract Support Costs (CSC)
- Senate and House Committees' Interior, Environment and Related Agencies bills continue the FY 2016 enacted policy of appropriating an indefinite amount ("such sums as may be necessary") to separate accounts for IHS and BIA.
  - Not classified as mandatory yet.
- CSC Policy - Several recommended changes to the CSC Policy were made following the March 28-29 CSC Workgroup meeting.

- Dear Tribal Leader sent out on 4/11/16 providing a 60-day comment period on the revised policy and three tribal consultations were held.
- Final draft policy will be reviewed by the CSC workgroup in September (15-16 in DC)

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.
- Telephone consultation on October 4 at 12 noon PST.
- Two in person consultations:
  - NIHB Annual Consumer Conference on September 19 in Scottsdale; and
  - NCAI Annual Convention on October 9 in Phoenix.
- Comments are due on October 27 (extended from July 29, 2016).

Tribal Premium Sponsorship

- On July 18th, 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.
- One telephonic consultation held; two in person scheduled:
  - NIHB Annual Consumer Conference on September 19 in Scottsdale; and
  - NCAI Annual Convention on October 9 in Phoenix.
- Comments due on October 31.

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.
- DTLL issued on July 29, 2016 with Tribal consultations set, as follows:
  - Telephone consultations on August 16 and October 24
  - In person consultations at NIHB ACC on September 19 in Scottsdale, and NCAI Annual Convention on October 9 in Phoenix

Medicare-Like Rates (MLR) to Non-Hospital Providers

- Final rule with comment period issued on March 21, 2016 – 81 Fed. Reg. 14977-84.
- Extends MLR to physicians and other health care professional services and non-hospital based services (non-hospital providers).
- Applies to IHS-operated PRC programs and urban Indian health programs; and only to Tribes/Tribal organizations if they opt-in.
- Rule effect on May 20, 2016 but comments were accepted up to this date.
- The Board submitted comments on the definition of “referral” and on opt-in method.

100% FMAP Update

- On February 26, 2016, CMS issued a letter to State Health Officials re-interpreting the scope of services to be considered "received through" an I/T to qualify for 100% FMAP:
    1. "Received through" now includes any services that an I/T is authorized to provide according to IHS rules, and that are also covered under the approved Medicaid state plan, including long-term services and supports (LTSS).
    2. May also include transportation (emergency and non-emergency) and other related travel expenses if it is a covered service under the Medicaid state plan.
    3. I/T's request for service from a non-I/T provider must be in accordance with a "care coordination agreement" and non-I/T provider must be a Medicaid provider.
    4. Two billing options presented: (a) non-I/T provider bills Medicaid directly; or (b) I/T handles all billing.
    5. Effective upon execution of a written care coordination agreement.
- CMS to issue a FAQ on new policy – still pending.

Other Policies

- 6/9/16 - IHS DTLL on FY 2016 $10m increase for Gen I Initiative Support
- 6/15/16 & 7/20/16 - IHS DTLL requesting Tribal Consultation on the draft Quality Framework policy for Direct Service Tribes.
    - Telephone consultation on 8/15/16 at 11 am PST
    - In person consultations at the Great Plains Tribal Chairman's Health Board Summit on August 30, and NIHB Annual Consumer Conference on September 19
    - Written comments due in 60 days
- 7/22/16 – IHS DTLL on SDPI FY 2016 Community-Directed grant application process

STAC Meeting Update

- Last meeting was June 7-8; next meeting is September 13-14
- Tribal leaders made several requests to Secretary Burwell, including:
    - Transition planning for STAC
    - A National Tribal Behavioral Health Summit
    - Work with White House Council on Native Americans to create a Tribal Action Plan
    - Provide information on Opioid abuse and addiction for Indian country
    - Tribal consultations related to CHAP expansion

MMPC & CMS TTAG Update

- Medicare, Medicaid and Health Reform Policy Committee (MMPC) conference call on May 4, retreat on June 13-14, 2016, and face-to-face meeting on July 26
- At retreat:
    - Developed action items
    - Identified priority areas
- CMS TTAG conference call on June 8 and face-to-face meeting July 27-29 in DC
    - CMS and IHS representatives provided updates to tribal leaders

Litigation Impacting Indian Health

- Section 2901(b) -- Payer of Last Report
  - *Redding Rancheria v. Burwell*, No. 15-152 (DDC)
  - IHS has argued in this litigation that Section 2901(b) of the Affordable Care Act (ACA), enacted in 2010, invalidated the IHS's longstanding policy exempting tribal self-insured health plans from the payer of last resort rule.
- Section 105(l) under ISDEAA – Lease Compensation
  - *Maniilaq Association v. Burwell,* No. 14-2035 (RMC)
  - Court held that IHS should negotiate proper lease compensation under 105(l) of the ISDEAA.
  - On July 27, Judge issued a Final Order.

Indian Legislative Issues 114th Congress

- The Comprehensive Addiction and Recovery Act of 2016 (S. 524)
- The Indian Health Service Accountability Act of 2016 (S. 2953)
- The Helping Ensure Accountability, Leadership and Trust in Tribal Healthcare Act (H.R. 5406)
- Department of Interior Tribal Self-Governance Act of 2015 (S. 286)
- Advance Appropriations (H.R. 395)
- Tribal Programs Exemption from Sequestration (S. 1497/H.R. 3063)
- Employer Mandate (S. 1771/H.R. 3080)
- Family Stability and Family Kinship Act of 2015 (S. 1964)
- Native American Suicide Prevention Act of 2015 (H.R. 3166)
- Ongoing:
  - IHCIA Technical Amendments (S. 2114)
  - SDPI Permanent Reauthorization
  - Contract Support Costs mandatory funding and reconciliation language
- **S. 524 –** The Comprehensive Addiction and Recovery Act of 2016 (CARA)
  - Signed into law by President Obama on July 22, 2016.
  - Addresses various issues through prevention and treatment of opioid abuse.
  - The House and Senate disagreed about funding.
  - No funds appropriated for emergency mandatory funding to address the opioid crisis.
  - Contains several competitive grant programs that tribes would be eligible for but there is no tribal-specific allocation of funds.
- House ($500m) and Senate ($261m) appropriation bills recommended discretionary opioid funding.
- **S. 2953** -- The Indian Health Service Accountability Act of 2016
  - Introduced by Sen. Barrasso (R-WY) and Sen. John Thune (R-SD). The Act will improve transparency and accountability at the IHS by:
    - Expanding removal and discipline authorities for problem employees at the agency;

- Providing the Secretary of HHS with direct hiring and other authorities to avoid long delays in the hiring process;
- Requiring Tribal consultation prior to hiring area directors, hospital CEOs and other key leadership positions;
- Commissioning GAO reports on staffing and professional housing needs;
- Improving protections for employees who report violations of patient safety requirements;
- Mandating that the Secretary of HHS provide timely IHS spending reports to Congress; and
- Ensuring the Inspector General of HHS investigates all patient deaths in which the IHS is alleged to be involved

– Referred to Senate Committee on Indian Affairs on 5/19/16.

- **S. 5406** – The Helping Ensure Accountability, Leadership and Trust in Tribal Healthcare Act
  – Introduced by Sen. Kristi Noem (R-SD) on 6/8/16; co-sponsors include Senators Ashford (D-NE), Smith (R-NE), Fortenberry (R-NE), Cramer (R-ND), McCollum (D-MN), and Cole (R-OK).
  – Addresses issues similar to S. 2953 on hiring, removal and demotion but also focuses on more substantive reforms including a long-term contracting pilot program and reforms on the PRC funding formula.
  – Referred to House Committees on Natural Resources, Energy and Commerce, and Ways and Means on 6/8/16; and to House Natural Resources Subcommittee on Indian, Insular and Alaska Native Affairs on 6/13/16.
  – Subcommittee hearing held on 7/12/16.
- **S. 286** – Department of Interior Tribal Self-Governance Act of 2015
  – Introduced by Sen. John Barrasso (R-WY) on 1/28/15; co-sponsors include Senators Tester (D-MT) , Murkowski (R-AK), Crapo (R-ID), Schatz (D-HI), Franken (D-MN)
  – Amends Title IV of of ISDEAA to make it consistent with Title VI, the Self-Governance Program for HHS
  – Creates the same administrative efficiencies for DOI that have been in place for HHS programs.
  – S. 286 passed Senate on 7/7/15 by Unanimous Consent with an amendment
  – Referred to House Natural Resources Subcommittee On Indian, Insular and Alaska Native Affairs on 8/4/15
- **H.R. 395** – Indian Health Service Advance Appropriations Act of 2015
  – Introduced by Rep. Young (R-AK) on 1/14/15; co-sponsors include Senators Kirkpatrick (D-AZ), Huffman (D-CA), Lujan (D-NM)
  – Amends IHCIA to authorize Advance Appropriations for the Indian Health Service and Indian Health Service Facility Accounts

  - Referred to House Natural Resources Subcommittee on Indian, Insular and Alaska Native Affairs on 3/2/15
- Senate and House Bills Exempting Tribal Programs From Sequestration
- **S. 1497**
  - Introduced by Sen. Tester (D-MT) and Sen. Udall (D-NM) on 6/3/15
  - S. 1497 would exempt IHS, BIA, HUD and other Indian programs from sequestration required under the Budget Control Act of 2011
- **H.R. 3063**
  - Companion bill to S. 1497
  - Introduced by Rep. Young (R-AK) on 7/14/15; co-sponsors include Representatives Grisham (D-NM), Cole (R-OK), Ruiz (D-CA), McCollum (D-MN)
- Both bills referred to Budget Committees
- Senate and House Bills Exempting Tribes from the ACA Employer Shared Responsibility Mandate
  - S. 1771-Tribal Employment and Jobs Protection Act introduced by Sen. Daines (R-MT) on 7/15/15; co-sponsors Senators Thune (R-SD), Crapo (R-ID), Rounds (R-SD), McCain (R-AZ), Risch (R-ID)
  - H.R. 3080 introduced by Rep. Noem (R-SD) on 7/15/15; 27 bi-partisan co-sponsors
  - Senate bill referred to Finance; House bill reported favorably out of House Ways and Mean on 6/15/16.
- **S. 1964** Family Stability and Family Kinship Act of 2015
  - Introduced by Sen. Wyden (D-OR) on 8/5/15; co-sponsors Sen. Bennett, Brown (D-OH), Cantwell (D-WA), Casey (D-PA), Gillibrand (D-NY), Menendez (D-NJ), Schumer (D-NY), Stabenow (D-MI), Warner (D-VA)
  - Reforms the federal finance system supporting state and child welfare services
  - Funds preventive services and kinship placements for children at risk of foster placement
  - Current law creates incentives to place Indian children outside of families in order to receive federal funding
  - Encourages child welfare system to forego alternatives to prevent breakup of families like parent training, mental health counseling, trauma recovery, etc.
  - Referred to Finance Committee on 8/5/15
- **H.R. 3166** Native American Suicide Prevention Act of 2015
  - Introduced by Rep. Grijalva (D-AZ) on 7/22/15; co-sponsors are Reps. Ruiz (D-CA), Huffman (D-CA), Young (R-AK), Moore (D-WI), McCollum (D-MN), Grisham (D-NM), Salmon (R-AZ), Napolitano (D-CA) and Cole (R-OK).
  - Amends the Public Health Service Act to require a state or state-designed entity to seek Tribal consultation as a condition of receiving a grant or cooperate agreement for development/implementation of a statewide youth suicide and early intervention and prevention strategy.

– Referred to Energy & Commerce, Subcommittee on Health on 7/24/15.
–

REGION X NATIVE AMERICAN CONTACT – RHONDA MARTINESZ-MCFARLAND, MSN-ED, FNP-BC, ARNP – GAVE ORAL INTRODUCTION AND PRESENTATION

LUNCH – COMMITTEE MEETINGS – WORKING LUNCH

ALZHEIMER'S ASSOCIATION - BOB LEROY, EXECUTIVE DIRECTOR, ALZHEIMER'S ASSOCIATION WASHINGTON STATE CHAPTER, & MICHAEL SPLAINE, SENIOR ADVISOR AND CONSULTANT TO ALZHEIMER'S ASSOCIATION –**PPT**

BILLABLE PEER DELIVERED SUPPORT SERVICE - LONI GRENINGER, TRIBAL ADMINISTRATOR DIVISION OF BEHAVIORAL HEALTH & RECOVERY, DEPARTMENT OF SOCIAL & HEALTH SERVICES

Agenda

1. What are peer support services?
   a. General description
   b. DBHR staff lead contact if you have any questions
2. How do tribes bill for peer support services?
   a. What are the billing requirements for this service?
   c. Is this service eligible for the IHS encounter rate?
   d. Some billing examples
   e. Other payable peer support counselor services
3. Questions and Answers

Peer Support services: Description

Peer Support Services

- Peer support is a service provided to improve recovery outcomes through connections with people with shared lived experience.
- In Washington State, peer supporters whose services are Medicaid reimbursable are called Certified Peer Counselors.
- Peer supporters are important members of the clinical team, and enhance services that can be provided.

Examples of Peer Counselor Roles

Assist in engaging with and communicating with providers
- Provide hope and encourage-ment in a unique way

Assist in maintaining community living skills, including housing and employment
- Provide role models in recovery

Provide a "bridge" for people transitioning from inpatient to the community
- Act as organizational change agents for recovery

Meet in outpatient settings to work on goals and crisis stabilization
- Teach classes leading to increased activation

Peer Support Values

Recovery

- Hope
- Empowerment
- Strengths based
- Respect

Resiliency

- Personal Responsibility
- Self-direction
- Individualized
- Non-linear

Wellness

- Holistic
- Trauma Informed
- Culturally appropriate

The Certification Process

Peers must:

- Be mental health consumers
- Apply for training and be accepted as a candidate
  - Attest to consumer status (including as parent of consumer)
  - Adequate reading and writing skills
  - In recovery at least one year
- Complete the 10 hour online course and the 40 hour in-person class
  - DBHR offers about six classes per year, and organizations can also purchase trainings from an approved contractor.
- Take and pass the state test
- If employed by a licensed agency, gain Agency Affiliated Counselor credential from DOH

Other Considerations

- Peer Services can only be billed by DBHR certified peers
- Must be supervised by a mental health professional
- May be employed by a health agency or subcontracted to a peer run organization
- Should receive on-going continuing education as well as role-specific training
- Employment expectations should be equal to other employees

Peer Support Outcomes

- **Satisfaction**
  - Almost universal satisfaction and appreciation by individuals and families
- **Outcomes**
  - Decrease in symptoms
  - Increased coping skills and awareness of early warning signs
  - Fewer hospitalizations, shorter lengths of stay
  - Improved social functioning
  - Increased feelings of hopefulness, self-advocacy and empowerment

  Peer specialists say “We are the evidence”

Peer Support services: Billing

This service is payable today

- This service has been payable in ProviderOne since April 1, 2015 for all dates of service

Peer Support: Billing Requirements

Client: Medicaid-enrolled AI/AN or clinical family member (CFM)
Peer Support Service Provider: Certified Peer Support Counselor
Minimum Time per Client: 10 minutes
Daily Maximum Time per Client: 4 hours
Payment Rate: $60 per hour (¼ hour increments)
Site of Service: Any location that meets privacy requirements
Support Group Peer Counselor-to-Client Ratio: No more than 1-to-20
Procedure Code: H0038 - "Self-help/peer services, per 15 minutes"
Procedure Code Modifier:

- "HE" for AI/AN client
- "SE" for non-AI/AN clinical family member client

- **Billing NPI:** IHS or Tribal 638 facility
- **Billing Taxonomy:** 2083P0901x
- **Servicing NPI:** Supervising ProviderOne-enrolled Mental Health Professional who understands rehabilitation and recovery
- **Servicing Taxonomy:** As applicable
- **Diagnosis Code:** Valid ICD-10 diagnosis as appropriate for service
- **Referring NPI:** Not required
- **Prior Authorization:** Not required other than EPA (see next)
- **Expedited Prior Authorization (EPA): Required - 870001349**
- *"Either: (1) client has elective exemption from Medicaid Managed Care under 42 U.S.C.1396u-2 (e.g., client is AI/AN); or (2) client is a Clinical Family Member."*

Peer Support: IHS Encounter Rate

The services of certified peer support counselors are not eligible for the IHS encounter rate.

- Peer support counselors are not included in the State Plan list of IHS encounter-eligible provider types.

Peer support services are considered a mental health service.

- The facility may not bill for the peer support counselor's services if the facility receives an IHS encounter payment for mental health services for the same client during the same 24-hour period.

Peer Support Counselors: Other Payable Services

- **Day Support**
  H2012 - "Behavioral health day treatment, per hour"
  - Rate: $31.05 per hour
- **Medication Monitoring**
  H0034 - "Medication training and support, per 15 minutes"
  - Rate: $22.47 per 15 minutes
- **Therapeutic Psycho-Education**
  H0025 – "Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)"

- Rate: $6.58 per service

H2027 – "Psycho-educational service, per 15 minutes"

- Rate: $12.01 per 15 minutes

EXECUTIVE SESSION: None

RECESS

WEDNESDAY AUGUST 10, 2016

Call to Order: Andy Joseph, Jr. Chairman

Invocation: Andy Joseph, Jr. Chairman

WEAVE PROJECT – EPICENTER SURVEY – NANETTE YANDELL, WEAVE PROJECT DIRECTOR

Introduction

- Survey conducted in Fall 2015
- Completed by 26 Tribes
- Purpose:
  - Feedback for EpiCenter
  - Health Priorities
  - Public Health Policies

What is the EpiCenter doing well?

- ✓ Data reports
  - ✓ http://www.npaihb.org/resource-lib/
- ✓ Public health information – general
- ✓ Grants, financial assistance
- ✓ Responsive and friendly staff

What can we improve?

- More outreach to programs outside of administration
- Tribal government public health policy
- Provide best practices, esp. tribally adapted & culturally appropriate
- Tribal data warehouse
- Technical Assistance for NextGen
- Better communication of what the EpiCenter does

Data products such as fact sheets and health profiles were the most commonly used

Top Three Health Priorities

1. Overweight and obesity (10)
2. Substance Abuse (7)

3. Mental health (6)

Please see the additional Charts and graphs included in the PowerPoint presentation
FOOD SOVEREIGNTY - VALERIE SEGREST, TRADITIONAL FOODS PROGRAM MANAGER FOR MUCKLESHOOT
Presentation done in Prezi, please visit
http://prezi.com/o0so50ckc4pt/?utm_campaign=share&utm_medium=copy&rc=ex0share

BREAK

COLVILLE'S NARCH PROGRAM – HAUS MAREMSUME, PPT INCLUDED

SALISH CANCER CENTER - DR. EIKO KLIMANT, CLINICAL DIRECTOR
Objectives

- Recognize the unique challenges of Native cancer care.
- Examine the integrative model of oncology care.
- Recognize the benefits of combining traditional healing services in the care of Native American cancer patients.
- Recognize the Salish Cancer Center, the first tribally owned cancer center in the nation

The Native American Population

- An estimated 4.5 million people are classified as American Indian or Alaska Native
- 1.5 percent of the total population
- Over 560 Federal and 100 State-recognized tribes nationally

Higher Native Cancer Mortality

Cancer Sites	AI/AN MIR (95% CI)	White MIR (95% CI)	AI/AN:White Ratio[a]
All cancers	0.49 (0.48, 0.50)	0.39 (0.39, 0.39)	1.26
Bladder	0.24 (0.20, 0.27)	0.20 (0.20, 0.20)	1.19
Breast (female)	0.22 (0.21, 0.24)	0.18 (0.18, 0.19)	1.22
Cervical (female)	0.38 (0.33, 0.44)	0.28 (0.27, 0.29)	1.36
Colorectal	0.42 (0.40, 0.44)	0.36 (0.36, 0.36)	1.16
Hodgkin disease	0.21 (0.14, 0.30)	0.15 (0.14, 0.15)	1.40
Kidney and renal pelvis	0.35 (0.32, 0.38)	0.30 (0.29, 0.30)	1.18
Leukemia	0.60 (0.55, 0.67)	0.58 (0.57, 0.58)	1.05

Liver/intrahepatic bile duct	0.91 (0.83, 0.99)	0.91 (0.90, 0.93)	1.00
Lung and bronchus	0.83 (0.80, 0.86)	0.77 (0.77, 0.78)	1.07
Ovary (female)	0.68 (0.61, 0.77)	0.66 (0.65, 0.67)	1.03
Pancreas	0.96 (0.88, 1.05)	0.95 (0.94, 0.96)	1.02
Prostate (male)	0.23 (0.21, 0.25)	0.17 (0.17, 0.17)	1.40
Stomach	0.70 (0.64, 0.78)	0.56 (0.55, 0.57)	1.27
Uterus (female)	0.18 (0.16, 0.21)	0.16 (0.16, 0.16)	1.14

Cancer Care in Native Population

- Lower overall incidence but higher overall cancer mortality
- Cultural barriers to prevention and care
- Community and system level barriers to care

The Future of Native Cancer Care

- Improved prevention, screening➔ Decrease Incidence
- Improved cancer care➔ Decrease mortality
- Respect for the culture of native cancer patients
- Whole person approach: Body, Mind, and Spirit I.e.

" A Integrative approach"

What is Integrative medicine?

"The practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals and disciplines to achieve optimal health and healing."

Integrative Oncology Care Model

- Medical Oncology
- Lifestyle counseling: Diet and Exercise education
- Naturopathy
- Native plant medicine
- Chinese Medicine
- Acupuncture
- Spiritual support

- Other evidenced based complementary or alternative therapies: biofeedback, massage, music therapy, art therapy, etc.

Native Healing in the Integrative Model of Care

- **Unique treatment goals in the Native American Population:**

1) Overcoming negative patient experiences and gaining trust
2) Overcoming historical trauma related to health care and boarding schools

Integrative Oncology Care

- By optimizing supportive care during treatment and beyond:

1) Enhance quality of life
2) Decrease treatment associated side effects (i.e chemotherapy toxicity)
1) Promote wellness and optimized survivorship
2) And potentially even enhance response to therapy

Salish Cancer Center: Addressing the Unique Needs of Native Americans

- Philosophy: To blend medical oncology with evidenced-based integrative therapies to treat the whole person — mind, body, and spirit. This unique approach is recognized as "Integrative Oncology".
- Team: 2 medical oncologists, 1 nurse practitioner, 1 naturopathic oncologist, 1 Chinese medical doctor and acupuncturist, and highly respected experienced native healers.
- Services: State-of-the-art medical oncology including 23 chair infusion centers combined with: naturopathic care, acupuncture, moxibustion, cupping, Chinese medicine, essential oil therapy, vitamin infusions, native healing, and survivorship care planning.
- Patients: Native and Non-Native with all cancer types with exception of acute leukemia.

Native traditional healers from various tribes throughout the US

At Salish Cancer Center, All patients are given an opportunity to supplement their healing process through services offered by our Native American Traditional Healers

Gaining Trust – Optimal Native Healing Environment

- Staff are empathetic compassionate
- Staff Understand various Native communication styles
- The environment is conducive to Native Healing

Salish Cancer Center Our Initiatives

1) Patient Care Excellence
    - Developing community partners and optimizing the patient care experience.
    - State of the art EHR
2) Survivorship
    - Program development with a native focus

- focus on continuum of care for the cancer patient starting with diagnosis and beyond

3) Research
    - Develop community partners and research network
    - Major areas of focus

Salish Initiative: Patient Care Excellence

- Evidence-based standard of care Oncology with adherence to guidelines eg NCCN and ASCO guidelines
- Optimized supportive care with an integrative approach
- New Electronic Health Record: high level documentation to capture outcomes, and show the value of care
- Develop Collaboration with Community partners such as the Franciscans, Multicare, and Group Health

Salish Initiative Survivorship: Current and Projected Cancer Survivors in US

- 14 million survivors (as of January 1, 2012)
- 18 million survivors (as of January 1, 2022)

Survivorship: Definition

Who: Anyone who has been diagnosed with cancer
When: From the time of diagnosis through the rest of their lives
How: Survivors embrace their lives beyond their illness
Who else: Family members, friends, and caregivers are also impacted by the survivorship experience

- Covers the physical, psychosocial, and economic issues of cancer, from diagnosis until the end of life
- Includes issues related to the ability to get health care and follow-up treatment, late effects of treatment, second cancers, and quality of life

4 Major Areas of Cancer Survivorship

1) Surveillance , screening and prevention of recurrence and new cancers
2) Identification and management of late and long-term effects
3) Recommendation and promotion of improvements of modifiable health behaviors
4) Coordination of care (provider-provider and patient-provider) to ensure that patient health needs are met

Salish Integrative Survivorship Program

- Survivorship medical care plan
- Native drumming and Meditation daily
- Native spiritual healing
- Acupuncture
- Naturopathy
- Nutrition education
- Tai Chi/Qi Gong classes

- Massage, counseling, on-line classes, native healing practices program all in development

Salish Initiative: Research

- 4 main areas : medical oncology, integrative medicine, cannabis, and Native American
- Participate in community based research networks
- Program development in the 4 major areas

Research

- **Current Collaboration** with Bastyr/Mayo Clinic/Arizona State University

-The Canadian/US Integrative Oncology Study (The CUSIOS study)
-Clinical Trial of Yoga in Myeloproliferative Neoplasms
-Clinical Trial of Tai Chi in Multiple Myeloma during Autologous SC Transplant

- **Goals:**

1) To advance integrative medicine and build evidence-base for integrative therapies
2) Develop research questions and collaborative partners with native focus
3) Build research infrastructure: research nurse, statistical support, etc

-If interested in collaborating on native specific or integrative research email: krisstina.gowin@salishcancercenter.com

Conclusions:

- Native cancer specific mortality is high
- Native cancer patients have many unique needs and risk factors
- The Integrative model of care offers a whole person system of healing that may address the unique needs of native cancer patients
- Salish Cancer Center is the first tribally owned integrative cancer clinic in the U.S. offering high level evidence-based medicine in combination with integrative services such as native healing.

Contact Information: eiko.klimant@salishcancercenter.com

LUNCH

Tribal Updates

1. Cow Creek - Sharon Stanphill, Health & Wellness Director
2. Jamestown S'Klallam – Brent Simcosky, Director of Health Services
3. Klamath – Sandy Walker, Tribal Council

NPAIHB WELLNESS AND TEAM HANDS – BIRDIE WERMY, EPICENTER NATIONAL EVALUATION SPECIALIST

Wellness @ Work

- NPAIHB Wellness Activities
  - Monthly wellness tips & weekly workouts led by staff
  - Spokane challenge
  - NPAIHB 8 wk fitness challenge – 3rd annual
  - Monthly Birthday recognition
    - Healthy all staff food
  - Quarterly potlucks
- NPAIHB Wellness Activities
  - Executive Director's Annual Hot Dog Feed/Chili Cook Off – Oregon Food Bank
  - Annual Picnic
  - Annual Indian Day Celebration
  - Co-Ed Basketball team (5 staff)
  - Team HANDS Hood 2 Coast Team

2015 Accomplishments

- Spokane Challenge – 6 weeks
- Valentine's Day Potluck
  - optional workplace activity – February
- St. Patrick's Day Potluck – March
- Graduate Recognition Potluck – June
- 2nd Annual 8 week summer challenge – staff awarded with NPAIHB shirt
- 2 Brown Bag luncheon presentations – nutrition
- Box of toiletries – NARA/Indian Day Celebration
- 3 baby showers
- Annual all staff picnic @ Oaks Amusement Park – August
- NICWA gifting program – partnered with BIA for Christmas gift tags
- Hot Dog Feed – Oregon Food Bank – December
- Holiday Party (Jon's Incredible Pizza)– December
- Oregonian Newspaper – Top Workplace award
- Sit-stand desks installed & used daily – 35 total (out of 43 staff)

Workplace Wellness

3 Treadmill desks, Lactation/Changing room – some Tribe's had to pass a resolution for mothers to breastfeed in the office. Private cubicle area, Sit-stand desk – started with one employee purchasing the desk in January of 2014. As of 2.15 16 staff have a sit-stand desk.
Shower/changing room

Weekly 3-5 Mile Runs

Groups of 3-5 staff each week take part in weekly runs/workouts. Turnout = more w/ calendar reminders.

Fitness Challenges

- 2014 & 2015 - 6 week Spokane Fitness Challenge
- 24 & 25 participants
- Log weekly minutes with a minimum goal of 150/week

- Aggregate reports
- Incentives
- 2016 update – 8 week
  - 1.08.16-3.07.16
- 25 participants in 2016. We've led each week in the "Urban Category" since week 1 out of 7 other organizations w/ an average of 8,357 minutes.
- **2014** NPAIHB 8 week Fitness Challenge
- 18 participants – honor system
- **2015** NPAIHB 8 week Fitness Challenge
- 22 participants
- T-shirt incentive & raffle drawing
- **2016** NPAIHB 8 week Fitness Challenge
- 32 participants!!

2015 NPAIHB Wellness Survey

- Survey was previously completed in 2012 & 2015
- 2.02.15 – Wellness Survey administered to all staff in office (40) 8 questions
- 29 respondents; 28 use their 30 mins of Wellness @ work
  - 24 staff members reported their use in 2014
  - Others use it at the gym
  - Cycle
  - Swim

Wellness Conferences

- Native Fitness Training
  - Beaverton, OR
  - Sept. 1-2 2015
- Native Women's & Men's Wellness Conference
  - San Diego, CA.
  - 2013, 2014 & 2015
- Wellness @ Work Steering Committee - quarterly
  - Oregon Public Health Institute
- Improve Employee Health & Well Being - OPHI Webinar
- Sedentary Work: Implications & Interventions for Worker Safety & Health
- Moore Institute Symposium – Nutrition of Girls & Women in Oregon

2016 Goals

- Send weekly workouts/monthly wellness tips
- Initiate 8 week challenge (summer)
  - Participate in other Tribal fitness challenges
  - Shamrock run, Race for the Cure, AIDS walk
- Continue to implement suggestions from NPAIHB Wellness survey
  - Secret Pal board – 6 months
  - Brown bag presentation(s)

  - Yoga sessions/videos & other weekly workouts (bike riding & meditation etc.)
- HANDS Hood to Coast Team (August)

Hood to Coast Race Series
WHAT IS Hood to Coast?

DATES: August 26 - 27, 2016
TOTAL TEAMS: 1,050 teams of 12 runners (minimum of 8)
RACE COURSE: Hood To Coast is 198 miles long.
TOTAL PARTICIPANTS: The 2016 event will include 12,600 runners and 3,600 volunteers
ORIGIN: HTC began in 1982 with 8 teams and has filled the team cap on the opening day of registration for the last 18 years straight!

Why do it?!?

- **We LOVE Wellness**
  - NPAIHB advocates for wellness in the workplace and we take advantage
- **We feel lucky!**
  - More than 2,800 teams from all 50 states and over 38 countries applied and ONLY 1,050 got in!
- **We are Healthy Active Natives Doing Something!**
  - Our team is NOT about becoming expert runners, our team IS about the joy of being physically active and healthy – walk the talk!

Hood to Coast is rewarding experience. It's more than just a run. It's a bonding experience. It's a way to express what your body can do. And it's just plain fun! You walk away feeling like "Wow I did that" or more likely "Wow WE did that."

Workplace Wellness

- Changing the workplace wellness dynamic – more staff are using their 30 minutes of wellness/fitness challenges!
- Different group activities! More staff are getting out to exercise!
- Supportive workplace for everything we do!
- Wellness is a big DEAL!
- Secretly challenging one another!
- Discipline
- Walk the talk!
- MORE to come!!!

CHAP/DHAT - PAM JOHNSON, ORAL HEALTH PROJECT SPECIALIST

IHS Draft Policy Statement Creating a National Community Health Aide Program
June 1, 2016 - Indian Health Service (IHS) released a Dear Tribal Leader Letter and a policy statement titled, "Creating a National Indian Health Service Community Health Aide Program." Their goal is to see community health aides utilized to the fullest extent permissible in IHS and tribally run hospitals and clinics

What is CHAP?
The Community Health Aide Program is a tribally-created, tribally-run healthcare delivery system in Alaska that uses a series of practitioners, recruited from their communities, to improve oral, behavioral, and overall health outcomes. They have served as the frontline of healthcare in their communities since the 1960s.

Certification

CHAP Certification Board
Federal Authority, 11 members

Standards and Procedures
Individuals, Training Centers, Curricula

468 individuals certified
357 CHA/Ps certified
63 Dental Health Aides certified
48 Behavioral Health Aides certified

Community Health Aides and Community Health Practitioners
There are 5 levels of Community Health Aides that build upon each other: Community Health Aide I, CHA II, CHA III, CHA IV and the top level, Community Health Practitioner (CHP).

What can CHA/P's do?
Depending on their level of certification, CHAs can provide services such as:

- Emergency first aid
- Patient examinations
- Carrying out treatment recommendations
- Patient and family focused education and instruction
- Preventive health programs
- Infection and disease control
- Immunizations
- Store and dispense prescription drugs (with physician instructions)

eCHAM
Alaska Community Health Aide/Practitioner Manual
Offline versions require initial Internet access.

- A guide to the CHA/P for every patient encounter
- Identifies specific section to guide exam and assessment and determine plan
- Online: eCHAM Website
- Offline: iCHAM (iPad app)
- Backups: ePub and PDF

- Personalization features (bookmarks, comments, highlights)

BHA Behavioral Health Aide

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

Who do BHAs provide services to?

- Individual (grief and loss, case management, substance abuse assessment and treatment, skills building)
- Elder (case management, welfare checks, community luncheons, appointments, housing or other resource applications, psychoeducation)
- Youth (IEP meetings, skill development, anti-bullying activities, youth groups, presentations, culture camps)
- Family (case management, resource identification and coordination, referrals, ICWA, WIC assistance, disability and Medicaid applications)

Types of Dental Health Aides (DHA)

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

Prevention, operative, urgent

Supervised providers

Teams led by Licensed Dentists

- **DHA Success**
  - 51 certified DHA
  - DHAT in 80+ communities
  - 40,000+ access to direct care

Expansion of CHAP Would Benefit the Tribes in the Lower 48

- Provides routine, preventive, and emergent care within the community;
- Respects the knowledge and resources in the Tribal community and grows providers from that source through accessible and achievable training programs;
- Delivers patient-centered quality care that comes from providers that understand the history, culture, and language of their patients;

- Fosters a team approach to delivering health care services, increasing the efficiency of the entire healthcare team;
- Provides continuity of care in communities that face recruitment and retention challenges;
- Results in cost savings to Tribes and individuals that no longer have to travel long distances or receive care outside of the IHS system.

Many Tribal Communities in the lower 48 have experienced similar barriers to consistent, high quality, culturally competent care as Alaska Native communities have. Instead of continuing to struggle with a health system that doesn't work for native communities The Alaska Native Tribal Health Consortium has put significant work into supporting innovative initiatives that has brought more native providers into the system and restructured the health care delivery system to meet the needs of the Alaska Native people and meet them where they are. There is no reason to continue to try to fit a square peg into a round hole. We have an opportunity with the expansion of CHAP to the lower 48 to replicate that success and reshape the health care delivery system for our communities that will begin to chip away at the damage done by years of little or no care, historical trauma, and a health care system that doesn't encourage our young people to become providers or take the unique needs of our communities into account. While the CHAP program was founded on the community health aide provider, it would be a mistake to expand the program without the other two provider categories in the program: DHATs and BHAs

There is significant lack of access to care for both oral and behavioral health. This is an opportunity to attach the head back to the rest of the body.

Legislative Fix needed to expand DHAT to lower 48

After losing its court battle in Alaska to prevent DHATs from providing services to Native Villages, the following language was inserted in the re-authorization of the Indian Health Care Improvement Act (as part of the Affordable Care Act):

Expansion of the Indian Health Service Community Health Aide Program "*shall exclude dental health aide therapist services from services covered under the program…"* Unless requested by *"an Indian tribe or tribal organization located in a State (other than Alaska) in which the use of dental health aide therapist services or midlevel dental health provider services is authorized under State law to supply such services in accordance with State law."*

In Order for the CHAP expansion to be complete, and include all of the providers currently serving Native communities in Alaska, there will need to be a legislative fix. After losing a court battle in Alaska to prevent DHATs from providing services in Native Villages, the ADA lobbied hard to include language in the permanent reauthorization of the Indian Health Care Improvement act that has served as an unnecessary barrier to oral health care. Tribal leaders now must go to the state and ask permission to use these providers and still be able to use their IHS resources to support the care provided by DHATs.

Swinomish Indian Tribal Community
On January 4, 2016, Daniel Kennedy, an experienced DHAT, joined the Swinomish Dental Team in making history by becoming the first Tribally licensed Dental Therapist providing services in the lower 48 states.
And it is important to recognize that we already have DHATs practicing in the lower 48. Daniel Kennedy has been providing services at the Swinomish Indian Tribal Community since the beginning of this year.. A licensing code and board were established, providing sovereign tribal authority for all of their dental providers, including DHATs to practice at Swinomish.

DHATs coming to Oregon Tribes
And in Oregon, there are two tribes with 4 students at the ANTHC DHAT Educational Program. Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians and the Coquille Indian Tribe will have DHATs practicing at their clinics under the authority of a state dental pilot program. DHATs are becoming a reality for Tribes in the lower 48, even without CHAP expansion, but as I said before, the ability to use IHS resources to fund the DHAT programs is a key ingredient to expanding DHATs to more tribes who want to employ them. CHAP expansion and possible legislative fixes is one pathway to do that.

Behavioral Health Aides Can Play a Key Role in Mental Health and Substance Abuse Care
Native communities face behavioral health service delivery issues that are complicated by personnel shortages, limited health care resources, and distances to obtain services. There also are other issues that inhibit access to appropriate behavioral health services. These include referrals from school, detention, court, housing, primary care, child welfare, and other systems.

Barriers to providing appropriate behavioral health care in our tribal communities have been; inadequate staffing levels, lack of available psychiatrist for adults and children, adult and child psychologist to see clients in need of specialized treatment and assessments, cultural competency, Native American staff, and funding. Other issues include inadequate prevention, education, and screening for early identification of youth or adults at risk for suicide. In order for these barriers to be addressed effectively we need to look at solutions that encourage and support more Native American and Alaska Native Staff and just like with oral health and physical health, we need to look at the current delivery system and the needs of our communities and find solutions like the Behavioral Health Aide providers that can start us down the path of a more responsive and successful behavioral health care delivery system.

Suggested process comments
- IHS must consult and work with each Area to establish regional Federal CHAP Certification Boards.
- Tribal participation in the CHAP program is optional

IHS should not adopt a national certification board. Instead, IHS should allow each of the IHS Area Offices to establish a Federal CHAP Certification Board. Tribes in the Area should then have the option to participate in CHAP or not. It is suggested that IHS look closely at the existing certification board in Alaska and licensing board at Swinomish when considering strategies and options for the nationalization of the CHAP program. It would be counterproductive to create national licensing processes, rules, regulations, and/or laws that would hinder, prohibit or make irrelevant the existing Tribal infrastructure and successful licensing and certification entities in Alaska and Washington. Any nationalization of the CHAP program should respect the sovereignty of Tribes currently using one or all of the providers in the CHAP program. 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 current needs. It would also ensure that successful programs like Alaska would not be adversely affected by changes made at the federal level in the program.

- IHS should host a 2-3 day national conference and workshop to educate tribal and health leaders about the CHAP program and start the dialogue for national expansion.

Due to the magnitude of the proposed transformation of the health care delivery system in Indian country in the lower 48, we suggest that IHS kicks off the national dialogue with a 2-3 day national conference to discuss with Tribes this program expansion. The CHAP program is well known in Alaska but less understood in the rest of Indian country. Tribal leaders and providers all over Indian country need adequate time to become educated in order to foster meaningful participation.
Finally, we believe that having the right expertise in the room through the nationalization process is of paramount importance. We suggest a nationalization workgroup be immediately formed that includes at a minimum the following individuals and/or expertise:

- Indian Health Law experts familiar with the CHAP program
- National Indian Health Policy experts familiar with the CHAP program
- Indian Health Policy experts from each of the IHS Areas
- Providers or individual representing different provider disciplines, including a Community Health Practitioner, a Dental Health Aide Therapist, and a Behavioral Health Practitioner, alongside a doctor, dentist, and behavioral health provider.
- A representative from the Alaska CHAP board
- A representative from the Alaska Native Tribal Health Consortium
- A representative from the Swinomish licensing board
- A representative from the National Congress of American Indians
- A representative from the National Indian Health Board

- IHS should convene a CHAP expansion workgroup with representation from those with experience and expertise in the areas of the providers, certification process, and legal issues

- IHS Must Foster an Internal Culture that Supports Mid-Levels to Ensure the Success of an Expansion

Ensure the Success of an Expansion

As with any significant change to the health care delivery system, there are professions with a vested interest in maintaining the status quo. The expansion of the CHAP program to the lower 48 will upset that status quo. It will be of paramount importance that the culture of professionals within the agency and serving Tribal communities throughout the country be one of acceptance. Without the support and advocacy of providers within the IHS, any expansion will be vulnerable to failure, obstructed, and potentially unsuccessful. The IHS leadership must begin to lay the groundwork now to change the culture of providers within the agency and insist that they accept and embrace new ideas to foster reformation of the health care delivery system in Indian country.

Next Steps

- Encourage your Tribe to send a letter of support. Template letter available
- **Comments Due October 27, 2016**
- IHS telephone consultation October 4, 2016 at 12pm PST
- In person consultations:
  NIHB ACC in Scottsdale on September 19th
  NCAI's Annual Convention in Phoenix, October 9th.

RECESS

THURSDAY, August 11, 2016

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

Invocation: Andy Joseph, Chairman

CHAIRMAN'S REPORT, ANDY JOSEPH, JR

This past quarter I attended over 10 events as Board chair.

In April, I attended the Tribal Self-Governance conference in Orlando, Florida. At the Self-Governance conference I participated in the Indian Health Service 2016 to 2018 Budget updates and was involved in the tribal consultation on the IHS Contracts Support Costs Policy.

The following week I was at the Tribal Emergency Preparedness Conference in Spokane. It's always good to attend events near home!

In May, I attended the HHS Region X Tribal Consultation meeting in Suquamish. Our Northwest Tribal Leaders brought many issues to the attention of Susan Johnson, Region X Director for HHS as well as other HHS leadership. Another Contract Support Costs Policy consultation took place at the Region X conference which I participated in. CMS leadership was asked many questions about managed care and its impact on Northwest tribes.

In May, I also had the opportunity to travel to Anchorage and participate in the Kellogg Alaska DHAT program education tour. I was able to see how the Alaska DHAT Education Program operates and meet dentists and stakeholders from other states who are interested in the program.

I attended the ATNI mid-year conference at Spirit Mountain and we worked on several important issues there. At ATNI, tribal leaders supported several resolutions including a tribal exemption from the Affordable Care Act large employer mandate.

In June, I travelled to DC to provide testimony to HHS on IHS funding as part of my work with the IHS Budget Formulation Workgroup.

I also attended a Facilities Appropriation Advisory Board (FAAB) meeting in Anchorage. The FAAB is a standing committee of Tribal and IHS representatives. FAAB makes recommendations to leadership at IHS on matters involving all Office of Environmental Health and Engineering (OEHE) programs.

In June I also attended the NCAI mid-year conference in Spokane. It was great to see so many Northwest Tribal Leaders at the meeting. Several important resolutions were passed including the one ATNI moved forward requesting a tribal exemption from the large employer mandate.

In July, I attended the Portland Area Direct Service Tribes meeting in Portland and the IHS Budget Formulation meeting in Denver, Colorado.

At the end of this month, I'll be attending the IHS Direct Service Meeting, Rapid City, South Dakota and in September I'll be at the ATNI fall convention in Tulalip.

FINANCE REPORT – Eugene Mostofi

MOTION: BY GREG ABRAHAMSON, SPOKANE, 2ND SHAWNA GAVIN, UMATILLA

COMMITTEE REPORTS

ELDERS COMMITTEE – Patti Kinswa-Gieser (A copy of the report is attached)

VETERANS – No meeting

PUBLIC HEALTH - Victoria Warren-Mears (A copy of the report is attached)

BEHAVIORAL HEALTH – Nanette Yandell (A copy of the report is attached)

PERSONNEL – Cassie Sellars-Reck (A copy of the report is attached)

YOUTH – Devonte Casey (A copy of the report is attached)

MINUTES - April 2016 Minute approval,
MOTION: BY LELAND BILL, YAKIMA, AND 2ND BRENT SIMCOSKY, JAMESTOWN

LEGISLATIVE/RESOLUTION COMMITTEE – Laura Platero: (A copy of the report is attached)

RESOLUTION: Resolution No.:16-04-01 Northwest NARCH 9 Program
MOTION: RATIFIED BY BOARD

RESOLUTION: 16-04-02 Portland Area Fetal Alcohol Spectrum Disorders Funding
MOTION: CASSIE SELLARS-RECK, COWLITZ, 2ND SHAWNA GAVIN, UMATILLA

RECOGNITION EMPLOYEE OF THE YEAR: Birdie Wermy

April 2016, Yakama will host if hotel is complete.

ADJOURN: MOTION: BY SHAWNA GAVIN, UMATILLA, 2ND BY LELAND BILL, YAKAMA

ADJOURN at 10:25 am

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
AUGUST 2016 QUARTERLY BOARD MEETING
12 Tribes Resort Casino, Omak, WA

MINUTES

_____ _____

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

_____ _____

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

_____ _____

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

QUARTERLY BOARD MEETING
12 Tribes Resort Casino
Omak WA 98841
August 9-11, 2016

AGENDA

MONDAY, AUGUST 8 2016

2-5 PM	Tribal Health Directors	

TUESDAY, AUGUST 9, 2016		
7:30 AM	**Executive Committee Meeting**	**The Boardroom**
9:00 AM	Call to Order Invocation Welcome Posting of Flags Roll Call	Andy Joseph, Chairman Barb Aripa, Tribal Elder Dr. Michael Marchand, Colville Chairman Omak Color Guard Shawna Gavin, Treasurer
9:15 AM	Area Director Report **(1)**	Dean Seyler, Area Director
10:00 AM	Executive Director Report **(2)**	Joe Finkbonner, Executive Director
10:30 AM	Policy & Legislative Update **(3)**	Laura Bird, Governmental Affairs/Policy Director
11:15 AM	Region X Native American Contact (NAC) **(4)**	CDR Rhonda Martinez-McFarland, MSN-ED, FNP-BC, ARNP
12:00 PM	**LUNCH** Committee Meetings *(working lunch)* 1. Elders 2. Veterans 3. Public Health 4. Behavioral Health 5. Personnel 6. Legislative/Resolution 7. Youth	Staff: Clarice Charging Staff: Don Head Staff: Victoria Warren-Mears Staff: Nanette Yandell Staff: Andra Wagner Staff: Laura Bird Staff:
1:30 PM	Alzheimer's Association **(5)**	Bob LeRoy, Executive Director, Alzheimer's Association Washington State Chapter, & Michael Splaine, Senior Advisor and Consultant to Alzheimer's Association

2:15 PM	Billable Peer Delivered Support Service ***(teleconference)*** **(6)**	Loni Greninger, Tribal Administrator Division of Behavioral Health & Recovery Department of Social & Health Services
3:00 PM	**BREAK**	
3:15 PM		
4:00 PM	Executive Session	
6:00 PM	***Dinner host by Colville at the Omak Longhouse***	

WEDNESDAY AUGUST 10, 2016

9:00 AM	Call to Order	Cheryle Kennedy, Vice-Chairman
9:15 AM	WEAVE Project – EpiCenter Survey **(7)**	Nanette Yandell, WEAVE-NW Project Director
9:45 AM	Food Sovereignty **(8)**	Valerie Segrest, Traditional Foods Program Manager for Muckleshoot (INVITED)
10:15 AM	Salish Cancer Center ***(teleconference)*** **(9)**	Dr. Eiko Klimant, Clinical Director
10:45 AM	**BREAK**	
11:00 AM	Colville's NARCH Program **(10)**	Haus Maremsum (House of Good Medicine)
12:00 PM	**LUNCH**	
1:15 PM	Tribal Updates 1. Cow Creek 2. Jamestown S'Klallam 3. Klamath	
1:45 PM	NPAIHB Wellness and Team HANDS **(11)**	Birdie Wermy, EpiCenter National Evaluation Specialist
2:15 PM	CHAP/DHAT **(12)**	Pam Johnson, Oral Health Project Specialist
2:45 PM	We R Native Youth Presenter	*(Invited)*
3:15 PM	**BREAK**	
3:00 PM	Lucy Covington Governance Center & Omak Clinic Tour	Shuttle Provided

THURSDAY, AUGUST 11, 2016

9:00 AM	Call to Order Invocation	Andy Joseph, Chairman
9:15 AM	Chair's Report	Andy Joseph, Chairman
9:45 AM	Financial Report	Eugene Mostofi, Fund Accounting Manager
10:00 AM	**BREAK**	
10:15 AM	Committee Reports: 1. Elders 2. Veterans 3. Public Health 4. Behavioral Health 5. Personnel 6. Legislative/Resolution	
11:15 AM	Unfinished/New Business 1. Approval of Minutes 2. Resolutions 3. Future Board Meeting Sites: ❖ *October 18-20, 2016 – Clearwater Resort & Casino (Suquamish)* ❖ *January 17-19, 2017 – Great Wolf Lodge (Chehalis)* ❖ *April 2017 – TBD* ❖ *July 2017 Joint Meeting w/ CRIHB – Canyonville, OR (Cow Creek)* ❖ *October 2017 - TBD*	
12:00 PM	**Adjourn**	

INDIAN HEALTH SERVICE PORTLAND AREA DIRECTOR'S UPDATE

Dean M Seyler - Area Director
August 9, 2016
NPAIHB Quarterly Board Meeting
12 Tribes Resort Casino
Omak, WA

Renew And Strengthen Our Partnership With Tribes

- Portland Area Direct Service Tribes Meeting
  - July 6th & 7th
  - Review of the Area's services to the Direct Service Tribes
  - One-On-One Meeting – Action Plans Developed
- 13th Annual National Direct Services Tribes Meeting
  - Rapid City, SD
  - August 31st – September 1st
  - Holiday Inn Rapid City-Rushmore Plaza
  - https://www.ihs.gov/dstnm/
- 2016 IHS National Behavioral Health Conference
  - August 9th – 11th
  - Portland, Oregon
  - https://www.ihs.gov/dbh/2016conference/

Renew And Strengthen Our Partnership With Tribes

- IHS Contract Support Costs Workgroup Meeting
  - September 15th & 16th
  - Washington, D.C.
- IHS Directors Award Ceremony
  - Rockville, MD
  - Date to be determined
  - https://www.ihs.gov/nda/
- Portland Area Fund Distribution Workgroup Meeting
  - August 25th
  - Portland, Oregon

Renew And Strengthen Our Partnership With Tribes

- Dear Tribal Leader Letters:

  https://www.ihs.gov/newsroom/triballeaderletters/

- Purchasing Health Care Coverage ( )
  - DTL dated July 18, 2016
  - Written comments by COB August 17th
  - Draft circular
- IHS Quality Framework
  - Improve health outcomes for patients receiving care
  - Provide a care delivery service all patients trust
  - Upcoming Tribal consultation
  - Written comments by COB September

Renew And Strengthen Our Partnership With Tribes

- PRC Rates
  - IHS Press Release New Medicare like rates (effective May 20, 2016)
  - https://www.ihs.gov/newsroom/pressreleases/2016pressreleases/ihs-implements-new-regulation-for-tribes-to-negotiate-medicare-like-rates/
  - Dear Tribal Leader letter
  - Tribes who wish to Opt in contact Denise Imholt at 503-414-5555 or at Denise.imholt@ihs.gov
  - If you wish to Opt out no action is necessary
  - Dear Provider Letter (send to all Providers)
- FY16 CHEF Balance –
  - $37,547,141.00 as of 06/01/2016
  - 15 CHEF cases, all reimbursed at 100%
  - Total YTD $288,954.00

To Improve the Quality of and Access to Care

- Purchase & Referred Care (PRC) Pool
  - Started in 2001
  - 8 Tribes participate
  - No claims or distributions in FY14 or FY15
  - Contact with Tribes will occur
- FY18 IHS Budget Formulation (Area Meeting)
  - Date – TBD
  - Location – TBD
  - Andy Joseph and Steve Kutz – Tribal Reps to National Mtg
  - CAPT Ann Arnett, Executive Officer – Area Rep

Renew And Strengthen Our Partnership With Tribes and Urban Indian Health Programs

- **New Staff:**
  - Dr. Cheryl Sixkiller, DDS – Area Dental Consultant
    - Cheryl.sixkiller@ihs.gov
    - 503-414-5555
  - Ms. Kristi Woodard, LICSW – Area Behavioral Health Consultant
    - Kristi.Woodard@ihs.gov
    - 503-414-5555
- **Current Vacancies:**
  - Chief Contracting Officer
  - Area Diabetes Consultant – Applicants being reviewed
  - ISDEAA Specialist

Renew And Strengthen Our Partnership With Tribes and Urban Indian Health Programs

- **Request for Public Comment - Federal Register**
  - Proposed Information Collection – Environmental Health Assessment of Tribal Child Care Centers
  - ~40 Daycare and Head Start Centers
  - Includes Routine Assessment of Environment as Conducted Annually by EHS, and Environmental Sampling for Lead, PCBs, Environmental Allergens, and Pesticides
  - Follow-up Activities will include Outreach, Training and Technical Assistance
  - https://www.federalregister.gov/articles/2016/07/25/2016-17494/request-for-public-comment-60-day-proposed-information-collection-environmental-health-assessment-of

Renew And Strengthen Our Partnership With Tribes and Urban Indian Health Programs

- **Implementing Section 1632 of the Indian Health Care Improvement Act – Sanitation Deficiencies**
  - The sanitation deficiencies review has been completed and has been reported to Congress as required. .
  - The initial 2017 list includes 91 projects with $65 million of need.
  - In recent years, Portland Area has been able to reach about $1.8 million with IHS and EPA Set-Aside Funding.

To Improve the Quality of and Access to Care

- **Federal Healthcare Facility Modernization**
  - Wellpinit Service Unit
    - Improvements to Front Entry, Patient Registration, Primary Care, IT System, and HVAC System.
    - Scheduled Construction Contract Award – October 2016
    - 6 – Month Construction Performance Period
    - $500,000 Investment
  - Yakama Service Unit
    - Renovating Former Physical Therapy to Six New Primary Care Exam Rooms with IPC Medical Teaming Area.
    - Scheduled A/E Design Contract Award – August 2016. Construction to Occur in FY 2017.
    - $300,000 Investment
  - Warm Springs Service Unit
    - IHS and Tribe Collaborating to Develop Health Facilities Master Plan, Goal to Complete in FY 2017.
    - Master Plan will Guide and Prioritize Major Facility Improvements.

To Improve the Quality of and Access to Care

- **Facility Condition Assessment Program**
  - DHFE Provides this Service to Tribal Health Facility Programs with Retained Shares At Least Every 5-years.
  - The Summary Report Provides Overall Facility Condition and is Useful for Prioritizing and Planning Facility Improvement Projects to Assure Reliable Facility Operation and a Quality Environment of Care.
  - FY 2016 Progress - Conducted Visits to 13 Tribal Health Programs with Plans to Complete Three More by the End of FY.

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.

Northwest Portland Area Indian Health Board

Executive Director Report

12 Tribes Resort Casino
Omak, WA
August 9, 2016

Joe Finkbonner, RPh, MHA

Northwest Portland Area Indian Health Board

Personnel

- **Promotions:**
  - Tanya Firemoon, NDTI Coordinator
  - Geo. Ann Baker, Receptionist
  - Candice Jimenez, Project Coordinator
- **Interns:**
  - Maggie Tafua, Temp Native Fitness Assistant
  - Devonte Casey, Temp Youth Track Assistant
  - Kim Kummer, Temp – TOTS2Tweens
  - Traven Joseph, PRT Temp

Northwest Portland Area Indian Health Board

Events

April

- Tribal Self Governance, Orlando, FL

May

- 2016 Tribal Emergency Preparedness Conf., Spokane, WA
- Oregon Health Insurance Marketplace, Pendleton, OR
- PHAB Accreditation Committee, Alexandria, VA
- ATNI Mid-Year, Grand Ronde, OR
  - Changes to our UPS service and cost savings
- WDSF Board Meeting, Seattle, WA

Northwest Portland Area Indian Health Board

Events Continued

June

- WDSF, Site visit to Swinomish
- Oregon Health Insurance Marketplace, Eugene, OR
- Summer Institute @ Board (3 Weeks)
- NWIC Foundation Board Meeting
- PHAB Board of Director's Meeting, Alexandria, VA
- NCAI Mid-Year Conf., Spokane, WA

Northwest Portland Area Indian Health Board

Events Continued

July

- DST Meeting, Portland, OR
- Public Health 3.0, Spokane, WA
- Dental Support Center meeting, Washington, DC

Northwest Portland Area Indian Health Board

Upcoming

August

- PHAB Accreditation Committee meeting, Washington, DC
- PHAB Executive Committee meeting, Seattle, WA
- National Tribal Forum, Spokane, WA

NPAIHB Staff Picnic, Oak Park (August 19th)

NPAIHB Hood to Coast (H2C)Team (August 26th – 27th)

Northwest Portland Area Indian Health Board

Upcoming

September

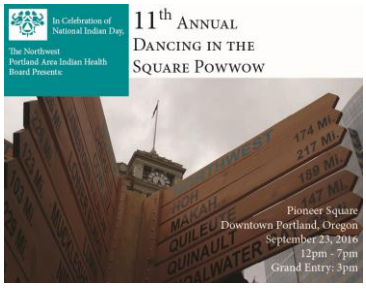
- *Oregon Health Insurance Marketplace, Bend, OR*
- *NIHB Annual Consumer Conference, Scottsdale, AZ*
- *WDSF Board Retreat*
- *ATNI, Tulalip, WA*

October

- NCAI, Phoenix, AZ

Northwest Portland Area Indian Health Board

Upcoming



Your invited:
September 23, 2016

Thank you to those who have sponsored the event!

Still time to sponsor see the website or Lisa for more information

Northwest Portland Area Indian Health Board

Questions…?

Legislative & Policy Update

NW Portland Area Indian Health Board
Quarterly Board Meeting
Hosted by the Colville Confederated Tribes

August 9, 2016

1

Report Overview

1. Status of FY 2017 IHS Budget
2. Contract Support Costs
3. Community Health Aide Program (CHAP) Expansion
4. Tribal Premium Sponsorship
5. Catastrophic Health Emergency Fund
6. Medicare-Like Rates for Non-Hospital Providers
7. 100% FMAP Update
8. Other Policies
9. STAC Meeting Update
10. MMPC CMS TTAG Update
11. Litigation Impacting Indian Health
12. Legislative Issues 114th Congress

Status of FY 2017 IHS Budget

- Congress will likely enact a continuing resolution for FY 2017 in September to fund IHS and other federal agencies.
- Senate and House Committees' Interior, Environment and Related Agencies appropriation bills reflect differences (detailed on next slide)
- Committee reports
  - Senate requests GAO report on Advance Appropriations
  - House questions the distribution of population growth funds; and directs IHS to provide a report on full funding for IHCIA
  - Concurrence on CSC; CSC for domestic violence, zero suicide initiative; and volunteer dentists/credentialing

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

- President's FY 2017 IHS budget proposes an increase of $82m above FY 2016 level for Contract Support Costs (CSC)
- Senate and House Committees' Interior, Environment and Related Agencies bills continue the FY 2016 enacted policy of appropriating an indefinite amount ("such sums as may be necessary") to separate accounts for IHS and BIA.
  - Not classified as mandatory yet.
- CSC Policy - Several recommended changes to the CSC Policy were made following the March 28-29 CSC Workgroup meeting.
- Dear Tribal Leader sent out on 4/11/16 providing a 60-day comment period on the revised policy and three tribal consultations were held.
- Final draft policy will be reviewed by the CSC workgroup in September (15-16 in DC)

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.
- Telephone consultation on October 4 at 12 noon PST.
- Two in person consultations:
  - NIHB Annual Consumer Conference on September 19 in Scottsdale; and
  - NCAI Annual Convention on October 9 in Phoenix.
- Comments are due on October 27 (extended from July 29, 2016).

Tribal Premium Sponsorship

- On July 18th, 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.
- One telephonic consultation held; two in person scheduled:
  - NIHB Annual Consumer Conference on September 19 in Scottsdale; and
  - NCAI Annual Convention on October 9 in Phoenix.
- Comments due on October 31.

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.
- DTLL issued on July 29, 2016 with Tribal consultations set, as follows:
  - Telephone consultations on August 16 and October 24
  - In person consultations at NIHB ACC on September 19 in Scottsdale, and NCAI Annual Convention on October 9 in Phoenix

Medicare-Like Rates (MLR) to Non-Hospital Providers

- Final rule with comment period issued on March 21, 2016 – 81 Fed. Reg. 14977-84.
- Extends MLR to physicians and other health care professional services and non-hospital based services (non-hospital providers).
- Applies to IHS-operated PRC programs and urban Indian health programs; and only to Tribes/Tribal organizations if they opt-in.
- Rule effect on May 20, 2016 but comments were accepted up to this date.
- The Board submitted comments on the definition of "referral" and on opt-in method.

100% FMAP Update

- On February 26, 2016, CMS issued a letter to State Health Officials re-interpreting the scope of services to be considered "received through" an I/T to qualify for 100% FMAP:
  1. "Received through" now includes any services that an I/T is authorized to provide according to IHS rules, and that are also covered under the approved Medicaid state plan, including long-term services and supports (LTSS).
  2. May also include transportation (emergency and non-emergency) and other related travel expenses if it is a covered service under the Medicaid state plan.
  3. I/T's request for service from a non-I/T provider must be in accordance with a "care coordination agreement" and non-I/T provider must be a Medicaid provider.
  4. Two billing options presented: (a) non-I/T provider bills Medicaid directly; or (b) I/T handles all billing.
  5. **Effective upon execution of a written care coordination agreement**.
- CMS to issue a FAQ on new policy – still pending.

Other Policies

- 6/9/16 - IHS DTLL on FY 2016 $10m increase for Gen I Initiative Support
- 6/15/16 & 7/20/16 - IHS DTLL requesting Tribal Consultation on the draft Quality Framework policy for Direct Service Tribes.
  - Telephone consultation on 8/15/16 at 11 am PST
  - In person consultations at the Great Plains Tribal Chairman's Health Board Summit on August 30, and NIHB Annual Consumer Conference on September 19
  - Written comments due in 60 days
- 7/22/16 – IHS DTLL on SDPI FY 2016 Community-Directed grant application process

STAC Meeting Update

- Last meeting was June 7-8; next meeting is September 13-14
- Tribal leaders made several requests to Secretary Burwell, including:
  - Transition planning for STAC
  - A National Tribal Behavioral Health Summit
  - Work with White House Council on Native Americans to create a Tribal Action Plan
  - Provide information on Opioid abuse and addiction for Indian country
  - Tribal consultations related to CHAP expansion

MMPC & CMS TTAG Update

- Medicare, Medicaid and Health Reform Policy Committee (MMPC) conference call on May 4, retreat on June 13-14, 2016, and face-to-face meeting on July 26
- At retreat:
  - Developed action items
  - Identified priority areas
- CMS TTAG conference call on June 8 and face-to-face meeting July 27-29 in DC
  - CMS and IHS representatives provided updates to tribal leaders

Litigation Impacting Indian Health

- Section 2901(b) -- Payer of Last Report
  - *Redding Rancheria v. Burwell*, No. 15-152 (DDC)
  - IHS has argued in this litigation that Section 2901(b) of the Affordable Care Act (ACA), enacted in 2010, invalidated the IHS's longstanding policy exempting tribal self-insured health plans from the payer of last resort rule.
- Section 105(l) under ISDEAA – Lease Compensation
  - *Maniilaq Association v. Burwell,* No. 14-2035 (RMC)
  - Court held that IHS should negotiate proper lease compensation under 105(l) of the ISDEAA.
  - On July 27, Judge issued a Final Order.

Indian Legislative Issues 114th Congress

- The Comprehensive Addiction and Recovery Act of 2016 (S. 524)
- The Indian Health Service Accountability Act of 2016 (S. 2953)
- The Helping Ensure Accountability, Leadership and Trust in Tribal Healthcare Act (H.R. 5406)
- Department of Interior Tribal Self-Governance Act of 2015 (S. 286)
- Advance Appropriations (H.R. 395)
- Tribal Programs Exemption from Sequestration (S. 1497/H.R. 3063)
- Employer Mandate (S. 1771/H.R. 3080)
- Family Stability and Family Kinship Act of 2015 (S. 1964)
- Native American Suicide Prevention Act of 2015 (H.R. 3166)
- Ongoing:
  - IHCIA Technical Amendments (S. 2114)
  - SDPI Permanent Reauthorization
  - Contract Support Costs mandatory funding and reconciliation language

Indian Legislative Bills in 114th Congress

- S. 524 – The Comprehensive Addiction and Recovery Act of 2016 (CARA)
  - Signed into law by President Obama on July 22, 2016.
  - Addresses various issues through prevention and treatment of opioid abuse.
  - The House and Senate disagreed about funding.
  - No funds appropriated for emergency mandatory funding to address the opioid crisis.
  - Contains several competitive grant programs that tribes would be eligible for but there is no tribal-specific allocation of funds.
- House ($500m) and Senate ($261m) appropriation bills recommended discretionary opioid funding.

Indian Legislative Bills in 114th Congress

- S. 2953 -- The Indian Health Service Accountability Act of 2016
  - Introduced by Sen. Barrasso (R-WY) and Sen. John Thune (R-SD). The Act will improve transparency and accountability at the IHS by:
    - Expanding removal and discipline authorities for problem employees at the agency;
    - Providing the Secretary of HHS with direct hiring and other authorities to avoid long delays in the hiring process;
    - Requiring Tribal consultation prior to hiring area directors, hospital CEOs and other key leadership positions;
    - Commissioning GAO reports on staffing and professional housing needs;
    - Improving protections for employees who report violations of patient safety requirements;
    - Mandating that the Secretary of HHS provide timely IHS spending reports to Congress; and
    - Ensuring the Inspector General of HHS investigates all patient deaths in which the IHS is alleged to be involved
  - Referred to Senate Committee on Indian Affairs on 5/19/16.

Indian Legislative Bills in 114th Congress

- S. 5406 – The Helping Ensure Accountability, Leadership and Trust in Tribal Healthcare Act
  - Introduced by Sen. Kristi Noem (R-SD) on 6/8/16; co-sponsors include Senators Ashford (D-NE), Smith (R-NE), Fortenberry (R-NE), Cramer (R-ND), McCollum (D-MN), and Cole (R-OK).
  - Addresses issues similar to S. 2953 on hiring, removal and demotion but also focuses on more substantive reforms including a long-term contracting pilot program and reforms on the PRC funding formula.
  - Referred to House Committees on Natural Resources, Energy and Commerce, and Ways and Means on 6/8/16; and to House Natural Resources Subcommittee on Indian, Insular and Alaska Native Affairs on 6/13/16.
  - Subcommittee hearing held on 7/12/16.

Indian Legislative Bills in 114th Congress

- S. 286 – Department of Interior Tribal Self-Governance Act of 2015
  - Introduced by Sen. John Barrasso (R-WY) on 1/28/15; co-sponsors include Senators Tester (D-MT) , Murkowski (R-AK), Crapo (R-ID), Schatz (D-HI), Franken (D-MN)
  - Amends Title IV of of ISDEAA to make it consistent with Title VI, the Self-Governance Program for HHS
  - Creates the same administrative efficiencies for DOI that have been in place for HHS programs.
  - S. 286 passed Senate on 7/7/15 by Unanimous Consent with an amendment
  - Referred to House Natural Resources Subcommittee On Indian, Insular and Alaska Native Affairs on 8/4/15

Indian Legislative Bills in 114th Congress

- H.R. 395 – Indian Health Service Advance Appropriations Act of 2015
  - Introduced by Rep. Young (R-AK) on 1/14/15; co-sponsors include Senators Kirkpatrick (D-AZ), Huffman (D-CA), Lujan (D-NM)
  - Amends IHCIA to authorize Advance Appropriations for the Indian Health Service and Indian Health Service Facility Accounts
  - Referred to House Natural Resources Subcommittee on Indian, Insular and Alaska Native Affairs on 3/2/15

Indian Legislative Bills in 114th Congress

- Senate and House Bills Exempting Tribal Programs From Sequestration
- S. 1497
  - Introduced by Sen. Tester (D-MT) and Sen. Udall (D-NM) on 6/3/15
  - S. 1497 would exempt IHS, BIA, HUD and other Indian programs from sequestration required under the Budget Control Act of 2011
- H.R. 3063
  - Companion bill to S. 1497
  - Introduced by Rep. Young (R-AK) on 7/14/15; co-sponsors include Representatives Grisham (D-NM), Cole (R-OK), Ruiz (D-CA), McCollum (D-MN)
- Both bills referred to Budget Committees

Indian Legislative Bills in 114th Congress

- Senate and House Bills Exempting Tribes from the ACA Employer Shared Responsibility Mandate
  - S. 1771-Tribal Employment and Jobs Protection Act introduced by Sen. Daines (R-MT) on 7/15/15; co-sponsors Senators Thune (R-SD), Crapo (R-ID), Rounds (R-SD), McCain (R-AZ), Risch (R-ID)
  - H.R. 3080 introduced by Rep. Noem (R-SD) on 7/15/15; 27 bi-partisan co-sponsors
  - Senate bill referred to Finance; House bill reported favorably out of House Ways and Mean on 6/15/16.

Indian Legislative Bills in 114th Congress

- S. 1964 Family Stability and Family Kinship Act of 2015
  - Introduced by Sen. Wyden (D-OR) on 8/5/15; co-sponsors Sen. Bennett, Brown (D-OH), Cantwell (D-WA), Casey (D-PA), Gillibrand (D-NY), Menendez (D-NJ), Schumer (D-NY), Stabenow (D-MI), Warner (D-VA)
  - Reforms the federal finance system supporting state and child welfare services
  - Funds preventive services and kinship placements for children at risk of foster placement
  - Current law creates incentives to place Indian children outside of families in order to receive federal funding
  - Encourages child welfare system to forego alternatives to prevent breakup of families like parent training, mental health counseling, trauma recovery, etc.
  - Referred to Finance Committee on 8/5/15

Indian Legislative Bills in 114th Congress

- H.R. 3166 Native American Suicide Prevention Act of 2015
  - Introduced by Rep. Grijalva (D-AZ) on 7/22/15; co-sponsors are Reps. Ruiz (D-CA), Huffman (D-CA), Young (R-AK), Moore (D-WI), McCollum (D-MN), Grisham (D-NM), Salmon (R-AZ), Napolitano (D-CA) and Cole (R-OK).
  - Amends the Public Health Service Act to require a state or state-designed entity to seek Tribal consultation as a condition of receiving a grant or cooperate agreement for development/implementation of a statewide youth suicide and early intervention and prevention strategy.
  - Referred to Energy & Commerce, Subcommittee on Health on 7/24/15.

Discussion?

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Indian Health Service
Rockville MD 20852

JUN 1 2016

Dear Tribal Leader:

I am writing to consult with Tribal Leaders on a draft policy statement that proposes an expansion in the use of community health aides at Indian Health Service (IHS) facilities across the country. Facilities operated by Tribes and the IHS could see expanded opportunities under the new draft policy for these aides, which could also include dental health aide therapists.

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 is initiating Tribal Consultation on this important proposed change. 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.

The IHS is proposing to expand our existing community health aide program, including exploring administrative requirements for this expansion. This could include the creation of a national certification board for community health aides in the IHS system. The IHS already runs an evaluation system mandated by statute to monitor IHS community health aides to assure that quality health care is being provided to patients.

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. Examples of community health aides within the Indian health system and other Federal agencies include the following:

- The IHS Community Health Representative (CHR) program, which currently deploys more than 1,000 well-trained, medically guided health care workers who provide health education, case management, patient transport, patient advocacy, and other services in Tribal communities: http://www.ihs.gov/chr;

- The Dental Health Aide Therapist (DHAT) program, operated by the Alaska Native Tribal Health Consortium (ANTHC), is a community-driven program providing culturally appropriate dental education and routine dental services in 81 Alaska Native communities serving over 40,000 Alaska Native people since 2004: http://anthc.org/dental-health-aide/;

- The principal provider of health services at the village level in Alaska is the Community Health Aide (CHA). Overseen by the village council, CHAs are responsible for giving emergency first aid, providing patient examinations and follow-up in conjunction with a treating physician, carrying out treatment recommendations, patient- and family-focused education and instruction, and conducting preventive health programs. Community health aides store and dispense prescription drugs with physician instructions. https://www.ihs.gov/alaska/includes/themes/newihstheme/display_objects/documents/hf/area.pdf; and

- Behavioral Health Aides (BHAs) are counselors, health educators, and advocates. These practitioners help address individual and community-based behavioral health needs, including those related to alcohol, drug and tobacco abuse, as well as mental health problems, such as grief, depression, suicide, and related issues. Behavioral Health Aides seek to achieve balance in the community by integrating their sensitivity to cultural needs with specialized behavioral health training and approaches to treatment. http://anthc.org/behavioral-health-aide-program/.

Thank you for your support and partnership. I look forward to your input on the draft policy statement to expand the Community Health Aide program. Please provide your comments and recommendations by E-MAIL at consultation@ihs.gov or by POSTAL MAIL to the address indicated below. **The comment deadline is Friday, July 29, 2016.**

Sincerely,

/Mary Smith/
Mary Smith
Principal Deputy Director

Enclosure

E-MAIL your comments to:	consultation@ihs.gov **SUBJECT LINE**: IHS Expansion of Community Health Aide Program Draft Policy Statement Consultation
MAIL your comments to:	Alec Thundercloud, M.D. Director, Office of Clinical and Preventive Services Indian Health Service 5600 Fishers Lane Mail Stop: 08N34-A Rockville, MD 20857 **ATTN**: IHS Expansion of Community Health Aide Program Draft Policy Statement Consultation

INDIAN HEALTH SERVICE POLICY STATEMENT
On
CREATING A NATIONAL INDIAN HEALTH SERVICE COMMUNITY HEALTH AIDE PROGRAM

With rising demand for comprehensive, quality health care, communities are increasingly looking for innovative approaches to health service delivery. Recognizing the success of community health aides, Congress authorized the creation of a national federal Community Health Aide Program (CHAP).[1] *See* 25 U.S.C. § 1616*l*(d)(1).

The Indian Health Service (IHS) is currently exploring necessary steps to create a national CHAP,[2] including the creation of a national certification board. The IHS is supportive of and committed to the expansion of CHAPs throughout Indian Country. It is our goal to see community health aides[3] utilized to the fullest extent permissible in IHS and tribally run hospitals and clinics.

Access to care (particularly dental care) in remote areas among the population we serve is very low. The use of paraprofessional health care workers, like community health aides, is a proven strategy for increasing access to much-needed health services and improving the quality of those services in Indian Country, as well as other rural and frontier areas. The IHS has a long history of using community health aides, dating back to the 1960s. Bader, J. D., Lee, J. Y., Shugars, D. A., Burrus, B. B., & Wetterhall, S. (2011). Clinical technical performance of dental therapists in Alaska. *Journal of the American Dental Association, 142*(3), 322–326; *see also* "Evaluation of Dental Health Aide Therapist Workforce in Alaska," October 2010 study by RTI International of Research Triangle Park, North Carolina, available at *https://www.ihs.gov/doh/DHAT.pdf*.

The use of paraprofessional health care workers in public health programs has increased exponentially. Community health aides have been employed to perform a wide range of duties in health programs, such as health education, communicable disease control, maternal and child health, dental health, behavioral health, family planning, environmental health, and other areas. Because of this far-reaching need in so many areas of health care, CHAPs have included paraprofessionals such as nursing aides, behavioral health aides, community health workers, psychiatric aides, and others. In certain limited circumstances, CHAPs can also include the services of dental health aide therapists.

The IHS developed the community health aide concept in the 1960s in response to a number of health concerns in rural Alaska, including the tuberculosis epidemic, high infant mortality, and high rate of injuries. In 1968, the IHS initiated the CHAP in Alaska. Congress amended the Indian Health Care Improvement Act (IHCIA) to authorize the CHAP in 1992. *See* Public Law

[1] S. 1790, The Indian Health Care Improvement Reauthorization and Extension Act, as enacted and amended by P.L. 111-148, the Patient Protection and Affordable Care Act of 2010, which amended the IHCIA.
[2] Before any implementation, many issues would need to be reviewed and resolved, including any legislative changes or funding needed, and the development of an implementation plan.
[3] The term community health aide includes behavioral health aide, nursing aide, and dental health aide.

102-573. The IHCIA mandated IHS create a CHAP in Alaska to train persons to become community health aides, develop a curriculum for the training of community health aides, and create and maintain a Federal Community Health Aide Program Certification Board, by which individuals who complete the training curriculum are certified to provide services through the CHAP. 25 U.S.C. §§ 1616*l*(a), (b). Further, the IHS conducts a statutorily mandated system to evaluate community health aides to assure that quality health care, health promotion, and disease prevention services are being provided to the target population. 25 U.S.C. § 1616*l*(b)(6). By statute, the IHS through its Federal Community Health Aide Program Certification Board is responsible for these functions in the oversight and creation of the CHAP, including the Alaska Dental Health Aide Program, even though the daily operations of the program are carried out through Tribes and Tribal organizations.

Community health aides are currently utilized in a variety of health care and community settings in Alaska. While many provide medical and dental services in village clinics under the supervision of a remote licensed physician or dentist, some are employed by Tribal health organizations in regional clinics and hospitals under direct physician or dentist supervision. As a result of dental therapists in Alaska, an additional 40,000 Alaska Natives have direct access to care in their remote villages.[4]

The IHS and Tribal communities have found community health aides and other paraprofessional health care workers, like nursing, behavioral, and dental health aides, to be important and essential members of health care teams. Not only do CHAPs contribute to the overall health care team, but the additional advanced training they receive often leads to improved health and quality of life for the communities they serve.

CHAPs are proven partners in health, and the IHS is committed to seeing them expand outside of the State of Alaska.

June 1 2016
Date

/Mary Smith/
Mary Smith
Principal Deputy Director

[4] Alaska Tribal Health System, Oral Health, available at http://dhss.alaska.gov/ahcc/Documents/meetings/201303/AlaskaTribalHealth-OralHealth-Williard.pdf

3B

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Indian Health Service
Rockville MD 20852

JUNE 1 2016

Dear Tribal Leader:

I am writing to provide an update on the Proposed Rule for the Catastrophic Health Emergency Fund (CHEF). The comment period for the Proposed Rule ended on May 11.

Several Tribes and Tribal Organizations expressed concern about provisions in the *Federal Register* Notice. In response to those concerns, the Indian Health Service (IHS) has made the determination that we will engage in additional Tribal consultation before moving forward. In addition to two telephonic consultation sessions to be scheduled during the summer and early fall, an in-person session is planned to be held during the National Congress of American Indians' Annual Convention, which is scheduled on October 9-14, in Phoenix, Arizona. The specific dates and times will be posted on the IHS Calendar of Events on our website when these details are available.

For additional information, please contact Ms. Terri Schmidt, Acting Director, Office of Resource Access and Partnerships. She can be reached by telephone at (301) 443-3216 or by e-mail at terri.schmidt@ihs.gov.

Sincerely,

/Mary Smith/

Mary Smith
Principal Deputy Director

3C

JUNE 9 2016

Dear Tribal Leader:

On April 1, 2016, I requested your input on the Fiscal Year (FY) 2016 $10 million increase for Generation Indigenous (Gen-I) Initiative Support, part of the Substance Abuse and Suicide Prevention (SASP) program, also formerly referred to as the Methamphetamine and Suicide Prevention Initiative (MSPI). I am writing to provide you with an update on how the Indian Health Service (IHS) will move forward with the three conferring areas that follow: 1) funding distribution for national management, area allocations for Tribal and Federal facilities, and Urban Indian organizations; 2) eligibility; and 3) the types of behavioral health providers to be included in the FY 2016 funding opportunity announcement (FOA).

Funding Distribution

There was no consensus reached on this topic. Moving forward, the IHS will use 5 percent of the $10 million to cover national management, 85 percent for IHS Area allocations, and 10 percent for Urban Indian organizations.

Eligibility

The majority of responses were in favor of expanding the eligibility criteria to include both current SASP projects and new applicants not currently funded. The IHS will proceed with opening the FY 2016 SASP FOA to both current projects and new applicants.

Behavioral Health Providers

The majority of responses were in favor of including paraprofessionals, such as community health aides, peer specialists, and behavioral health technicians, to be included as eligible behavioral health providers. The IHS will proceed with this recommendation.

The IHS will publish a notice with comment in the *Federal Register* in June 2016. Applications will be due 60 days after the *Federal Register* notice is issued. For additional information, please visit our Web site at www.ihs.gov/mspi. If you have any questions, please contact Ms. Audrey Solimon, National MSPI Coordinator, Division of Behavioral Health, IHS, by e-mail at audrey.solimon@ihs.gov or by telephone at (301) 443-2038. Thank you for your continued work to address these serious issues in our communities.

Sincerely,

/Mary Smith/

Mary Smith
Principal Deputy Director

3D

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

JUN 15 2016

Dear Tribal Leader:

I am writing to provide an update on the Indian Health Service's (IHS) strategy to improve quality health care delivery for American Indians and Alaska Natives. Our top priority at the IHS is making sure that American Indian and Alaska Native families have access to quality health care. We are not accepting business as usual here at IHS. We are hard at work to make sustainable improvements.

This year, we laid out an aggressive strategy to improve the quality of care in the Great Plains Area and across the country. It is a strategy that consists of five major areas. First, we are taking a close look to assess the quality of care and to work quickly to make any needed improvements. Second, we are transforming the way these hospitals deliver care. Third, we are strengthening our Area management. Fourth, we are bringing experts in health care quality to support these direct service facilities. Fifth, and most importantly, we are doing this work hand-in-hand with the Tribes and local organizations that are valuable sources of expertise and partnership.

Point 1: Assessing Care

We want to lift up the facilities across Indian Country that deliver high quality care, and we want to work closely with those that need improvement. We are taking a very close look at the quality of care delivered through direct service hospitals at IHS facilities across the Great Plains Area as well as throughout Indian Country. For the past 10 years, health care systems have been embracing a new focus on quality improvement, and it is that orientation that we are working to bring into sharper focus within IHS. For example, IHS is beginning a system-wide mock survey initiative at all 27 of its hospitals to assess compliance with the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and readiness for re-accreditation. These mock surveys are being conducted by survey teams from outside each respective Area to reduce potential bias. And this information will be shared widely – summaries of the information collected from the surveys will be shared with Tribal leadership.

Point 2: Improving How We Deliver Services

The IHS continues to face significant workforce challenges with a chronic shortage of quality health care providers. While we have taken immediate steps to address some local shortages and are in the process of adding more, such as telemedicine, these longstanding challenges require building up and expanding the training and deployment pipelines and full use of innovative approaches to delivering care. In the near-term, with Secretary Burwell, Acting Deputy Secretary Wakefield, and the U.S. Surgeon General's support, over two dozen Commissioned Corps clinicians have been deployed for temporary placements into the Great Plains Area hospitals with CMS findings. In addition, the National Institutes of Health has been helping IHS deploy strategies it has used to recruit nurses into its clinical program. IHS is also revising position descriptions and deploying more comprehensive recruitment plans around key positions, in an effort to recruit a greater number of qualified candidates. IHS is also deploying pay

increases for high-demand physicians and has established relocation pay for GS-12 and lower clinical positions and lower grades.

However, even with these and a number of other strategies that have been deployed during the past two months or that are in development right now, there is still much more work that needs to be done to attract and retain an adequate health care workforce.

In that regard, I will soon be announcing a Tribal consultation on workforce issues.

Point 3: Strengthening Management
We want every hospital to be a top quality facility on its own. But we are also taking a broad view by bringing top quality management to the Great Plains Area and our other Areas. We have implemented a stronger search committee process for recruiting highly qualified managers and executives. IHS is also more widely advertising vacancies through federal, state, and non-profit partners. Additionally, we have expanded Tribal participation in filling vacant Area Director positions and members of a Tribe from each area will, for the first time, play a role at the outset of the hiring process.

Point 4: Bringing Health Care Quality Expertise to IHS
One of the best ways that we can improve the quality of care at IHS facilities is by helping these facilities share and benefit from innovative ideas and evidence-based tools that work. For example, we recently launched a Hospital Engagement Network (HEN 2.0) that can reach across all 27 hospitals operated by IHS. Through this network, these hospitals can share strategies on how to reduce avoidable readmissions and hospital-acquired conditions. Working together, they can learn more, and improve faster. We are also bringing in quality experts from different parts of HHS to consult with IHS hospitals. These experts will help make sure that our improvements are real and measurable.

Point 5: Engaging Local Resources
Our government-to-government relationship with Tribes is the foundation of our work at IHS. That is why we are always working to strengthen and renew our partnerships with Tribes. Some of the most helpful expertise and the most effective leadership is right in the Tribal communities we work with every day. We are committed to strengthening these relationships, and also engaging further with partners from the local community – like local and regional health care systems, local colleges and universities, and the leadership of direct service hospitals. We are all stronger when we work together.

The IHS is committed to working together to bring about needed changes and improvements. I will provide regular updates on the progress we make in implementing these strategies.

Sincerely,

/Mary Smith/

Mary Smith
Principal Deputy Director

DEPARTMENT OF HEALTH & HUMAN SERVICES

3E
Public Health Service

Indian Health Service
Rockville MD 20852

JULY 18 2016

Dear Tribal Leader:

The Indian Health Service (IHS) is requesting your comments and recommendations on a draft Circular that the IHS has created to address the purchase of health care coverage, which is commonly referred to as Tribal Premium Sponsorship (Sponsorship). Sponsorship occurs when a Tribe pays health insurance premiums on behalf of IHS beneficiaries. As you know, when Tribal members enroll in coverage they are able to improve their access to care through increased options for health care. In turn, revenue collected by Tribal and IHS providers goes back into the facility to meet conditions of participation and provide additional funds to hire staff and purchase services and new equipment. In addition, with greater alternate resources, Purchased/Referred Care (PRC) funds go farther as more patients have coverage. The purpose of this draft Circular is to provide further detailed guidance to IHS Area Offices regarding the current IHS policy if a Tribe, Tribal organization, or Urban Indian organization wishes to purchase coverage for IHS beneficiaries with Indian Self-Determination and Education Assistance Act (ISDEAA) funding or other IHS-appropriated funds. Per Section 402 of the Indian Health Care Improvement Act (25 U.S.C. § 1642) Indian Tribes, Tribal organizations, and Urban Indian organizations may use federally appropriated funding, to the extent it is available under law, to purchase health insurance for IHS beneficiaries.

The draft Circular is needed as many Tribes across the country have created Sponsorship programs. Tribes have reported success stories as their members enroll in health benefits coverage and access care. Tribes have also reported increased revenues tied to these Sponsorships, which often result in additional revenue that lets them supplement operations, procure services and new equipment, and allows them to hire more providers. Tribes have also reported savings in PRC programs, which has led to PRC funds lasting longer and facilitated payment for lower priority services. The IHS is pleased to hear of this success and is committed to supporting and encouraging Tribes in their efforts to enhance access to care for their members, improve third party collections, and cost savings. Tribes have primarily used their own funds to pay premiums and some now seek to use appropriated funds.

The draft Circular provides guidance to IHS Area Offices regarding eligible beneficiaries and funding sources, along with recommended language to be included in new or existing contracts, compacts or funding agreements between Tribes, Tribal organizations, and the IHS. The draft Circular also addresses PRC Residual Responsibility and Coordination of Benefits when a Direct Service Tribe (DST) decides to take a portion of their PRC funds to purchase insurance for some or all of their Tribal members, and leaves a residual of funds in the DST PRC program to provide care for PRC-eligible patients who do not have alternate resources, and when a premium sponsorship program is self-funded in part or whole with ISDEAA funds. Finally, the draft Circular provides guidance on when a plan self-funded in part or whole with ISDEAA funds will be considered eligible for reimbursement from the Catastrophic Health Emergency Fund.

I hope that you will find the draft Circular to be useful in understanding IHS's views on the purchase of health care coverage and that it will be helpful in any planning and implementation efforts to provide health benefits coverage to IHS beneficiaries. The IHS is committed to working with all Tribes to improve access to care for American Indians and Alaska Natives.

The IHS will consult with Tribal Leaders from July 18 through August 17. Written comments by Tribal Leaders or Tribal organizations can be e-mailed to consultation@ihs.gov by COB August 17.

Please participate on a telephone Tribal Consultation and Urban Confer Call that will provide an overview and discussion of the draft Circular.

Telephone Tribal Consultation and Urban Confer Call:

Call date:	July 25, 2016 (Monday)
Call time:	3:00 p.m. – 4:00 p.m. (Eastern Time)
Call In Number:	(888) 323-5260
Passcode:	5432202

Thank you for your support and partnership. I look forward to hearing your input on this purchase of health care coverage draft Circular.

If you have any questions about this draft Circular, please contact Ms. Terri Schmidt, Acting Director, Office of Resource Access and Partnerships at (301) 443-4973 or by e-mail at terri.schmidt@ihs.gov.

Sincerely,

/Mary Smith/

Mary Smith
Principal Deputy Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service
Rockville, Maryland 20857

Refer to: ORAP

INDIAN HEALTH SERVICE CIRCULAR NO. 2016-08

PURCHASING HEALTH CARE COVERAGE

Sec.

1. PURPOSE. The purpose of this circular is to provide further detailed guidance into the current policy (Oct. 2013 Dear Tribal Leader Letter) if a Tribe, Tribal organization, or urban Indian organization wishes to purchase coverage for Indian Health Service (IHS) beneficiaries under 25 *United States Code* (U.S.C.) § 1642 with Indian Self-Determination and Education Assistance Act (ISDEAA) funding or other IHS appropriated funds.

2. CONTRACT/COMPACT LANGUAGE. The following language is recommended to be inserted into a new or an existing Tribal-IHS contract/compact or funding agreement to identify:

   A. The funding source, i.e., Purchased/Referred Care (PRC), Hospital & Clinic (H&C) funds, third-party revenues, or tribal supplements

   B. The specific amount of funding needed

   C. The type of coverage that will be provided

   D. Eligibility criteria

   E. Alternate resource rules, if applicable

DRAFT
Distribution: IHS-wide
Date: XX/XX/2016

F. If third-party revenues collected by the Tribe are identified as part or all of the funding source, IHS recommends the following:

(1) The funds should have already been collected and not yet expended (i.e., not amounts owed or future projections for anticipated collections).

(2) In accordance with 25 U.S.C. § 1641, Medicare and Medicaid collections are intended to be used first to maintain or achieve compliance with the respective program.

(3) To the extent the third-party revenues are collected by IHS, the contract/compact should not promise or guarantee the award of third-party revenue, including revenue derived from sponsorship coverage. Such collections may only be transferred as authorized by law and shall be considered nonrecurring.

3. ELIGIBILITY CRITERIA. Tribes and Tribal Organizations may make eligibility determinations for IHS programs under 25 U.S.C. 450j-1, but must follow applicable eligibility rules and regulations. In addition, the purchase of health care coverage by an Indian tribe, tribal organization, or urban Indian organization can be based on the financial need of the beneficiary, if the Tribe/Tribal Organization or urban Indian organization wishes to limit the number of beneficiaries covered, pursuant to 25 U.S.C. §1642. The statute specifies that the financial need of the beneficiary is determined by the tribe(s) served, based upon a schedule of income levels developed by the tribe(s) served. The IHS makes the following recommendations with respect to eligibility:

A. Eligibility should follow the source of funding.

(1) If non-PRC funds are utilized, direct service eligibility rules should apply.

(2) If PRC funds are utilized, alone or in combination with non-H&C funds, including supplements from the tribe, PRC eligibility should apply.

(3) If both unrestricted H&C and PRC funds are utilized, the contract/compact should state whether direct service or PRC eligibility will be followed and the funds should be rebudgeted accordingly.

B. If any PRC funds are used and they are not rebudgeted as H&C funds according to the guidance above, PRC eligibility rules should be followed for the sponsorship and references to the following PRC eligibility rules should be included in the contract or compact:

(1) 42 Code of Federal Regulations (CFR) 136.23 – Persons to whom contract health services (now known as Purchased/Referred Care) will be provided.

(2) The language of 42 CFR 136.22(a) – (PRC Service Delivery Area) - "In accordance with the congressional intention that funds appropriated for the general support of the health program of the IHS be used to provide health services for Indians who live on or near Indian reservations…"

C. Coverage can be provided to IHS beneficiaries who are also employees of tribal businesses, but eligibility should not be limited to tribal employees.

4. Purchased/Referred Care Residual Responsibility & Coordination of Benefits. IHS recommends the following:

A. When a Direct Service Tribe (DST) decides to take a portion of its PRC funds to purchase insurance for some or all of their tribal members, this leaves a residual of funds in the DST PRC program to provide care for those who are PRC eligible who do not have alternate resources. IHS makes the following recommendations with respect to PRC residual responsibility:

(1) IHS considers sponsorship through indemnity to be an alternate resource under the payer of last resort rule.

(2) In the case of sponsorship through a self-insurance plan, where the plan is self-funded in part or whole with ISDEAA funds and there is no reinsurance or indemnity, the self-funded plan will be considered a payer of last resort, but benefits will be coordinated between the PRC program and the self-funded plan as set forth in subsection 4.B., below.

(3) IHS does not consider an IHS beneficiary to be eligible for PRC to the extent that the sponsorship provides coverage.

B. Under the payer of last resort rule and a coordination of benefits process, the PRC program shall not pay primary to any third-party payers, including sponsorship in any form.

C. To the extent that a plan is indemnified or reinsured, it does not qualify as a self-insurance plan that is exempt from IHS' right of recovery under 25 U.S.C. § 1621e(f). IHS shall have the right to recover under 25 U.S.C. § 1621e(a) from any indemnity or reinsurance, whether or not it is purchased through 25 U.S.C. § 1642.

5. ELIGIBILITY FOR THE CATASTROPHIC HEALTH EMERGENCY FUND. In the case of sponsorship through a self-insurance plan, where the plan is entirely self-funded in part or whole with ISDEAA funds and there is no reinsurance or indemnity, and the plan is designed to follow PRC eligibility, the self-funded plan will be considered eligible

for reimbursement from the Catastrophic Health Emergency Fund on the same basis and under the same terms that PRC programs are eligible for such reimbursement.

6. EFFECTIVE DATE. This circular becomes effective on date of signature.

Mary Smith
Principal Deputy Director
Indian Health Service

3F

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

JUL 20 2016

Indian Health Service
Rockville MD 20857

Dear Tribal Leader:

I am writing to provide an update about the Indian Health Service's (IHS) efforts to increase access to quality health care for American Indians and Alaska Natives and to initiate a 60-day Tribal consultation on a draft Quality Framework (Framework).

The IHS strives to provide access to quality health care for all patients receiving health care in the Indian health system, at both tribally operated facilities as well as federally operated (direct service) facilities. On June 15, I sent a letter to Tribal Leaders to describe the IHS's strategy to enhance the quality of health care in the Great Plains Area and across the country. As part of this strategy, IHS developed a Framework to outline key priorities and objectives that focus on strengthening the underlying foundation of the direct service health facilities within the IHS system of care. This Framework builds on existing initiatives and programs to drive improvements in service delivery. For your review, I have enclosed a copy of the Framework.

The Framework focuses on federally operated facilities to align with the following quality priorities: 1) Strengthen organizational capacity to improve quality of care and systems; 2) Meet and maintain accreditation for IHS direct service facilities; 3) Align service delivery processes to improve patient experience; 4) Ensure patient safety; and 5) Improve processes and strengthen communications for early identification of risks.

With these priorities to guide our quality improvement efforts, IHS will work closely with our Area Offices and direct service facilities to strengthen capacity to provide patient-centered, timely, effective, safe, and reliable health care of the highest quality. In addition, IHS will work to standardize key processes and policies aimed at improving the patient experience. IHS will also enhance our communication activities to keep stakeholders informed and engaged about Framework progress and achievements.

Over the next couple of months, IHS will convene two in-person Tribal consultation sessions and one telephone consultation with a 60-day comment period to invite written comments from Tribes and Tribal organizations across the country concerning the Framework and improving the quality of care provided at federally operated facilities.

The in-person consultation sessions will be:

August 30, 2016
13th Annual Direct Service Tribes National Meeting &
6th Annual Great Plains Tribal Chairmen's Health Board Health Summit
Holiday Inn Rapid City – Rushmore Plaza
505 North Fifth Street
Rapid City, South Dakota 57701

September 19, 2016
National Indian Health Board 33rd Annual Tribal Health Conference
Talking Stick Resort
9800 E. Talking Stick Way
Scottsdale, Arizona 85256

The telephone consultation session will be:

August 15, 2016
2:00 p.m. – 4:00 p.m. (Eastern Time)
Conference Call Dial-in: (800) 988-9462
Passcode: 6895736

Written comments from Tribes and Tribal organizations can be e-mailed to consultation@ihs.gov.

A summary of all comments received during the Tribal consultation sessions will be made available on the IHS web site following the close of the comment period. Please provide your written comments as instructed below.

Thank you for your partnership and your engagement as we continue to work to strengthen access to quality health care at IHS. I look forward to hearing your input.

Sincerely,

/Mary Smith/

Mary Smith
Principal Deputy Director

Enclosure

Instructions for Submitting Written Comments:

Please send input by e-mail to:	consultation@ihs.gov Subject line: IHS Quality Framework
Send input by postal mail to:	Ms. Rebecca Spitzgo Indian Health Service 5600 Fishers Lane Mail Stop: 08E86 Rockville, MD 20857 ATTN: IHS Quality Framework
Send input by facsimile to:	Ms. Rebecca Spitzgo (301) 443-4794 Subject line: IHS Quality Framework

Indian Health Service (IHS) Quality Framework, 2016-2017

Introduction

The Indian Health Service (IHS) seeks to provide safe, trusted, high quality health care to American Indians and Alaska Natives and promotes policies, practices, and programs that improve health outcomes.

The IHS Quality Framework describes the vision, goals, and priorities to develop, implement, and sustain an effective quality program that improves patient experience and outcomes, strengthens organizational capacity, and ensures the delivery of reliable, high quality health care for IHS Direct Service facilities. This Framework is consistent with the aims of the 2011 National Quality Strategy established by the U.S. Department of Health and Human Services (HHS) and is aligned with HHS Strategic Goals (#1: Strengthen Health Care, and #4: Efficiency, Transparency, Accountability, and Effectiveness), the IHS mission, and key IHS priorities.

The Quality Framework was developed by assessing current IHS quality policies, practices, and programs, incorporating standards from national experts, and including best practices from across the IHS system of care. The Framework is a living document with an initial focus on strengthening the underlying quality foundation of the federally-operated facilities within the IHS system of care that builds upon existing initiatives and programs. IHS is also committed to sharing best practices, models, and policies with Tribes and Urban Indian programs and strengthening partnerships with Tribes, local communities and regional health care systems. This Framework will be reviewed and updated annually.

The IHS Quality Implementation Plan, 2016-2017, is a companion document to this Framework and describes specific activities IHS will undertake to implement changes in support of the priorities and objectives outlined in the Framework.

IHS Mission Statement

To raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

Quality Vision

IHS will provide patient-centered, timely, effective, safe, and reliable health care of the highest quality.

Quality Goals

1) Improve Health Outcomes for Patients Receiving Care
2) Provide a care delivery service all patients trust

Quality Priorities

1) Strengthen Organizational Capacity to Improve Quality of Care and Systems
2) Meet and Maintain Accreditation for IHS Direct Service Facilities
3) Align Service Delivery Processes to Improve Patient Experience
4) Ensure Patient Safety
5) Improve Processes and Strengthen Communications for Early Identification of Risks

Priority 1: Strengthen Organizational Capacity to Improve Quality of Care and Systems

In order to provide patient-centered, timely, effective, safe, and reliable health care of the highest quality, IHS will strengthen its capacity through establishing leadership in quality, standardizing governance, workforce development, incorporating data-supported decision making, and reporting. IHS will strengthen and unify oversight and support functions of facilities, personnel and processes that directly impact the quality of health care delivery services.

Objectives:

1A) Provide Leadership in Quality

IHS will establish a Quality Office at Headquarters, overseen by a Deputy Director of Quality, who will report to the IHS Director. The Quality Office will lead the development of a culture of quality in all IHS Direct Service facilities that embodies trust and respect, and fosters continuous learning; assess Area Office and Service Unit functions, staffing, and critical quality assurance activities; and will identify resource needs, structures, processes and supports for an effective and sustainable quality assessment and performance improvement system. The Quality Office will be staffed to manage the functions that support activities such as assessing and addressing quality and patient safety issues, in addition to monitoring trends in performance and progress in achieving quality improvements. Additionally, leadership in quality will be provided in the field through the establishment of Chief Quality Officers at each Area Office to serve as critical liaisons between Headquarters and Service Units.

1B) Standardize Governance

Standardizing and strengthening governance processes and structures promotes reliability, consistency, and management excellence while emphasizing quality improvement as an Agency priority. Through the IHS Quality Consortium, a standard governing body structure will be developed to improve planning and oversight processes while ensuring that all Direct Service facilities are meeting external accreditation and certification Governance requirements.

1C) Strengthen Human Resources

Increasing Quality Improvement capacity at Headquarters, Area Offices, and Service Units will ensure staff have knowledge, skills, and abilities to actively contribute to process improvements that impact quality of health care service delivery. IHS will support enhanced efforts to recruit and retain highly qualified clinicians and executives, assess training needs, encourage staff development, provide training on quality improvement topics for IHS leaders, and maintain an ongoing commitment to quality improvement at all levels.

1D) Standardize Data and Reporting Requirements

The use of data to drive action and provide feedback is critical to assessing and improving performance. Across the Agency, data collection, data analytics, and reporting requirements will be standardized to inform program, policy, and resource decisions. Roles, responsibilities, and timelines for review and oversight of data and reports will be established. These efforts will initially focus on clinical data and the electronic health records and will subsequently focus on operations, management, and human resources.

Priority 2: Meet and Maintain Accreditation for IHS Direct Service Facilities

Ensuring that all Direct Service facilities comply with regulatory and quality standards through

accreditation is key to achieving IHS quality goals. IHS will build the capacity to ensure standards are identified, maintained, and disseminated and that facilities are prepared for and successful in the accreditation process.

Objectives:

2A) Ensure Accreditation of IHS Direct Service Facilities
IHS will secure the services of a single accrediting organization for all IHS Direct Service facilities to assure uniformity of approach, methods, and standards. Increased training and technical assistance opportunities will be provided to ensure staff have the skills, information, equipment, and resources necessary for carrying out their duties and achieving compliance with quality and safety standards.

2B) Implement Annual Mock Surveys for all IHS Direct Service Facilities
IHS will conduct mock surveys annually to assist facilities to maintain a state of continual readiness for accreditation surveys. The mock survey process will incorporate an assessment against the accrediting/certifying organizations' standards, correction of any deficiencies identified, verification that corrective actions have been completed, and continual monitoring to ensure ongoing compliance with standards. Each Area will build the capacity to respond to survey findings and support monitoring of compliance with standards.

2C) Conduct Quarterly Meetings for Survey Readiness
To support Service Units in survey readiness and building a learning environment, IHS Headquarters will conduct quarterly conference calls with Area Office and Service Unit leaders to discuss deficiencies found through the mock and actual survey processes, and corrective actions taken. Quarterly conference calls will highlight best practices to meet accreditation standards and guide Service Units to proactively address problem areas and reduce risks to quality and safety.

Priority 3: Align Service Delivery Processes to Improve Patient Experience

IHS will focus on standardizing key processes and policies aimed at improving the patient experience. First among these will be the implementation of a Patient Perception Survey process. Survey data will inform and guide our patient experience improvement efforts and provide the opportunity for a data-driven approach. A number of efforts will also focus on reducing unnecessary clinical and administrative variation, and medical, legal and financial risks across the system. Standardization of processes will provide efficiencies across the IHS system by reducing duplication of effort, spreading of best practices, and creating economies of scale.

Objectives:

3A) Improve the Patient Experience
IHS will continue to develop and adopt processes to improve the patient experience of care through the development and implementation of a Patient Perception Survey process to gather valuable information to inform our efforts.

3B) Improve Patient Wait Times
IHS will focus on reducing patient wait times for appointments, cycle time during appointments, and Emergency Department wait times, by reviewing and leveraging best practices from Service Units and the health care industry.

3C) Improve the Credentialing Process
IHS will standardize the credentialing business process and implement a single credentialing software system for direct service facilities. IHS will automate business processes where possible and review, update, and simplify credentialing and privileging policies and procedures. Training and technical assistance will be provided to staff. The Quality Office will oversee and perform intermittent random assessments to ensure the credentialing processes and procedures are followed.

3D) Central Repository of Policies and Procedures
IHS will conduct a feasibility analysis of moving to a system-wide repository to ensure access to key policies and procedures from IHS, CMS, State Department, etc. IHS will develop a central repository of key IHS policies and procedures accessible to each Area Office to ensure consistency among Areas and enable easy access to and version control of current policies and procedures for Service Units. This effort will include a review of policies and procedures to determine differences across Service Units and consolidating to a single policy and procedure system.

Priority 4: Ensure Patient Safety

Improving patient safety involves eliminating harm due to health care related errors and adverse events, by aligning with nationally recognized external patient safety standards and managing risk through transparency, accountability, and fair/equitable response to such events. To accomplish this, IHS will work toward transformation into a learning organization by cultivating an environment in which all staff feel comfortable reporting medical errors or "near misses," and instituting processes to support learning from experiences.

Objectives:

4A) Promote a Culture of Patient Safety
IHS will promote a culture of patient safety by educating and encouraging staff to value continuous quality improvement and developing expertise at all levels in patient safety to include a focus on high reliability, Just Culture, event investigation and management, teamwork principles, and critical communication.

4B) Enhance Patient Safety Event Reporting and Identification
IHS will enhance its current patient safety reporting systems to encourage consistent use by staff. Data analysis and management will be crucial to identifying risks and taking action to reduce the occurrence of adverse events. Patient safety indicators will be included in an internal data monitoring system for quality measurement. Communication and reporting channels will be reviewed, updated, and monitored.

4C) Strengthen Processes for Addressing Patient Safety Events
IHS will adopt a systems approach and expand the use of techniques including prospective risk assessments (e.g., Failure Mode and Effects Analysis) and retrospective risk analysis (e.g., Root Cause Analysis) as part of a comprehensive approach to reduce adverse events and risks to patient safety.

4D) Control Healthcare Associated Infections
IHS will assess nationally endorsed programs and adopt new approaches to reduce healthcare associated infections. Participation in national networks and collaborative relationships supported and

coordinated by the Quality Office and Quality Consortium will provide access to recognized experts and industry best-practices in support of quality improvement.

Priority 5: Improve Processes and Strengthen Communications for Early Identification of Risks

In order to promote transparency and accountability, IHS will establish processes using available data to warn of potential risks, mitigate risk, take corrective action, and ensure resolution. Identifying a set of measures from IHS data sources will enable Headquarters, Area Offices, and Service Units to monitor performance on indicators that could include clinical quality and administrative measures. IHS will determine quality measures and benchmarks to track with a focus on making improvements at all organizational levels. IHS will also enhance its communication activities with internal and external audiences to keep stakeholders informed about IHS progress and achievements.

5A) Implement a Data Monitoring System for Quality Measurement

IHS will develop a process for monitoring select indicators (e.g., measures of clinical care, patient access, and financial performance) for periodic review by Agency, Area, and Service Unit leadership. The monitoring system will be designed using currently available data sources, with maximum automation to reduce the reliance on manual data collection, and include data at the facility level.

5B) Improve Communications throughout the Agency

Transparency and accountability will be fostered through regular and frequent (i.e., monthly or quarterly) communications from the Quality Office to Headquarters, Areas, and Service Units. This information sharing will unify staff at all levels in working to continuously improve the quality of care and health care operations.

DEPARTMENT OF HEALTH & HUMAN SERVICES

3G
Public Health Service

Indian Health Service
Rockville MD 20852

JULY 22 2016

Dear Tribal Leader:

I am writing to update you on the Indian Health Service (IHS) Special Diabetes Program for Indians (SDPI) and its fiscal year (FY) 2016 Community-Directed (C-D) grant application process.

The SDPI is currently authorized through FY 2017 at $150 million per year. The President's FY 2017 budget proposes to make the SDPI permanent at this funding level. We are grateful for your partnership and support of this important program, which provides funding for critically important diabetes treatment and prevention services in our communities.

As you know, the IHS conducted a national Tribal consultation regarding proposed changes to the SDPI in preparation for the FY 2016 funding opportunity announcement. Among the decisions announced in the June 29, 2015-dated Tribal Leader Letter, was that funds that had previously been directed to the SDPI Diabetes Prevention and Healthy Heart (DP/HH) Initiatives would be used to augment the SDPI C-D funds. Also stated in this letter was that it was essential that all applicants submit quality applications by the due date in order to receive SDPI FY 2016 funding. The IHS Division of Diabetes Treatment and Prevention provided extensive technical assistance to all applicants starting before and continuing throughout the application process.

The SDPI differs from other grant programs in that SDPI C-D funds are allocated to successful applicants through national and Area formulas. The formula that allocates national funds to each IHS Area undergoes national Tribal consultation with each new grant cycle and the formulas used to allocate Area funds to grantees are agreed upon by the grantees in each Area. As such, the competition required under the new funding opportunity announcement was to achieve a fundable score in the objective review process, not against other applicants. All eligible applicants whose applications received a score of at least 60 points (out of a possible 100 points) in the objective review process were awarded funding. Under these criteria, a majority of the Tribal, Urban, and IHS applicants were successful in achieving this threshold.

SDPI FY 2016 funding was awarded to 276 primary grantees, with an additional 25 sub-grantees, for a total of 301 programs. Of the primary grantees, 232 are Tribes; 29 are Urban Indian Organizations; and 15 are IHS sites. With the addition of the DP/HH funds, virtually all SDPI C-D grantees received an increase in funds compared to FY 2015.

Congratulations to each of the SDPI FY 2016 grantees. We look forward to working together over the course of this 5-year grant cycle (pending continued SDPI authorization).

For a complete list of FY 2016 grantees and their funding amounts, please visit the Web site at: https://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Resources/FactSheets/SDPI_FY2016_CD_GrantPrograms.pdf.

I am also pleased to announce that the IHS Report to Congress, "*Special Diabetes Program for Indians 2014 Report to Congress, Changing the Course of Diabetes: Turning Hope Into Reality*," is now available on our Web site at the following address: https://www.ihs.gov/newsroom/reportstocongress/.

I hope you will take a few minutes to read the good news in this Report about how our collective efforts are truly changing the course of the diabetes epidemic in our communities:

- Increases in diabetes prevalence (proportion of people with diabetes) among adults are slowing;
- In youth, diabetes remains rare and prevalence is not increasing;
- Long-term control of key diabetes clinical measures is being sustained; and
- The incidence rate (new cases) for end-stage renal disease in people with diabetes is decreasing.

If you have any questions relating to the SDPI, please contact Ann Bullock, M.D., Director, Division of Diabetes Treatment and Prevention, IHS, by telephone at (844) 447-3387. For questions relating to SDPI grant issues, please contact Mr. Robert Tarwater, Director, Division of Grants Management, IHS, by telephone at (301) 443-5204.

Thank you for your partnership with the IHS in advancing the important work of diabetes treatment and prevention in our communities.

Sincerely,

/Mary Smith/

Mary Smith
Principal Deputy Director

DEPARTMENT OF HEALTH & HUMAN SERVICES

3H
Public Health Service

Indian Health Service
Rockville MD 20852

JULY 29 2016

Dear Tribal Leader:

I am writing to provide an update to my June 1, Tribal Leader Letter on the Proposed Rule for the Catastrophic Health Emergency Fund (CHEF). Several Tribes and Tribal Organizations expressed concern about provisions in the *Federal Register* Notice. In response to those concerns, the Indian Health Service (IHS) made the determination that we would engage in additional Tribal Consultation before moving forward.

Telephone and in person Tribal Consultation sessions have been scheduled as follows:

Telephone Tribal Consultation Sessions

Call Date:	Tuesday, August 16, 2016
Call Time:	3:00 p.m. – 4:00 p.m. (Eastern Time)
Call In Number:	(888) 790-3108
Participant Passcode:	4110567

Call Date:	Monday, October 24, 2016
Call Time:	1:00 p.m. – 2:00 p.m. (Eastern Time)
Call In Number:	(888) 790-3108
Participant Passcode:	4110567

In Person Tribal Consultation Sessions

National Indian Health Board Consumer Conference on September 19, 2016, from 9:00 a.m. – 9:50 a.m., in Scottsdale, Arizona.

National Congress of American Indians 73rd Annual Convention and Marketplace scheduled for October 9, 2016, from 1:00 p.m. – 2:00 p.m., in Phoenix, Arizona.

Thank you for your support and partnership. I look forward to hearing your input on the proposed CHEF regulations.

For additional information, please contact Ms. Terri Schmidt, Acting Director, Office of Resource Access and Partnerships. She can be reached by telephone at (301) 443-3216 or by e-mail at terri.schmidt@ihs.gov.

Sincerely,

/Mary Smith/

Mary Smith
Principal Deputy Director

JULY 29 2016

Dear Tribal Leader:

I am writing to provide an update to my July 18 letter regarding the draft Circular that addresses the purchase of health care coverage, which is commonly referred to as Tribal Premium Sponsorship. During the July 21 Tribal Self-Governance Advisory Committee meeting, Tribal Leaders asked the Indian Health Service (IHS) to extend the comment period for Tribal Premium Sponsorship and include in-person consultation sessions. In response to this request, the IHS will extend the Tribal comment period to October 31 and hold two in-person consultation sessions.

The first consultation session will be held at the National Indian Health Board Annual Consumer Conference in Scottsdale, Arizona, on September 19, 2016, from 11:00 a.m. to 11:50 a.m.

The second consultation session will be held at the National Congress of American Indians 73rd Annual Convention and Marketplace in Phoenix, Arizona, on October 9, 2016, from 3:45 p.m. to 5:00 p.m.

Written comments can be e-mailed to consultation@ihs.gov by COB October 31.

Thank you for your support and partnership. I look forward to receiving your input on the draft Circular for Tribal Premium Sponsorship and have enclosed a copy for your review.

For additional information, contact Ms. Terri Schmidt, Acting Director, Office of Resource Access and Partnerships. She can be reached by telephone at (301) 443-3216 or by e-mail at terri.schmidt@ihs.gov.

Sincerely,

/Mary Smith/

Mary Smith
Principal Deputy Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service
Rockville, Maryland 20857

Refer to: ORAP

INDIAN HEALTH SERVICE CIRCULAR NO. 2016-08

PURCHASING HEALTH CARE COVERAGE

Sec.

1. PURPOSE. The purpose of this circular is to provide further detailed guidance into the current policy (Oct. 2013 Dear Tribal Leader Letter) if a Tribe, Tribal organization, or urban Indian organization wishes to purchase coverage for Indian Health Service (IHS) beneficiaries under 25 *United States Code* (U.S.C.) § 1642 with Indian Self-Determination and Education Assistance Act (ISDEAA) funding or other IHS appropriated funds.

2. CONTRACT/COMPACT LANGUAGE. The following language is recommended to be inserted into a new or an existing Tribal-IHS contract/compact or funding agreement to identify:

   A. The funding source, i.e., Purchased/Referred Care (PRC), Hospital & Clinic (H&C) funds, third-party revenues, or tribal supplements

   B. The specific amount of funding needed

   C. The type of coverage that will be provided

   D. Eligibility criteria

   E. Alternate resource rules, if applicable

DRAFT
Distribution: IHS-wide
Date: XX/XX/2016

F. If third-party revenues collected by the Tribe are identified as part or all of the funding source, IHS recommends the following:

(1) The funds should have already been collected and not yet expended (i.e., not amounts owed or future projections for anticipated collections).

(2) In accordance with 25 U.S.C. § 1641, Medicare and Medicaid collections are intended to be used first to maintain or achieve compliance with the respective program.

(3) To the extent the third-party revenues are collected by IHS, the contract/compact should not promise or guarantee the award of third-party revenue, including revenue derived from sponsorship coverage. Such collections may only be transferred as authorized by law and shall be considered nonrecurring.

3. ELIGIBILITY CRITERIA. Tribes and Tribal Organizations may make eligibility determinations for IHS programs under 25 U.S.C. 450j-1, but must follow applicable eligibility rules and regulations. In addition, the purchase of health care coverage by an Indian tribe, tribal organization, or urban Indian organization can be based on the financial need of the beneficiary, if the Tribe/Tribal Organization or urban Indian organization wishes to limit the number of beneficiaries covered, pursuant to 25 U.S.C. §1642. The statute specifies that the financial need of the beneficiary is determined by the tribe(s) served, based upon a schedule of income levels developed by the tribe(s) served. The IHS makes the following recommendations with respect to eligibility:

A. Eligibility should follow the source of funding.

(1) If non-PRC funds are utilized, direct service eligibility rules should apply.

(2) If PRC funds are utilized, alone or in combination with non-H&C funds, including supplements from the tribe, PRC eligibility should apply.

(3) If both unrestricted H&C and PRC funds are utilized, the contract/compact should state whether direct service or PRC eligibility will be followed and the funds should be rebudgeted accordingly.

B. If any PRC funds are used and they are not rebudgeted as H&C funds according to the guidance above, PRC eligibility rules should be followed for the sponsorship and references to the following PRC eligibility rules should be included in the contract or compact:

(1) 42 Code of Federal Regulations (CFR) 136.23 – Persons to whom contract health services (now known as Purchased/Referred Care) will be provided.

(2) The language of 42 CFR 136.22(a) – (PRC Service Delivery Area) - "In accordance with the congressional intention that funds appropriated for the general support of the health program of the IHS be used to provide health services for Indians who live on or near Indian reservations…"

C. Coverage can be provided to IHS beneficiaries who are also employees of tribal businesses, but eligibility should not be limited to tribal employees.

4. Purchased/Referred Care Residual Responsibility & Coordination of Benefits. IHS recommends the following:

A. When a Direct Service Tribe (DST) decides to take a portion of its PRC funds to purchase insurance for some or all of their tribal members, this leaves a residual of funds in the DST PRC program to provide care for those who are PRC eligible who do not have alternate resources. IHS makes the following recommendations with respect to PRC residual responsibility:

(1) IHS considers sponsorship through indemnity to be an alternate resource under the payer of last resort rule.

(2) In the case of sponsorship through a self-insurance plan, where the plan is self-funded in part or whole with ISDEAA funds and there is no reinsurance or indemnity, the self-funded plan will be considered a payer of last resort, but benefits will be coordinated between the PRC program and the self-funded plan as set forth in subsection 4.B., below.

(3) IHS does not consider an IHS beneficiary to be eligible for PRC to the extent that the sponsorship provides coverage.

B. Under the payer of last resort rule and a coordination of benefits process, the PRC program shall not pay primary to any third-party payers, including sponsorship in any form.

C. To the extent that a plan is indemnified or reinsured, it does not qualify as a self-insurance plan that is exempt from IHS' right of recovery under 25 U.S.C. § 1621e(f). IHS shall have the right to recover under 25 U.S.C. § 1621e(a) from any indemnity or reinsurance, whether or not it is purchased through 25 U.S.C. § 1642.

5. ELIGIBILITY FOR THE CATASTROPHIC HEALTH EMERGENCY FUND. In the case of sponsorship through a self-insurance plan, where the plan is entirely self-funded in part or whole with ISDEAA funds and there is no reinsurance or indemnity, and the plan is designed to follow PRC eligibility, the self-funded plan will be considered eligible

for reimbursement from the Catastrophic Health Emergency Fund on the same basis and under the same terms that PRC programs are eligible for such reimbursement.

6. EFFECTIVE DATE. This circular becomes effective on date of signature.

Mary Smith
Principal Deputy Director
Indian Health Service

JULY 29 2016

Dear Tribal Leader:

On June 1, 2016, I initiated a Tribal Consultation on a draft policy statement to expand the Community Health Aide program (https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2016_Letters/55744-1_DTLL_CHAP_Expansion.pdf).

While we have received several comments to date, Tribes and Urban Indian Organizations have requested additional time to comment on this important draft policy statement. Accordingly, I am extending the comment submission deadline until October 27, 2016. Please provide your written comments as instructed below.

In addition, telephone and in person Tribal Consultation/Urban Confer sessions have been scheduled as follows:

Telephone Tribal Consultation/Urban Confer session

Call Date:	October 4, 2016 (Tuesday)
Call Time:	3:00 p.m. – 4:30 p.m. Eastern
Call In Number:	1-888-955-8942
Participant Passcode:	9659843

In Person Tribal Consultation/Urban Confer sessions

National Indian Health Board Consumer Conference on September 19, 2016, from 1:00 p.m. – 2:30 p.m., in Scottsdale, Arizona.

National Congress of American Indians 73rd Annual Convention and Marketplace scheduled for October 9, 2016, from 2:15 p.m. – 3:30 p.m. in Phoenix, Arizona.

Thank you for your partnership. I look forward to hearing your input on the Community Health Aide program.

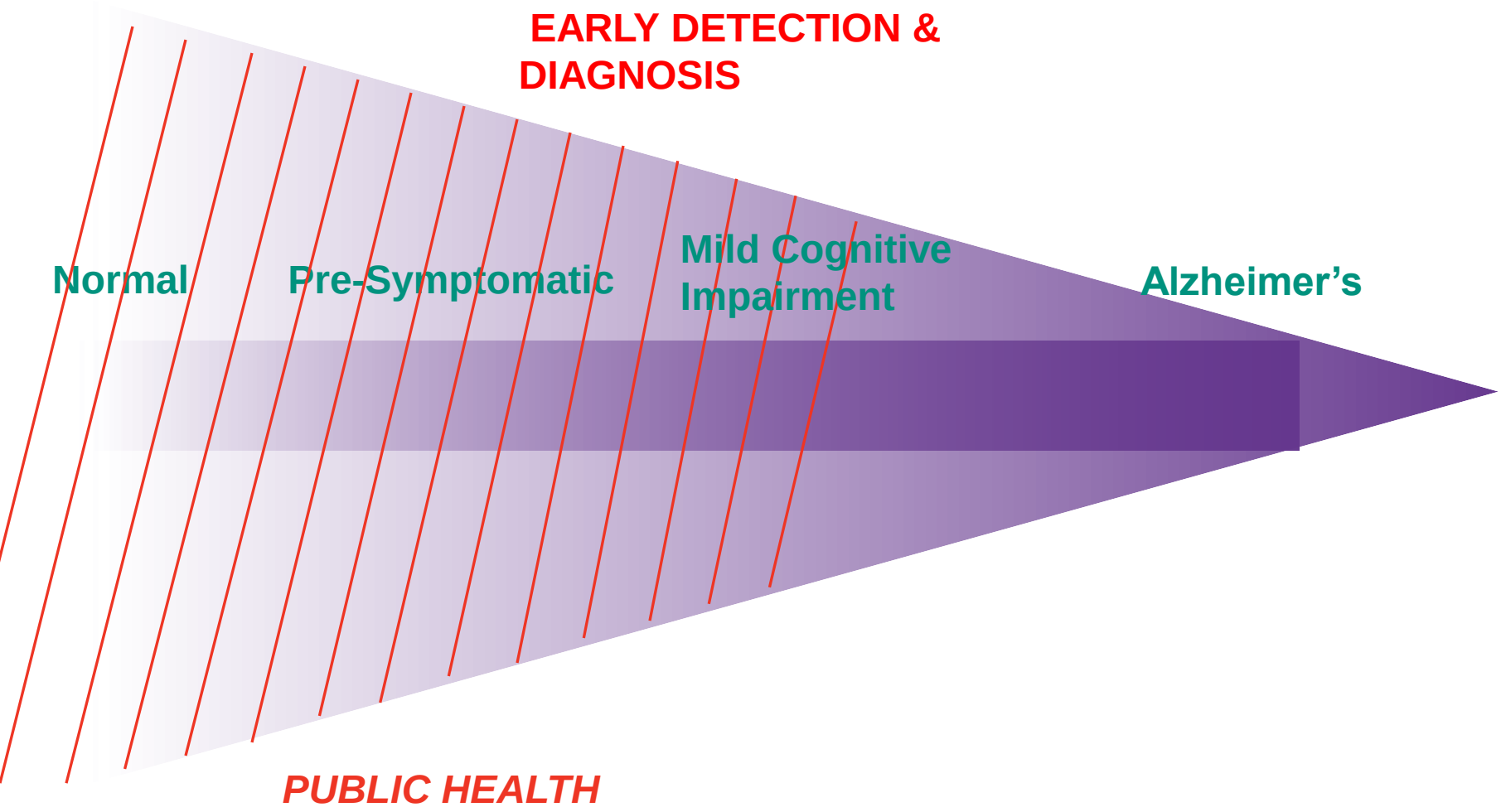
Sincerely,

/Mary Smith/

Mary Smith
Principal Deputy Director

Tribal Leaders, please send input by e-mail to:	consultation@ihs.gov Subject line: IHS Expansion of Community Health Aide Program Draft Policy Statement Consultation
Send input by postal mail to:	Alec Thundercloud, M.D. Indian Health Service 5600 Fishers Lane, Mail Stop: 08N34-A Rockville, MD 20857

RISK REDUCTION



The Healthy Brain *Initiative*

The Public Health Road Map for State and National Partnerships, 2013–2018

alzheimer's association

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

The Healthy Brain Initiative:
The Public Health Road Map for State and National Partnerships, 2013–2018

Table of Contents

Suggested Citation: Alzheimer's Association and Centers for Disease Control and Prevention. *The Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, 2013–2018*: Chicago, IL: Alzheimer's Association; 2013.

The Alzheimer's Association and the Centers for Disease Control and Prevention's (CDC) Healthy Aging Program have developed the second in a series of road maps to advance cognitive health as a vital, integral component of public health. *The Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, 2013–2018,* outlines how state and local public health agencies and their partners can promote cognitive functioning, address cognitive impairment for individuals living in the community, and help meet the needs of care partners. Specific actions are addressed in four traditional domains of public health: monitor and evaluate, educate and empower the nation, develop policy and mobilize partnerships, and assure a competent workforce. Public health agencies and private, non-profit, and governmental partners at the national, state, and local levels are encouraged to work together on those actions that best fit their missions, needs, interests, and capabilities.

Healthy Brain Initiative

A Public Health Crisis

Dementias, including Alzheimer's disease

- In 2013, an estimated 5 million Americans aged 65 and older have Alzheimer's disease (Hebert, Weuve, Scherr & Evans, 2013). By 2050, unless more effective ways to prevent and treat the disease are identified and implemented, the prevalence may triple to as high as 13.8 million people (Hebert et al., 2013).
- Aging is the best known risk factor for developing Alzheimer's disease. The likelihood of developing Alzheimer's doubles about every five years after age 65 (Hebert et al., 1995).
- Alzheimer's disease is now the 6th leading cause of death and 5th among adults 65–85 years of age (Xu, Kochanek, Sherry, Murphy & Tejada-Vera, 2010).

Healthy Brain Initiative

- In 2010, the direct and indirect costs of dementia among those aged 70 and over totaled an estimated $159 billion to $215 billion (depending upon the monetary value placed on informal care). The direct healthcare expenditures were significantly higher than cancer and similar to heart disease (Hurd, Martorell, Delavande, Mullen & Langa, 2013). In 2013, total direct payments for all healthcare, long-term care, and hospice services incurred by those aged 65 years and older with Alzheimer's and other dementias are estimated to be $203 billion (Thies & Bleiler, 2013). The growing demand for care poses challenges to the healthcare workforce (IOM, 2008), and economic strain on Medicare and Medicaid programs as the major funders of this care (USDHHS, 2012).

Cognitive decline

- One in eight adults aged 60 and older (12.7%) report experiencing "confusion or memory loss that is happening more often or is getting worse" over the past 12 months (Centers for Disease Control and Prevention [CDC], 2013).

- Among these individuals, only 19.3% reported discussing these changes with a healthcare provider, and 35.2% reported difficulties due to confusion or memory loss. Additionally, 34.5% live alone (CDC, 2013). Changes in cognitive abilities affect individuals differently and can gradually compromise an individual's ability to care for themselves; conduct necessary activities of daily living, such as meal preparation and money management; and effectively manage medications and existing medical conditions (Wagster, King, Resnick & Rapp, 2012).

What is cognition?

Cognition can be viewed along a continuum—from optimal functioning to mild cognitive impairment to Alzheimer's disease and severe dementia—and may include tasks involved with cognitive function such as: language, thought, memory, executive function (the ability to plan and carry out tasks), judgment, attention, perception, remembered skills such as driving, and the ability to live a purposeful life.

What is cognitive impairment?

When cognitive abilities are impaired (often referred to as cognitive impairment), a person has trouble with cognitive processes that begin to affect the things he or she can do in everyday life. Dementia is not a disease itself, but rather a syndrome defined by a group of symptoms that often occur together in various combinations and severity. Alzheimer's disease is the most common cause of dementia and along with other conditions such as stroke and traumatic brain injury can result in impairment in cognitive abilities. It is important to note that some causes of cognitive impairment are related to treatable health issues (e.g., medication side effects, vitamin B12 deficiency, and depression).

Impact at Multiple Levels

On individuals

Although the majority of Americans live without cognitive impairment, they often feel uninformed and fearful of the disease. According to a recent public opinion poll, 44% of Americans fear Alzheimer's disease more than any other disease, including cancer (Marist Poll, 2012). About 75% of adults report not being knowledgeable about the disease (Anderson, Day, Beard, Reed & Wu, 2009). Additionally, several reports documented a great deal of concern about the disease, both from a personal perspective and the potential of caring for someone who may develop the disease in the future. Most concerns focus on memory loss: 73% of adults are concerned or very concerned about the possibility that their memory may worsen with age (Friedman et al., 2013).

Furthermore, people with dementia report being afraid of the reactions of others and a lower perceived status within society because of the diagnosis (Katsuno, 2005). The stigma associated with dementia may promote social exclusion, a reluctance to seek help (Link & Phelan, 1999; Corrigan, 2004), a sense of shame and inadequacy, and low self-esteem (Batsch & Mittelman, 2012).

On families

Family members have traditionally been responsible for the caregiving of individuals with Alzheimer's and other dementias. The vast majority (80%) of care partners are family members in home settings (IOM, 2008). As lifespans lengthen and the population ages, a corresponding increase is expected in the number of individuals providing care, the length of time spent caregiving, and the breadth of required tasks (Schulz & Martire, 2004).

"Productivity, independence, and quality of life for millions of Americans depend on the nation's collective ability to prevent and treat cognitive impairment and dementia, and to promote cognitive functioning for individuals living in our communities. To accelerate efforts to meet these goals and help incorporate cognitive health in the plans and initiatives of states, territories, and communities in the U.S., we look forward to working with our partners to implement the actions identified in *The Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, 2013–2018*."

Lynda A. Anderson, PhD, and Robert Egge
Co-chairs of Leadership Committee

Care partners of individuals with dementia spend much more time providing care than care partners of individuals with other conditions. The average length of time caregivers report providing care is 4.6 years (National Alliance for Caregiving & AARP, 2009), but in the case of dementia, caregiving may range from 4 to 20 years. In 2011, over 15 million Americans spent an average of 21.9 hours per week caring for a family member with dementia—a total of 17.5 billion hours at a value of $216 billion dollars (Thies & Bleiler, 2013).

While family care partners typically assume their responsibilities willingly (Family Caregiver Alliance, 2006), the demands of caregiving can take a toll on their health, compromising their ability to care for themselves and their family members. Family care partners of individuals with dementia are at greater risk for anxiety, depression, and poorer quality of life than care partners of individuals with other conditions (Ory, Hoffman, Yee, Tennstedt & Schulz, 1999; Pinquart & Sörensen, 2007). Between 28% and 55% have depression, compared with 15% in the non-caregiving older adult population (Elliott, Burgio & Decoster, 2010).

On healthcare professionals

The public health workforce is large and diverse ranging from physician specialists to community health workers (Frank & Weiss, 2012). They are an important source of information and can play a critical role in caring for someone with cognitive impairment (USDHHS, 2012) as well as in attending to the needs and health of care partners as they cope with the physical and emotional impact of their responsibilities (Talley & Crews, 2007). Yet only 19% of people aged 60 and older who reported worsening confusion or memory loss have discussed their symptoms with a healthcare provider (CDC, 2013).

Among those living in the community, approximately two-thirds of the people who meet the diagnostic criteria for Alzheimer's disease or other dementias have not received a diagnosis (Boustani, Peterson, Hanson, Harris, & Lohr, 2003). Although there are no disease-modifying therapies, studies have shown consistently that active management can significantly improve quality of life through all stages of the disease for individuals with dementia and their care partners (Vickrey et al., 2006; Voisin & Vellas, 2009; Grossberg et al., 2010; Blendon et al., 2012).

Caregiving

Care for people with dementia, such as Alzheimer's disease, is often provided in the home by family members or friends. These caregivers typically have a longer and harder caregiving journey than caregivers for people with other conditions. While they provide a tremendous service to the person with dementia and to society, they are at greater risk for developing health problems.

Family Partners

The vast majority of caregivers for people with dementia, such as Alzheimer's disease, **are family members in home settings.**

Risks of Caregiving

Caregivers of people with Alzheimer's disease are **at greater risk for anxiety, depression, and poorer quality of life** compared to caregivers of people with other chronic conditions.

National Response

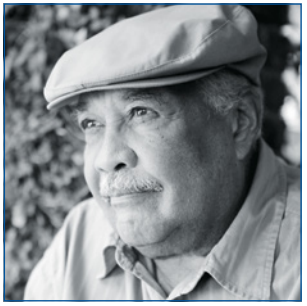
The National Alzheimer's Project Act (NAPA) was signed into law on January 4, 2011. Passed unanimously in both the Senate and House of Representatives, NAPA (Public Law 111-375) calls for a national strategic plan among federal agencies to address and overcome the rapidly escalating crisis of Alzheimer's disease. The first National Plan to Address Alzheimer's Disease, released in May 2012, recognizes Alzheimer's disease as a major public health issue; provides a blueprint for coordinating Alzheimer's disease efforts across the federal government; and outlines concrete goals, strategies, and actions for eliminating the burden of the disease. Additionally, NAPA and the National Plan are generating numerous activities on the part of multiple stakeholders. The Advisory Council on Alzheimer's Research, Care, and Services monitors implementation of the National Plan and recommends changes for annual updates of its activities (USDHHS, 2012).

Origin of the Healthy Brain Initiative

Supported by a congressional appropriation beginning in fiscal year 2005, the Centers for Disease Control and Prevention (CDC) established the Alzheimer's-specific segment of CDC's Healthy Aging Program, referred to as The Healthy Brain Initiative. CDC partnered with the Alzheimer's Association and together they engaged other groups, including the National Institute on Aging at the National Institutes of Health (NIH), Administration on Aging (now within the Administration for Community Living), AARP, and other public and private sector organizations to launch the activities of The Healthy Brain Initiative. Together, these organizations embarked on a deliberative 18-month process to create a road map to guide a coordinated public health response across agencies and organizations. *The Healthy Brain Initiative: A National Public Health Road Map to Maintaining Cognitive Health* (CDC & Alzheimer's Association, 2007) offered a "synergistic" model for moving science into practice based on several principles: a firm grounding in science, an emphasis on primary prevention, a community and population approach, and a commitment to eliminating disparities (CDC & Alzheimer's Association, 2007).

The overall intent of the Healthy Brain Initiative is to better understand the public health burden of cognitive impairment through surveillance; build a strong evidence base for policy, communication, and programmatic interventions for improving cognitive health; and translate that foundation into effective public health practice in states and communities.

Healthy Brain Initiative



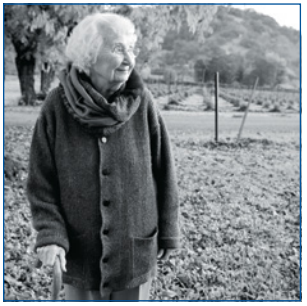
The Road Map (2007) served as a catalyst for numerous accomplishments on the part of multiple stakeholders (CDC, 2011c). Successes included the national recognition of cognitive health as a public health issue by its inclusion, for the first time, as a new topic area of, "Dementias, including Alzheimer's disease" in Healthy People 2020. This 10-year set of national objectives for improving the health of all Americans cites the goal of the new topic area to "reduce the morbidity and costs associated with, and maintain or enhance the quality of life for, persons with dementia, including Alzheimer's disease" (USDHHS, 2013a). This topic area currently consists of two developmental[1] objectives—

- To increase the proportion of persons with diagnosed Alzheimer's disease and other dementias, or their caregiver, who are aware of the diagnosis.
- To reduce the proportion of preventable hospitalizations in persons with diagnosed Alzheimer's disease and other dementias (USDHHS, 2013a).

[1]Developmental objectives currently do not have national baseline data and, therefore, have abbreviated or no operational definitions.

Additionally, three of the objectives in the new topic area, Older Adults, also address issues of importance to this population:

- To reduce the proportion of older adults who have moderate to severe functional limitations.
- To increase the proportion of older adults with reduced physical or cognitive function who engage in light, moderate, or vigorous leisure-time physical activities.
- To reduce the proportion of unpaid caregivers of older adults who report an unmet need for caregiver support services (developmental) (USDHSS, 2013b).



Using this Road Map: State and Local Focus

Given the need to update the Road Map and the release of the National Plan in 2012, the Alzheimer's Association and CDC agreed to revisit the Road Map with a specific focus on the role and contribution of state and local public health agencies. While federal agencies play a critical role in leading and funding efforts to address Alzheimer's disease, state and local agencies organize and provide public health services on the ground level. For example, state agencies are critical to the development and implementation of strategic plans and services tailored to the needs of their states and local communities. Although there is considerable variation in structure and organization, each state has a department of health. State and local public health agencies with their vast network of partners play a critical role in protecting and improving the health of communities through education, organized interventions, tracking and monitoring health of populations, and research on chronic conditions and injury prevention.

The initial challenge in creating a Road Map that would speak to state and local public health professionals and their partners was how best to engage the broad public health community to apply its traditional core functions—assessment, policy development, and assurance—to facilitate the inclusion of cognitive health within priority domains of public health. The Alzheimer's Association and CDC also wished to explore how public health could complement and facilitate the work of its key partners, enhancing the synergy of investments for even greater national impact.

Guided by a Leadership Committee, an extensive concept mapping process was used to engage a wide array of stakeholders at national, state, and community levels—including content experts, practitioners, and decision makers across the nation. Input was solicited on how state and local public health and their partners could promote cognitive functioning, address cognitive impairment for individuals living in the community, and help meet the needs of care partners. Results were used to identify the set

Healthy Brain Initiative

of strategic actions that comprise *The Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, 2013–2018*.

Public health takes a broad view of, and seeks to achieve lasting change in, the health of entire populations, extending beyond the medical treatment of individual people. Thus, the Road Map's strategies are expansive in scope and recognize that it takes effective partnerships at many levels to achieve meaningful outcomes. Its developers recognize the vital contributions of private, non-profit, and governmental partners at the national, state, and local levels to address and promote cognitive functioning and the needs of care partners, and to embrace areas where synergistic opportunities exist.

Section II of the Road Map identifies specific action items that state and local public health could do—on their own or with other national, state, and local partners—and is designed to enable agencies to choose actions that best fit their needs, capabilities, and resources. The actions are grouped into four domains of activity: Monitor and Evaluate; Educate and Empower the Nation; Develop Policy and Mobilize Partnerships; and Assure a Competent Workforce.

The Healthy Brain Initiative envisions a nation in which the public embraces cognitive health as a vital component of health and is committed to its inclusion in public health efforts. To achieve that vision, the long-term goal is to maintain or improve the cognitive performance of all adults.

Action Items

Public health seeks to achieve lasting change in the health of entire populations. Thus, the Healthy Brain Initiative envisions a nation in which the public embraces cognitive health as a vital component of health and is committed to its inclusion in public health efforts. *The Public Health Road Map for State and National Partnerships, 2013–2018* lays out a spectrum of broad actions designed to promote cognitive functioning and address the needs of care partners for pursuit over the next 5 years. The actions are intended as a guide for what state and local public health could do—on their own or with other national, state, and local partners. Agencies are encouraged to select those actions that best fit state and local needs and customize them to match priorities, capabilities, and resources.

The actions are grouped into four domains:

- Monitor and Evaluate
- Educate and Empower the Nation
- Develop Policy and Mobilize Partnerships
- Assure a Competent Workforce.

Action Items

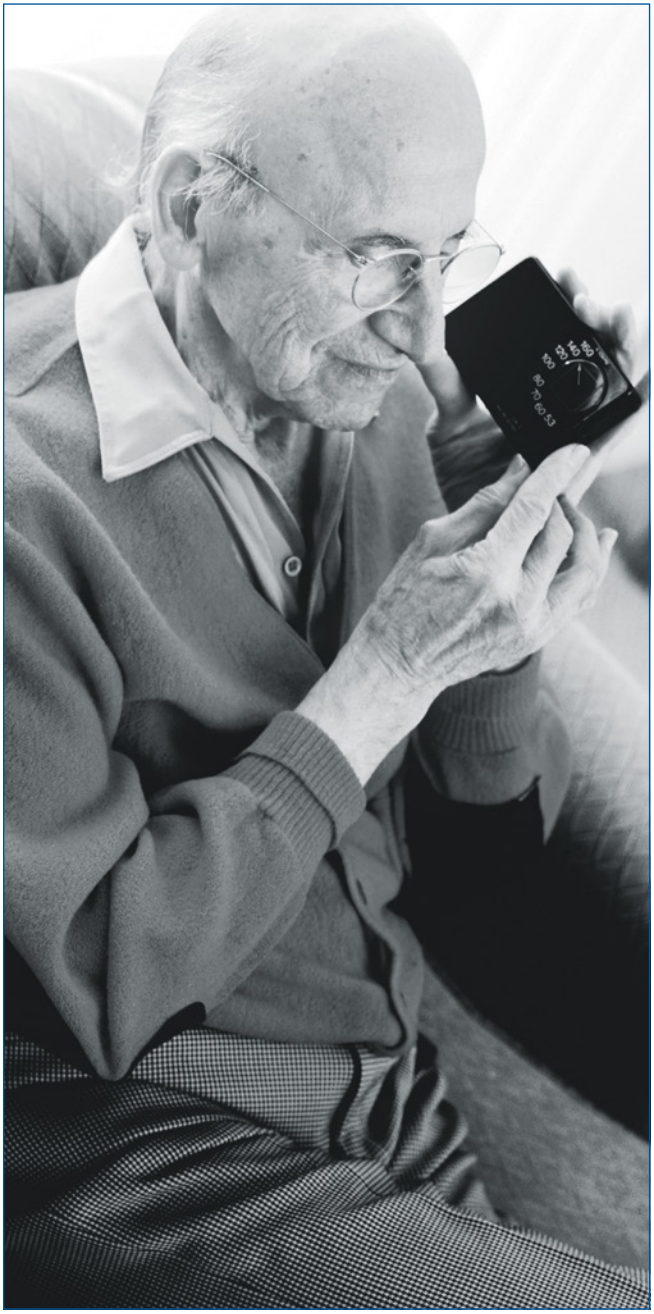
The domains are consistent with the core public health functions of assessment, assurance, and policy development (IOM, 1988) and aligned with the Essential Services of Public Health (USDHHS, 1997). They are interdependent and essential to help ensure desired results. The process for identifying the domains and action items is detailed in Section III.

Within each domain are specific action items. All items are deemed important and are not listed in any order of priority. Within each domain, however, one or more actions are bolded because they were judged by the Leadership Committee to be issues of particular importance and areas in which movement could be achieved in the near term by groups new to this topic. Some best practices and supplementary Web sites are also provided.

The long-term goal of the Healthy Brain Initiative, to maintain or improve the cognitive performance of all adults, can only be achieved through collaborative and effective partnerships at national, state, and local levels. The coordination of contributions by private, non-profit, and governmental partners may provide leverage for synergistic opportunities, and more comprehensively address and promote cognitive functioning and the needs of care partners. Thus, the Road Map does not focus on any individual agency or entity but instead encourages groups to work collaboratively to use and incorporate the action items into their own strategic planning efforts.

"We applaud the creation of a Road Map that promotes partnerships with states and communities across the U.S. This helps to ensure critical linkages at the national, state, and community levels which are vital to the success of our National Plan to Address Alzheimer's Disease."

Helen Lamont, PhD
U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation



Monitor and Evaluate

Surveillance, defined as the "ongoing, systematic collection, analysis, and interpretation of health-related data," is a fundamental tool of public health. Its methodologies have been applied for decades to numerous causes of disease, injury, disability, and death. Incorporating measures concerning cognition and caregiving into existing surveillance can help understand the public health burden, inform public health policy and strategies, and monitor progress toward promoting quality of life.

M-01 **Implement the Behavioral Risk Factor Surveillance System's cognitive impairment and caregiver modules.**

M-02 **Use surveillance data to enhance awareness and action in public health programming (e.g., link Behavioral Risk Factor Surveillance System questions on cognition to health-related quality of life or falls prevention).**

M-03 **Determine key questions concerning cognition for inclusion in the National Health Interview Survey and other relevant national datasets by conducting a national-level review and promoting their use.**

M-04 **Engage national organizations and agencies to develop standardized questions that can be used at the national, state, and local levels to track awareness and perceptions about cognitive health and impairment, including decline in cognitive functioning.**

Increased Ability to Track the Public Health Burden of Cognitive Decline

A priority action from *The Healthy Brain Initiative: A National Public Health Road Map to Maintaining Cognitive Health* (2007) called for tracking the public health burden of cognitive decline through existing surveillance systems. Today, thanks to partnerships at the state and national levels, a cognitive impairment optional module is now part of the **Behavioral Risk Factor Surveillance System**. The module provides states and territories with the ability to collect state-specific data on self-reported cognitive decline. To date, 45 states plus the District of Columbia and Puerto Rico have included the questions in their **BRFSS surveys during 2011–2013**.

The Alzheimer's Association and CDC convened a diverse panel of experts to help inform the content and design of the module, which includes 10 questions that seek information about self-reported cognitive decline and burden. Through partnerships with the state health departments' BRFSS Programs, the Alzheimer's Association's local chapters, and the aging services network, the module was disseminated and supported by numerous states.

Current efforts focus on disseminating the data through various channels, such as state data briefs, manuscripts, interactive Web sites, briefings, and presentations. With this information, state planners and decision-makers can examine the burden of cognitive decline in their states and gain insights about current and future needs.

Action Items

> "Monitoring and evaluation are key practices of public health. The tools we traditionally have applied to physical health are equally valuable to understand the impact of cognitive impairment."
>
> Jill Myers Geadelmann, BS, RN
> *Bureau Chief, Chronic Disease Prevention and Management, Iowa Department of Public Health*

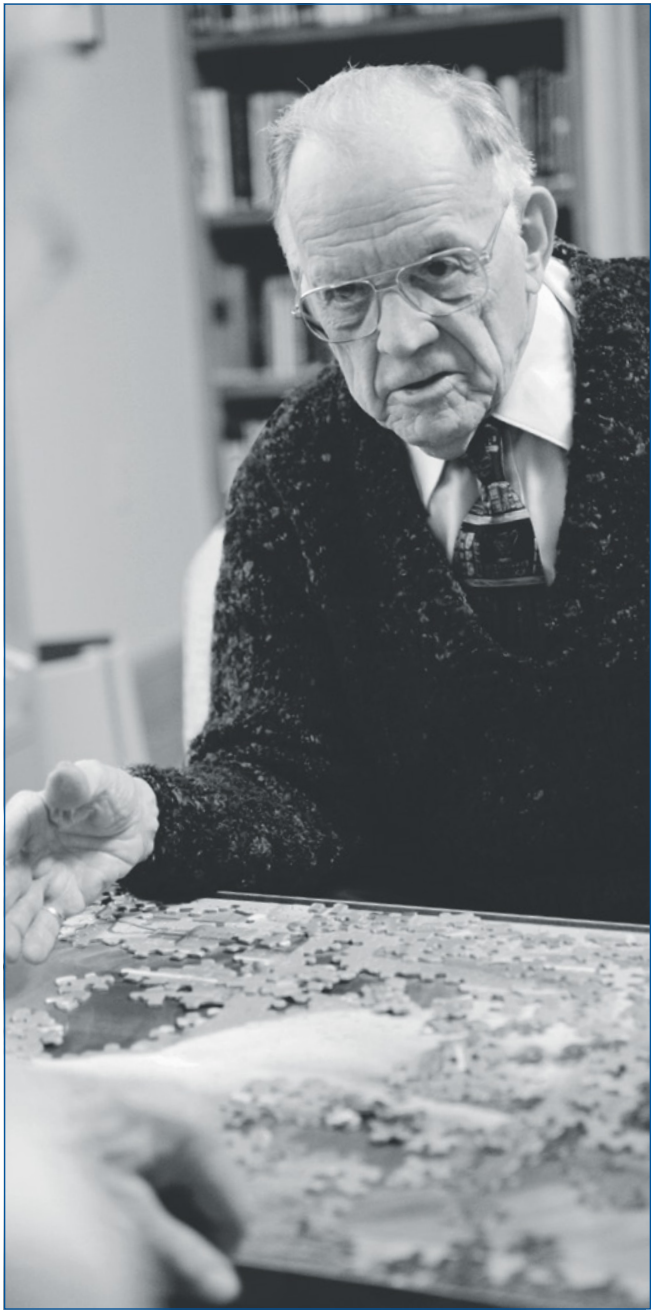
At the same time that surveillance is conducted and suitable measures of cognitive health for public health surveillance are developed or refined, the effects of cognitive impairment on economic and social systems need to be monitored. Assessments can help clarify the cost burden to states and communities as well as the important health inequities affecting the lives of people with cognitive impairment and their care partners.

M-05 **Assess information about the economic impact of dementia, including Alzheimer's disease, on states and communities and disseminate the findings.**

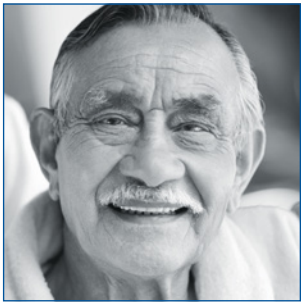
M-06 **Support state and local needs assessments to identify racial/ethnic; lesbian, gay, bisexual, and transgender; socioeconomic; and geographic disparities related to cognitive health and impairment and help ensure materials are culturally appropriate.**

Understanding Public Views About Cognitive Health and Dementia

Perceptions about health, including perceptions about cognitive health and impairment, affect the way individuals understand and respond to health messages. The **CDC Healthy Aging Research Network** has been reaching out to older adults and healthcare providers, using focus group methods to better understand perceptions about cognitive health and impairment in diverse groups. They have conducted 55 focus groups with over 450 participants from 9 states and found **several lessons**. First, messages about cognitive health need to be aligned with perceptions about healthy aging or "aging well." Second, messages must be sensitive to diverse cultural views to make them more salient. A special issue of **The Gerontologist**, Promoting Cognitive Health in Diverse Populations of Older Adults, published in 2009, shared the results of this formative research.



Action Items



Research has focused on the needs of individuals with cognitive impairment and their care partners as well as the effectiveness of various interventions on their health and quality of life. That wealth of information continues to be a critical resource for the developing evidence base for intervention. Updated systematic reviews that analyze available research and practice information and disseminate conclusions are invaluable for public health use in designing effective programs and policies.

M-07 **Conduct a review of the literature on co-occurring chronic conditions and dementia, including Alzheimer's disease, to understand the effect of dementia on various outcomes such as depression, disease management, morbidity, and mortality.**

M-08 **Define the needs of caregivers and persons with dementia, including Alzheimer's disease and younger onset, as they relate to employment and employers.**

M-09 **Conduct a national-level literature review to identify public health interventions that are effective in decreasing preventable hospitalizations among persons with dementia, including Alzheimer's disease, and disseminate findings.**

M-10 **Conduct a national-level review of caregiver programs and policies consistent with *The Guide to Community Preventive Services* methodologies.**

M-11 **Examine the Chronic Disease Self-Management Program and other evidence-based programs to determine their ability to include persons with dementia and their care partners.**

M-12 **Update and disseminate national-level reviews on the public health impact of physical activity programs and other behavioral risk factors associated with cognitive health and impairment.**

M-13 **Conduct a national-level literature review on the potential and optimal use of technology for delivering best practices in programs for caregivers and persons with dementia, including Alzheimer's disease.**

Examining Co-Occurring Chronic Conditions

Investigators at the University of Washington received funding from CDC's Healthy Aging Program for a 3-year project (2011–2013): ***Examining the Impact of Cognitive Impairment on Co-occurring Chronic Conditions and Geriatric Syndromes***. This project is being conducted in partnership with members of the CDC's Healthy Aging Research Network, a thematic network of the Prevention Research Centers that is funded by the Healthy Aging Program. The study was designed to examine the effects of multiple chronic conditions (dementia plus other chronic illnesses or geriatric syndromes) on various health outcomes such as functioning, depression, and mortality. The resulting findings from the literature review may assist public health practitioners and researchers in developing messages about the effect of cognitive impairment on public health strategies and policies as well as identifying gaps in research. Understanding the effect of depression and dementia can also help inform the design and delivery of evidence-based care-management programs for depression. A complementary effort will be an inventory of databases that include dementia and other chronic conditions, with the hope that this inventory will promote efforts to fill research gaps identified through the literature review.

This project is an example of efforts to implement the **Department of Health and Human Services' Strategic Framework on Multiple Chronic Conditions**, an innovative private-public sector collaboration to coordinate responses to a growing public health challenge. The strategic framework is designed to reduce the risks of complications and improve the overall health status of individuals with multiple chronic conditions by fostering change within the system; provide more information and better tools to help healthcare professionals as well as consumers learn how to better coordinate and manage care; and facilitate research to improve oversight and care.

Action Items

Educate and Empower the Nation

Public health plays an important role in informing the nation about the causes of disease, injury, and disability; ways to prevent and treat them; and strategies to preserve overall quality of life. This role is critical for both physical and cognitive health issues, particularly in light of the heightened fear surrounding dementia and the uncertainties about prevention. It is important to raise public awareness and improve access to available information and resources.

E-01 **Identify and promote culturally appropriate strategies designed to increase public awareness about dementia, including Alzheimer's disease, to reduce conflicting messages, decrease stigma, and promote early diagnosis.**

E-02 **Create awareness by contributing public health information and data about cognitive health and impairment to national reports and partners.**

E-03 **Encourage public health entities to provide links on their Web sites to local, state, and national dementia resources, including those specific to Alzheimer's disease and caregiving, such as www.alzheimers.gov.**

Using the Behavioral Risk Factor Surveillance System (BRFSS) to Understand Caregiving Prevalence and Association with Health Factors

With the support from CDC and state BRFSS Coordinators, a BRFSS **Caregiver module** is available. Each state can ask a common set of questions about caregiving and align those questions with "core" questions to examine a variety of issues such as health status and emotional and social support. Five states included the Caregiver Module on the 2010 BRFSS. They learned, for example, that caregivers of persons with Alzheimer's disease or dementia provided care over a longer period of time and were more likely to report that caregiving created or aggravated their own health problem compared to other caregivers (Bouldin & Andresen, 2010). This reinforces the need for strategies aimed at caregivers of persons living with Alzheimer's disease. Using this module along with the Cognitive Impairment module could provide valuable insights to states.

Expanding Information About the Public's Beliefs and Concerns About Cognitive Health and Impairment

Developing measures to assess and track changes in attitudes of consumers and healthcare providers can help inform communication messages related to cognitive health and appropriate dissemination methods for future health promotion campaigns. Working with a set of partners, CDC and the Healthy Aging Research Network are examining consumers' and healthcare providers' attitudes and beliefs about cognitive health and dementia using available data sources. Two surveys, HealthStyles and DocStyles, which are proprietary databases of Porter Novelli and licensed by the CDC for **analysis in health communication planning**, have been modified to include a set of questions about beliefs and practices related to cognitive health as well as dementia and caregiving. This **information** will be important for understanding perceptions today as well as over time.

References

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Action Items

Helping the public take recommended actions to promote cognitive health requires clear and consistent messages about what is known—and what is yet to be discovered. Robust and reliable coordination of prevention and risk reduction messages will minimize confusion and ensure that public, private, and non-profit organizations serve their respective constituencies effectively and reliably.

E-04 **Coordinate national and state efforts to disseminate evidence-based messages about risk reduction for preserving cognitive health.**

E-05 **Promote consistency of cognitive health messages among national, state, and local levels using models such the National Diabetes Education Program.**

E-06 **Identify and promote strategies for the public about how to communicate effectively and sensitively with persons with dementia, including Alzheimer's disease, and their families.**

"We can no longer overlook the fear and concern shared by aging Americans and their adult children. Additional work is needed to ensure that the nation is informed about cognition and its impact on families and communities, and updated over time as scientific discoveries emerge."

Marilyn Albert, PhD
Johns Hopkins Alzheimer's Disease Research Center

The strengths and capacities of public health can be particularly valuable in advancing communication in four specific areas: advance care planning, clinical trials and studies, younger-onset dementia, and abuse and exploitation. Public health can raise awareness and sensitivity about these issues, and work with aging services networks, healthcare provider networks, and other partners at state and local levels.

E-07 **Promote advance care planning and advance financial planning to care partners, families, and individuals with dementia in the early stages before function declines.**

E-08 **Promote appropriate partnerships and strategies to educate and increase local participation in clinical trials and studies on cognitive health and impairment.**

E-09 **Develop strategies to promote the availability of services for people with younger-onset dementia, including Alzheimer's disease.**

E-10 **Promote awareness of abuse and exploitation and support related prevention efforts as they relate to persons with dementia, including Alzheimer's disease.**

"Creating a new road map for cognitive health provides a new window of opportunity to promote health equity."

J. Neil Henderson, PhD
University of Oklahoma

Special Challenges of Younger Onset Alzheimer's Disease

Although risk for developing Alzheimer's disease increases with age, it has been estimated that between 220,000 and 640,000 people under age 65 in the U.S. have Alzheimer's or other dementias, defined as **younger onset**. These individuals and their care partners face several unique challenges. Diagnosis of younger onset often is delayed by several months or years because symptoms are attributed to other external factors or inaccurate diagnoses. Individuals with younger onset are often raising their families—and some also are caring for elderly parents. Workplaces can become stressful environments because colleagues or employers may not understand changes in behavior or work performance. Individuals who leave the workplace before receiving a diagnosis could be denied assistance that would otherwise be provided to individuals with disabilities, and also may lose health insurance coverage provided through their employers. Additionally, individuals with younger onset face the loss of income in the prime earning years and may not be eligible for certain support or financial services because they do not meet the age eligibility requirements or they may not be aware that they could qualify for disability benefits.

Alzheimer's disease occurs three to five times more often among people with **Down syndrome** than the general population, and often occurs at a younger age than for other adults.

A special task force has been created by the U.S. Department of Health and Human Services to improve care for special populations, including individuals with Down syndrome and those with younger onset.

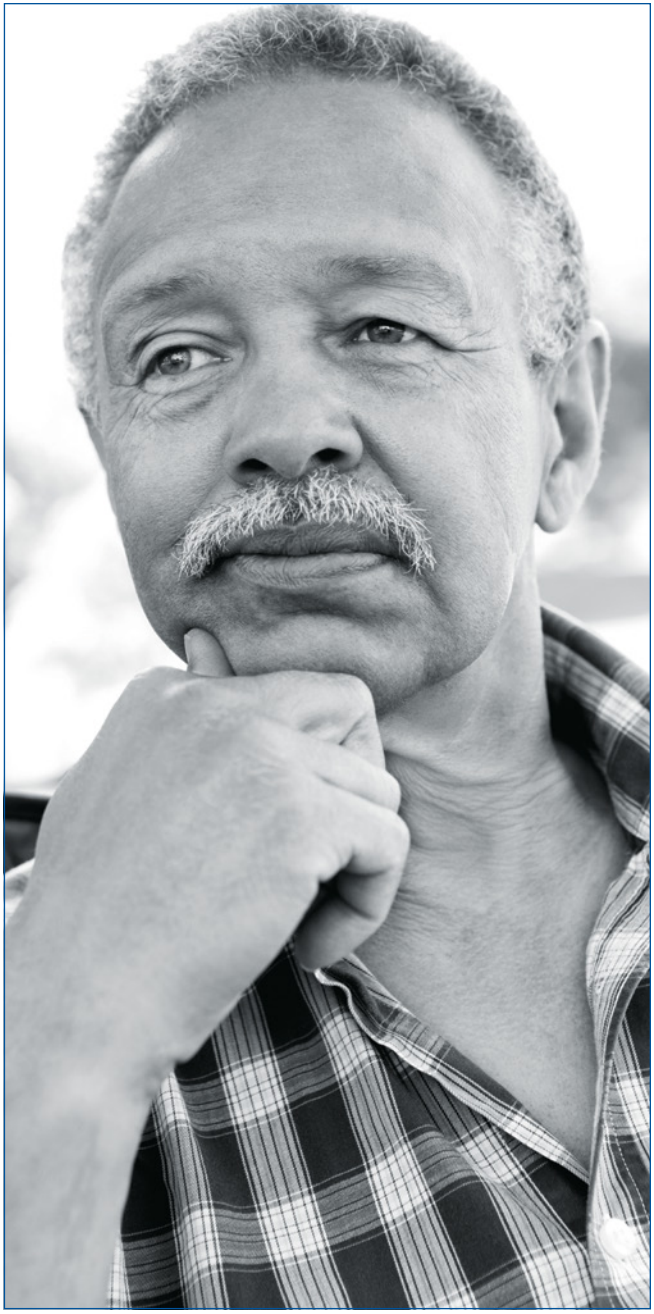
Additionally, people with younger-onset dementia are speaking out about their unique needs and forming support networks. In 2006, for example, the **Alzheimer's Association National Early-Stage Advisory Group** was formed. It includes individuals from across the U.S., including those with younger-onset Alzheimer's, who provide their unique insights on the needs of people living with Alzheimer's and their caregivers. In 2012, the Early-Stage Advisors developed tips about how to combat stigma based on their personal experiences, which was published during **World Alzheimer's Month**. States can help by offering programs and services for people with Alzheimer's disease, regardless of their age.

Importance of Clinical Trials and Recruitment of Diverse Volunteers

Thanks to advances in understanding dementia, including Alzheimer's disease, scientists are making progress toward identifying ways to help diagnose, slow, treat, and ultimately prevent the disease. As basic research advances, continued progress will depend, in large part,

on volunteers willing to participate in **clinical trials and studies**.

To find out whether a drug, intervention, or diagnostic tool is safe and effective, it needs rigorous testing. In the U.S., at any given time there are more than **150 clinical trials** related to Alzheimer's disease and cognitive decline needing at least 50,000 participating volunteers. To reach that goal, researchers will need to screen at least **half a million potential participants** in communities across the U.S. Since interventions may work differently for some groups than others, it is important to recruit diverse volunteers—encompassing a range of ages and backgrounds—to fully test the safety and effectiveness of interventions. For that reason, clinical trials and studies seek to recruit individuals of diverse backgrounds and cognitive function. This requires creative recruitment strategies that fully inform eligible participants about the **risks and benefits of the study**, secure participation, ensure that participant questions are answered along the way, and, in the end, report overall study results to volunteers.



Develop Policy and Mobilize Partnerships

The Healthy Brain Initiative is committed to integrating cognitive health into the broad spectrum of public health work and focuses on increasing quality of life for those with cognitive decline. To the extent possible, cognitive health needs to be included as a major consideration in strategic planning for other public health efforts, chronic diseases and issues related to aging and caregiving. In addition, dedicated state plans for Alzheimer's disease and other dementias can be considered as part of that larger picture.

P-01 **Collaborate in the development, implementation, and maintenance of state Alzheimer's disease plans.**

P-02 **Integrate cognitive health and impairment into state and local government plans (e.g., aging, coordinated chronic disease, preparedness, falls, and transportation plans).**

P-03 **Promote incorporation of cognitive health and impairment into state and local public health burden reports.**

"As we worked on the Road Map, Superstorm Sandy occurred—reminding us that public health must continue to identify and prepare to meet the needs of all vulnerable populations before the next crisis, including people with cognitive impairment and their caregivers."

David Hoffman, MEd, CCE
Board Member, National Association of Chronic Disease Directors

State Alzheimer's Disease Plans

Alzheimer's disease plans aim to create the infrastructure and accountability to create programs and policies regarding the needs of people with the disease and supporting structures in communities. This is referred to as being **"dementia-capable"**—being skilled in identifying people with dementia and working effectively with them and their caregivers, knowledgeable about the kinds of services needed, and aware of agencies and individuals that provide such services. A comprehensive plan helps to unite state public health partners around a range of issues including: creating dementia-capable support services for people at all stages of the disease; reporting state estimates of Alzheimer's disease prevalence; assuring quality of long-term care; providing home and community services; helping identify and track the availability of diagnostic services; protecting the safety of persons who wander; and supporting caregivers and healthcare professionals. As of April 2013, 28 states have published **Alzheimer's disease plans**.

Nearly all of the published plans include public health recommendations and strategies for monitoring the burden of cognitive decline, public awareness, early detection, and communication about brain health. A majority of state plans include early detection and diagnosis as a main focal point, and several states have taken significant steps toward accomplishing established goals in such areas as creating public awareness campaigns and promoting access to early detection and diagnosis.

Considering Dementia in Preparedness Planning

Because dementia affects cognitive ability and judgment, those with cognitive impairment may be particularly vulnerable during all-hazard emergencies, yet their special needs may not be recognized during emergency planning and preparedness activities. Of the confirmed fatalities in Hurricane Katrina, it is unknown how many people had dementia, but approximately 64% were older than age 60. During **Hurricane Sandy** several older adults drowned alone in their homes. To help prevent future devastating situations like these, it is important to **include experts** in cognitive impairment, individuals with cognitive impairment and their care partners in local and state **preparedness planning efforts**, and to train responders and shelter staff about signs and symptoms of dementia, or conditions that can mimic cognitive impairment. Just as with the general population, it is important for individuals with dementia and their care partners to have a personal **preparedness plan** so that they can deal with disasters of all sorts much more effectively when they occur.

Action Items

Efforts at the national level to integrate cognitive health into ongoing planning and policy initiatives offer opportunities to engage additional national and state partners. Adopted national health objectives can be leveraged by states, and synergies can be gained by examining potential policies in a concerted fashion.

P-04 **Integrate Healthy People 2020 objectives on "Older Adults" and "Dementias, including Alzheimer's disease" topic areas into state-based plans.**

P-05 **Engage national and state organizations and agencies to examine policies that may differentially impact persons with dementia, including Alzheimer's disease.**

> "We must capitalize on state efforts to coordinate public health chronic disease programs and include cognitive health in that larger picture."
>
> Sharon Moffatt, RN, BSN, MSN
> *Association of State and Territorial Health Officials*

Integrating Early Detection and Diagnosis into Medical Homes

ACT on Alzheimer's is a voluntary, statewide collaboration focused on transforming Minnesota's medical and long-term care systems and communities to better support individuals with Alzheimer's disease and other dementias and their families. Its members—representing over 50 medical, academic, community, government, business, and non-profit organizations throughout the state—are guided by a common vision, five goals, and specific **success measures** by which to gauge progress. The first of those goals is "increase early identification of Alzheimer's disease and improve ongoing treatment based on recommended care practices." Corresponding success measures call for incorporating dementia specific practices into applicable providers' curricula; and offering a practice algorithm that supports screening, early diagnosis and intervention, and quality care. The effort embraces the innovative, cost-saving **medical care home model** for delivering preventive and primary care, which focuses on patient needs, improved access to care, and increased care coordination. If successful, by June 2018, 75% of medical care home providers who received the practice algorithm will have implemented that algorithm into their practices.

Assure a Competent Workforce

As cognitive health continues to gain recognition as an important public health issue, state and local public health professionals will be called upon to translate current and emerging research into practice. Competency-based educational strategies and materials are needed to give the public health workforce the knowledge and skills for carrying out this vital role.

W-01 **Develop strategies to help ensure that state public health departments have expertise in cognitive health and impairment related to research and best practices.**

W-02 **Develop introductory, basic materials for public health professionals on cognitive health and impairment to help them understand their role.**

"People with Alzheimer's disease and other dementias can be found throughout the healthcare system, even if they are not recognized as such. Community-clinical partnerships are essential to address this burgeoning crisis."

Elizabeth Edgerly, PhD
Alzheimer's Association
of Northern California/Northern Nevada

The Impact of Care Consultations

The **North Dakota Dementia Care Services Project** (DCSP) began in January 2010, with funding from the North Dakota Department of Human Services, Aging Services Division, to the Alzheimer's Association of Minnesota/North Dakota. Newly hired care consultants meet with people with dementia and their caregiversto increase knowledge and decrease caregiver stress by assessing needs; identifying issues, concerns, and resources; developing care plans and referrals; and providing education and follow-up. Employed by the Alzheimer's Association, care consultants have a background in counseling, social work, or long-term care administration; all have a bachelor's degree and many a relevant master's degree. They are supervised by a clinical services director with a master's in social work and extensive experience in care consultation.

The impact of these consultations was immediate and significant. An evaluation by the Center for Rural Health at The University of North Dakota School of Medicine and Health Sciences documented—

- After just 3 months: A savings of $60,064 due to decreased hospital stays, 911 calls, and ambulance services.
- After 6 months: A healthcare savings of $323,098 and a doubling of the percent of caregivers who completed important dementia care-related tasks: establishing power of attorney, instituting healthcare directives and acquiring long-term care insurance for their person with dementia.
- After 9 months: an **estimated healthcare savings** of $1,838,519 due to delays in placing persons with dementia in long-term care facilities.

Action Items

Educational initiatives that maximize partnerships between academic institutions and practice and care partner organizations, and align with major competency-based efforts, can increase awareness, knowledge, and abilities of healthcare providers who interact with and support people with cognitive impairment and their care partners. By defining various providers' roles, offering formative and continuing education, preparing professionals, and providing practical tools and resources, strong partnerships can be forged in states and communities to enhance community-clinical capacity for effective detection, early diagnosis, referral, and care.

W-03 **Support continuing education efforts that improve healthcare providers' ability to recognize early signs of dementia, including Alzheimer's disease, and to offer counseling to individuals and their care partners.**

W-04 **Identify appropriate roles and determine effectiveness of community health workers, promotoras, patient navigators, and paraprofessionals with respect to care related to dementia, including Alzheimer's disease.**

W-05 **Develop strategies to help ensure that healthcare professionals recognize the role of care partners in the care coordination of persons with dementia, including Alzheimer's disease.**

W-06 **Educate healthcare providers about validated cognitive assessment tools that could be administered in such settings as physicians' offices, clinics, emergency rooms, and acute care hospitals' admission offices.**

W-07 **Increase awareness among healthcare professionals about care partner health.**

Promoting Detection and Diagnosis

As many as half of those who meet the diagnostic criteria for dementia have not received that diagnosis from a physician (Boustani, Peterson, Hanson, Harris & Lohr, 2003; Bradford, Kunik, Schulz, Williams & Singh, 2009). **Early detection and diagnosis** are essential to providing the best medical care and outcomes for those at any stage of the disease. Even without a way to cure or slow the progression of dementia, including Alzheimer's disease, an early formal diagnosis offers the best opportunities for intervention and better outcomes. With a diagnosis in hand, individuals and their caregivers can access available treatments, build a care team, and better manage co-existing chronic conditions. Additionally, early **diagnosis** allows for some forms of cognitive impairment, such as those caused by drug interaction and dosage or a vitamin B12 deficiency, to be reversed. A meta-analysis of 39 published articles showed that 9% of individuals experiencing dementia-like symptoms had potentially reversible forms of cognitive impairment upon proper workup (Clarfield, 2003).

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Bradford A, Kunik ME, Schulz P, Williams SP, Singh H. *Missed and delayed diagnosis of dementia in primary care: prevalence and contributing factors.* Alzheimer Disease & Associated Disorders 2009;23(4):306–14.

Clarfield AM. *The decreasing prevalence of reversible dementias: an updated meta-analysis.* Archives of Internal Medicine 2003; 163(18):2219-29.

Non-Pharmacological and Care Practice Interventions

A **recent white paper** (Administration on Aging & Alliance for Aging Research, 2012) identifies 44 effective interventions to support people with Alzheimer's disease and their caregivers at home and in the community. Based on the proceedings of a meeting in 2012 and a review of the literature, these interventions had been studied using randomized controlled trials and had documented positive effects on a broad set of outcomes. The report details such key features as: who received the intervention, what type and stage of condition, where the intervention was delivered, and through what delivery mechanism. Additionally, the report describes the current state of **translational studies**, research gaps, support to move more **effective interventions** into practice, and need for strategies and tools to promote the alignment of specific interventions with persons and families in need. Despite the increasing numbers of effective interventions, they are not well known to the practice community and warrant further attention.

References

Administration on Aging and Alliance for Aging Research. *White paper: translating innovation to impact: evidence-based interventions to support people with Alzheimer's disease and their caregivers at home and in their communities.* September, 2012. www.agingresearch.org/section/translating_innovation_to_impact.a

Conceptual Framework

Public Health Core Functions

Public health efforts have yielded remarkable achievements during the last century and continue to make significant progress (CDC, 1999). In 2010, CDC published the 10 top public health achievements of the first decade of the 21st century (CDC, 2011b): reducing heart disease and death, better cancer prevention, doing a better job of fighting use of tobacco, improvements in preparedness, declines in vaccine-preventable diseases, better maternal and infant health, improved occupational safety, fewer childhood lead poisonings, greater control over infectious diseases like tuberculosis, and improving motor vehicle safety. The report further underscores the importance of fundamental public health tools such as the establishment of surveillance systems, implementation of research findings, and development of effective public health programs. These tools enable public health to carry out the three core functions of public health recommended by the Institute of Medicine in The Future of Public Health (1988): assessment, policy development, and assurance.

Conceptual Framework

Assessment refers to the systematic collection and analysis of data including information on health status, health needs, and other public health and health issues (IOM, 1988). The assessment function also includes diagnosing and investigating health hazards in the community.

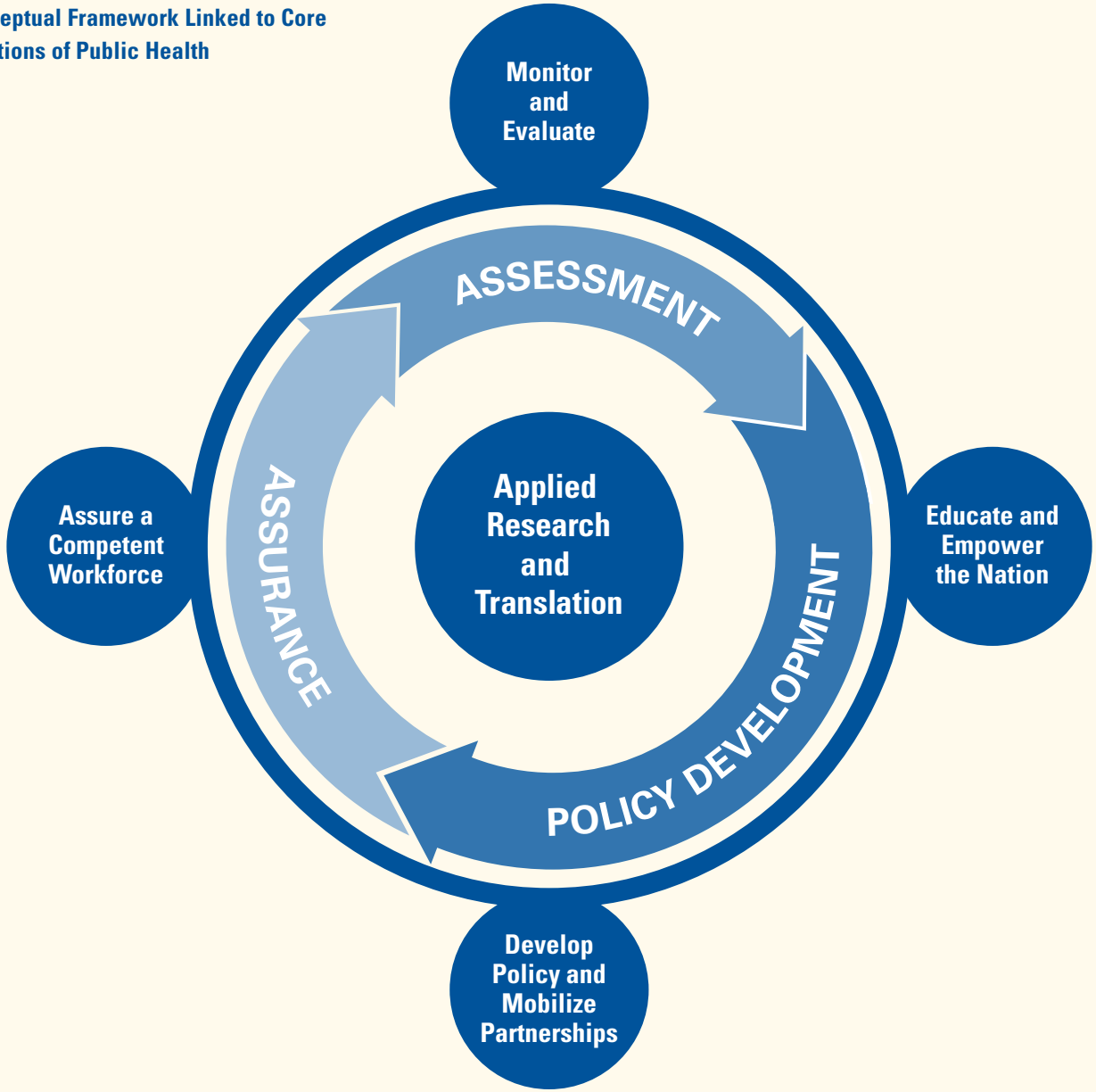
Policy development includes informing, educating, and empowering the public on health issues of concern; promoting awareness of public health services; and promoting health education initiatives that contribute to individual or collective changes in health knowledge, attitudes, and practices that make for a healthier community. It also includes promoting partnerships and actions designed to identify and solve health issues, as well as creating policies and planning activities to support various health efforts.

Assurance activities provide a guarantee that the services needed to achieve agreed-upon goals are provided. This third core public health function includes a wide range of activities involving managing resources and developing organizational structures; implementing programs for priority health needs; and evaluating and providing quality assurance to ensure that programs are consistent with plans and policies—or that needed corrective actions are taken promptly.

Assuring the delivery of public health services requires a public health infrastructure at federal, tribal, state, and local levels that possesses: a qualified and capable workforce; functional, up-to-date data and information systems; and the capacity to assess and respond to public health needs (USDHHS, 1997). Increasing attention to public health infrastructure has underscored the importance of systems research in identifying and promoting the evidence base for community interventions, with a critical focus on applied research and translation. The results of systems research help determine the need for the effective organization, administration, and financing of public health services (USDHHS, 1997).

The application of these public health core functions to cognitive health offers hope of similar achievements as scientific knowledge advances. The Healthy Brain Initiative Road Map conceptual framework integrates the public health core functions plus systems research with the four domains identified through concept mapping.

Conceptual Framework Linked to Core Functions of Public Health



Conceptual Framework

Guiding Principles

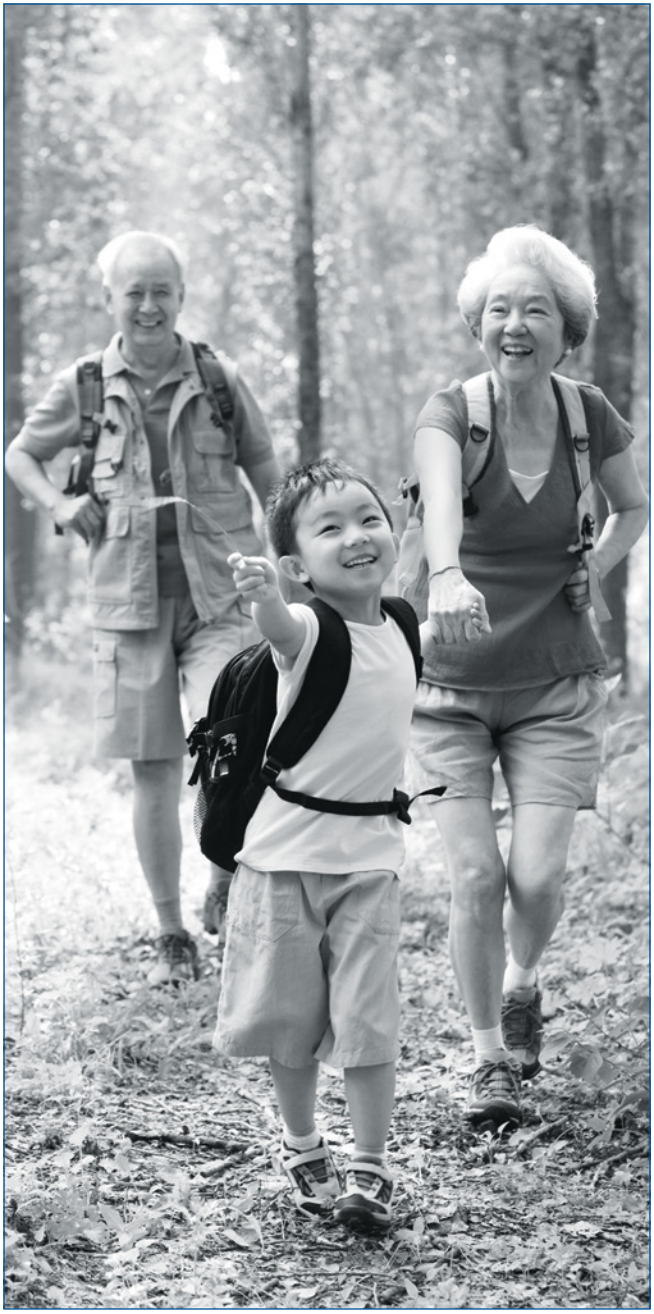
The Healthy Brain Initiative is grounded in a firm commitment to collaborative public-private partnerships as a prerequisite for achieving meaningful outcomes. As such, the Leadership Committee of the Road Map wishes to build upon the National Plan to Address Alzheimer's Disease and other relevant plans and strategic frameworks. The Committee recognizes the vital contributions of private, non-profit, and governmental partners at the national, state, and local levels to address and promote cognitive functioning and the needs of care partners, and embraces areas where synergistic opportunities exist. Several key principles underlie the collaborative approach to addressing and promoting cognitive functioning and attending to the needs of care partners:

Address cognitive functioning along a continuum. Cognitive health can be viewed along a continuum—from the promotion of optimal functioning to early diagnosis of mild cognitive impairment to support services for severe dementia or Alzheimer's disease. Tasks involved with cognitive function include: language, thought, memory, executive function (the ability to plan and carry out tasks), judgment, attention, perception, remembered skills such as driving, and the ability to live a purposeful life.

Commit to promoting health equity. Health equity is defined as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities" (USDHHS, 2010). As documented in the *2011 Department of Health and Human Services' Action Plan to Reduce Racial and Ethnic Health Disparities, A Nation Free of Disparities in Health and Health Care,* the leading health indicators have demonstrated little improvement in disparities over the past decade according to analyses of progress on key objectives in Healthy People 2010 (USDHHS, 2011). The recently issued Healthy People 2020 objectives look beyond disparities toward greater health equity.

The Leadership Committee embraces health equity and recognizes its value in shaping policy initiatives, communication strategies, lifestyle interventions, and population-based surveillance related to cognitive health and impairment.

Stay grounded in science. Through public health surveillance, epidemiology, and applied research, public health can contribute to the understanding of cognitive functioning and, with biomedical and clinical research, identify promising interventions that may be effective in promoting or protecting it. The Leadership Committee recognizes that this process is evolutionary, requiring methods and processes to build upon what is currently known, share new discoveries as they emerge, and support advancements through promoting involvement in clinical studies and applied research.

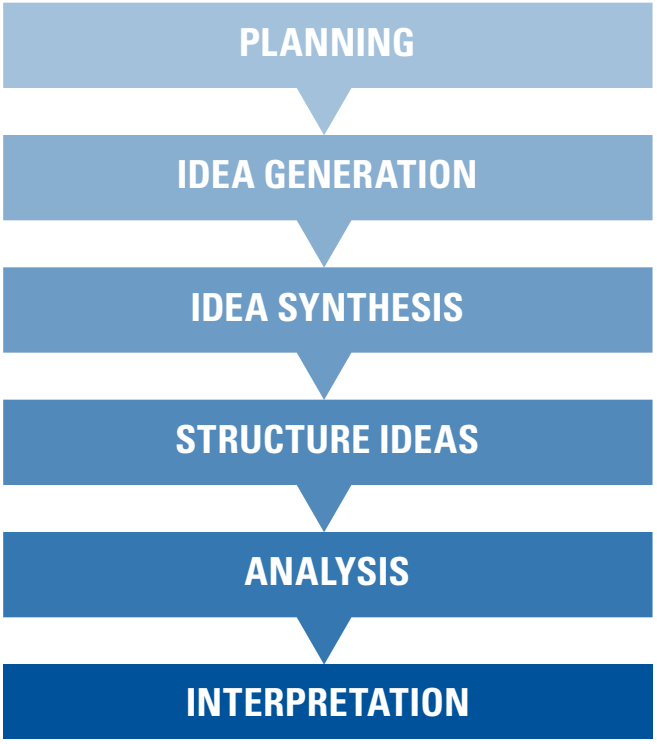


Conceptual Framework

Use of Concept Mapping to Identify Action Items

The Leadership Committee, made up of 15 experts from state and national organizations, provided overall guidance and coordination for the development and dissemination of the Road Map (Appendix A). The final product reflects the culmination of a process that merged critical input from the Leadership Committee with the voices of more than 280 informed and knowledgeable professionals in public health, aging, and Alzheimer's disease who represented national, state, and local agencies, non-governmental organizations, and academic institutions.

A concept mapping process, which consists of a sequence of phases that yields a visual picture of a shared group consensus of ideas, was used to form a conceptual framework and identify action items for the Road Map. A concept map provides a pictorial representation of a set of ideas, which are clustered in groups so that a complex set of ideas can be more readily understood. The project was organized into three overarching phases following the six-step process of concept mapping.



The first phase included planning and idea generation. During this phase, the Leadership Committee agreed on the core question that needed to be addressed and developed this prompt: "A specific action that state or local public health could do—on their own or with other national, state, or local partners—to address or promote cognitive functioning for people living in the community and the needs of care partners is…". Additionally, members of the committee reviewed background and introductory materials including the history of the effort and the definitions of terms and phrases such as cognition and care partners. They also identified individuals who would be invited to generate ideas related to the core question because of their experience and expertise about public health, research, and aging services as it relates to cognitive health and impairment.

Conceptual Framework

Between September 11, 2012 and September 30, 2012, 287 participants were invited to contribute ideas in response to the core question using a secure Web site (The Concept System® Global MAXTM, 2012) or by mailing or faxing their ideas. The ideas were provided anonymously to encourage participation and help avoid any potential inhibition or bias in submitted responses. As a consequence, response rates or the average number of items submitted per respondent are unknown. However, there were 151 unique visits to the Web site and a total of 370 ideas were generated.

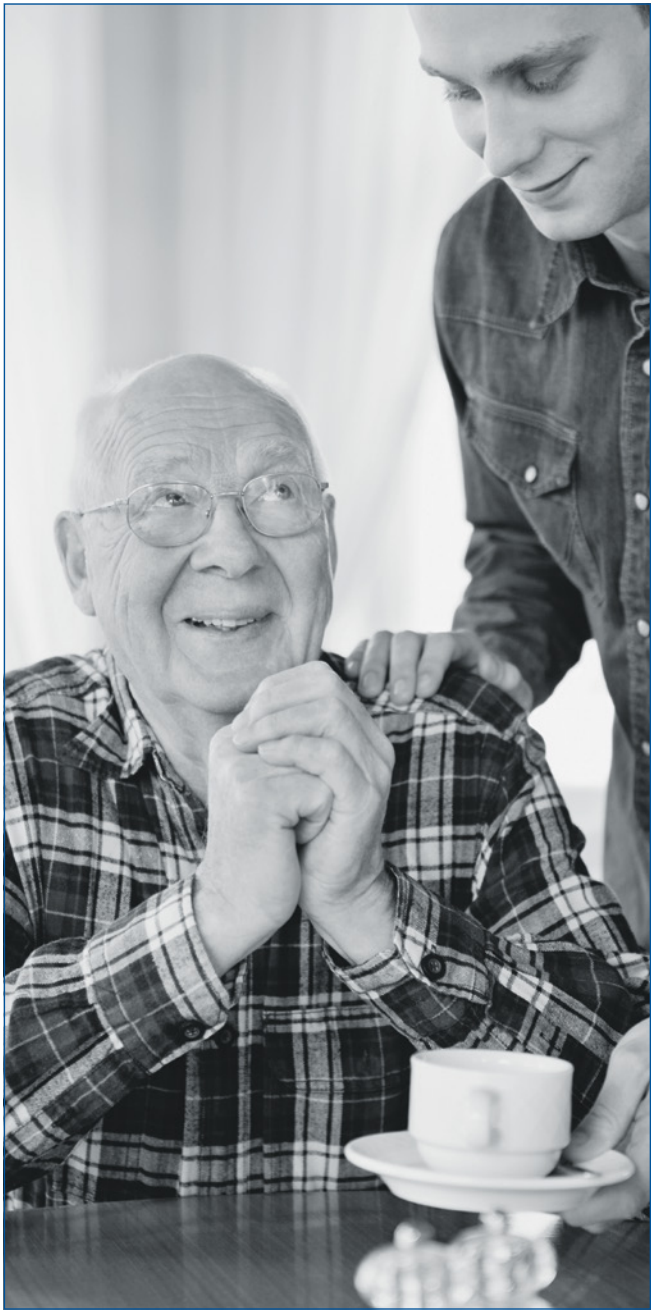
Members of a planning group (Appendix A) reviewed the statements that had been generated and eliminated repetitive statements and those not addressing the focus question. The remaining 80 ideas were presented to the Leadership Committee for further scrutiny.

A total of 54 unique statements were identified using the following criteria:

- **Is credible based on solid science or best practices;**
- **Reflects an appropriate role for state and local public health agencies on their own or with their national, state, and local partners;**
- **Addresses a single action; and**
- **Is sufficiently broad to encompass many activities that could be undertaken by states and partners depending on needs and resources.**

The second phase focused on idea synthesis and structuring through the generation of concept maps and rating of ideas for criticality and feasibility. Members of the Leadership Committee and an additional 64 individuals were invited to sort the ideas into themes; the Leadership Committee and an additional 274 individuals were invited to rate the 54 ideas. This phase was conducted between October 31, 2012 and November 30, 2012.

For sorting, individuals were asked to group the statements into categories, or themes, based on similarity of ideas. Participants used the project's Web site for this sorting and were asked to create their own categories. They were told that each statement could be placed into only one category, and that the sorting process should result in more than one category but fewer categories than the total number of statements.



Conceptual Framework

For rating, each idea was considered on two dimensions:

Criticality – How critical each idea is for state or local public health to pursue in the next 5 years, on their own or with support from national, state, or local partners.

Feasibility – How feasible each idea is for state or local public health to pursue in the next 5 years, on their own or with support from national, state, or local partners.

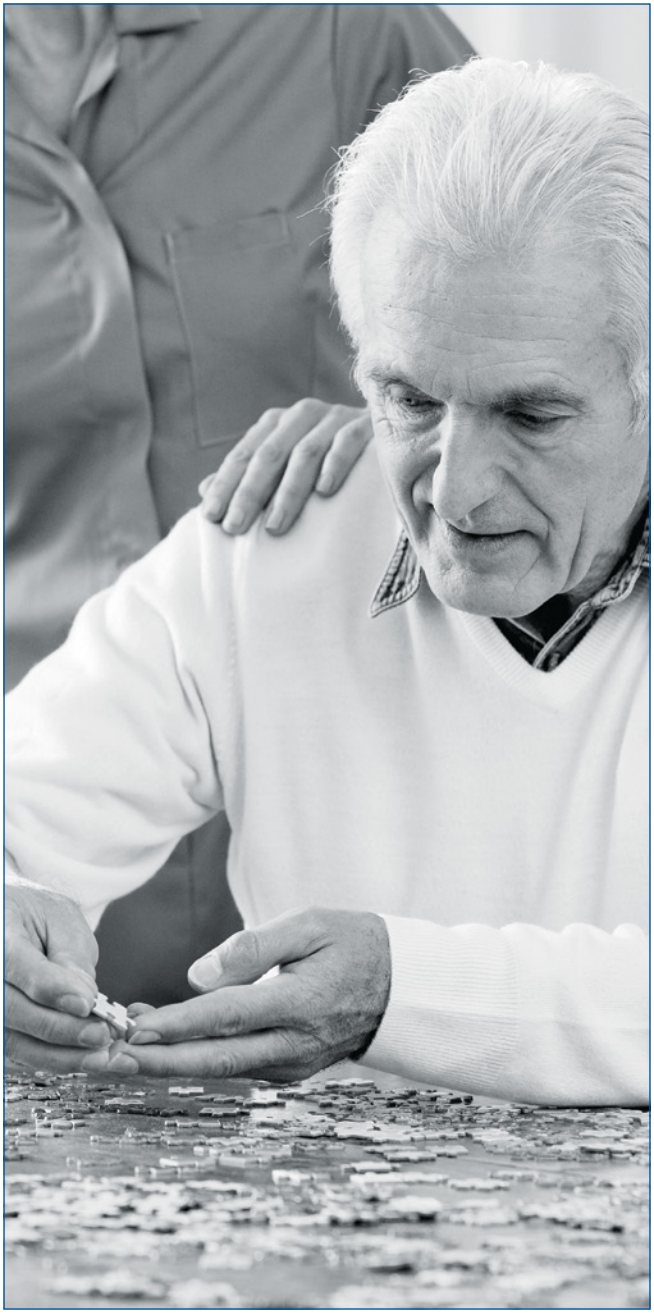
Again, because participation was anonymous, exact response rates could not be calculated. However, based on unique identifiers, an estimated 53% of those invited to sort completed the task and about one-third of those invited rated the items. These completion rates are comparable to other concept mapping projects (Anderson et al., 2006; Rosas & Kane, 2012).

The third phase included analysis and interpretation of maps. A concept mapping firm conducted a systematic and sequential analysis following established methods for group concept mapping (Trochim, 1989; Kane & Trochim, 2007). The analysis of the sorting data produced a network of ideas that represented the relationship between those ideas, as organized by the participants. The ideas were then grouped together, based on their similarity, to represent larger concepts.

As a result of the analysis and input from the Leadership Committee, the ideas were grouped into four clusters and labeled in alignment with the Essential Services of Public Health (USDHHS, 1997) as follows:

- Monitor and Evaluate
- Educate and Empower the Nation
- Develop Policy and Mobilize Partnerships
- Assure a Competent Workforce

The final concept map serves as the framework for the Road Map. Additionally, using the analyzed rating data as well as the set of criteria outlined above, the Leadership Committee examined and provided input on a subset of action items to be considered for inclusion in the Road Map. The 35 final action items are provided in Section II along with rationale.



Applied Research and Translation

The collective undertaking of state and national partnerships to maintain or improve the cognitive performance of all adults is only as effective as the evidence on which it is based. During the five-year time span of this Road Map, current and future research will yield new knowledge to better understand the public health burden of cognitive impairment, refine current practices and interventions to promote cognitive functioning, and help support the complex needs of individuals living with cognitive impairment and their care partners.

A few notable areas on the horizon—

Prevention research: An increasing research focus is anticipated on the vast majority of Americans living without cognitive impairment who "still face the looming specter of dementia in much later life and very likely have experienced subtle declines in cognitive function" (Wagster et al., 2012). Among the key research questions is what impact physical activity and other behavioral interventions have on maintaining healthy brains and preventing cognitive decline.

Applied Research and Translation

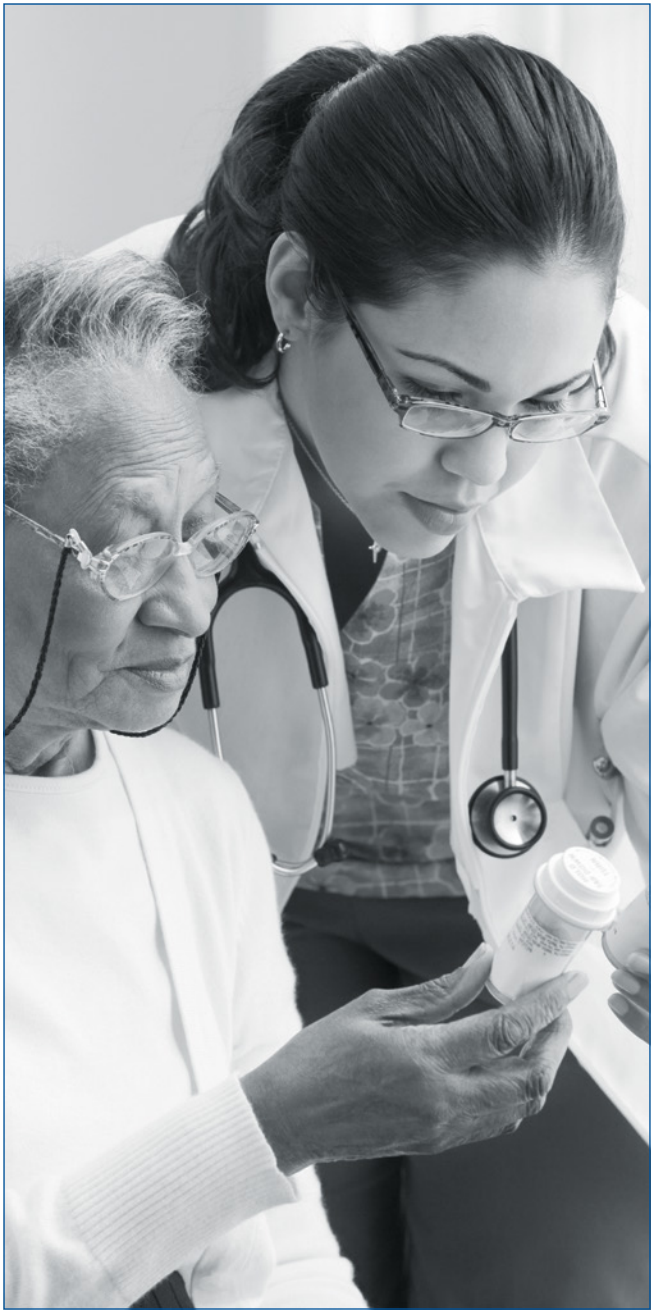
Expanded use of technology: Few fields continue to evolve as rapidly as technology. Tools that were hard to imagine only a few years ago are now essential for everyday functioning. Some have great potential for improving the quality of life of individuals with cognitive impairment and their care partners. Audible and visual prompts, for example, in Geographic Information Systems and Global Positioning Systems, can make it easier for them to navigate their communities safely and gain greater mobility and independence.

Focus on promoting mobility: Communities are increasingly cognizant of the value of optimal mobility, defined as "the ability to safely and reliably go where you want to go, when you want to go, and how you want to get there (Satariano et al., 2012)." The concept broadly includes basic ambulation, transferring from a bed to a chair, walking for leisure and the completion of daily tasks, engaging in activities associated with work and play, exercising, driving a car, and using various forms of public transport. This ability is important for all community-dwelling older adults through the life course, including individuals with cognitive impairment and their care partners.

> "Unless public health engages our partners to act quickly and strategically, issues of aging—falls, mobility, cognitive health—will consume our healthcare system."
>
> Toni Miles, MD, PhD
> *Institute of Gerontology, University of Georgia*

Community-clinical linkages: In recent years, the public health community has focused on developing stronger links between clinical and community providers for the delivery of a wide range of healthcare services (IOM, 2012). For cognitive impairment, these links could improve management of coexisting conditions; access to support groups and supportive services such as counseling, coordination of care, social services, and respite care; and sharing of information about available treatment options.

Rapid dissemination and implementation of research findings into widespread practice is crucial so that the benefits are equally available to all Americans, regardless of race/ethnicity, gender, socioeconomics, and geography. Accomplishing the actions in this Road Map will lay a solid foundation from which to anticipate and respond to emerging innovations and developments. By strengthening the capacity of public health agencies and leveraging strong state and national partnerships, energy and resources can be dedicated to incorporating cognitive health and impairment into ongoing chronic disease efforts at national, state, and community levels.



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The actions in this Road Map provide a solid foundation for the public health community to anticipate and respond to emerging innovations and developments. By strengthening the capacity of public health agencies and leveraging strong state and national partnerships, cognitive health and impairment can be incorporated into ongoing public health efforts at national, state, and community levels.

Disclaimer

The findings and conclusions in this report do not necessarily reflect the official position of the Centers for Disease Control and Prevention or the affiliated institutions of any of the contributors. Use of trade names is for identification only and does not imply endorsement by any of contributors' institutions. Links to non-federal government organizations found in this document are provided solely as a service to the reader. These links do not constitute an endorsement of these organizations or their programs by CDC or the federal government, and none should be inferred. CDC is not responsible for the content of the individual organization sites listed in this document.

Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention, as the sentinel for the health of people in the United States and throughout the world, strives to protect people's health and safety, provide reliable health information, and improve health through strong partnerships. CDC's mission is to promote health and quality of life by preventing and controlling disease, injury, and disability.

alzheimer's association

Alzheimer's Association

The Alzheimer's Association is the leading voluntary health organization in Alzheimer's care, support and research. Our mission is to eliminate Alzheimer's disease through the advancement of research; to provide and enhance care and support for all affected; and to reduce the risk of dementia through the promotion of brain health. Our vision is a world without Alzheimer's.

5B

Combating Alzheimer's Disease:
A Public Health Approach for Indian Country

alzheimer's association

Alzheimer's Disease: A Public Health Crisis that Demands Action

Alzheimer's is the most under-recognized public health crisis of the 21st century. The disease affects Americans across all walks of life and all communities. The inclusion of Alzheimer's disease in *Healthy People 2020* – the nation's health prevention and promotion goals for the next decade – confirms that Alzheimer's is a pivotal public health issue, requiring bold action before the crisis worsens.

American Indians and Alaska Natives are particularly at risk for developing dementia.

1 in 3 elders suffer from dementia.

Elders with:	have a:
Depression	42 %
Stroke	32 %
Diabetes	24 %

increased risk of developing dementia.

Increase early diagnosis of Alzheimer's

Action 1

Fewer than half of all people who have been diagnosed with Alzheimer's disease, or their caregivers, are aware of the diagnosis. Early detection and diagnosis – and knowing of the diagnosis – are essential to ensuring the best medical care and outcomes for those affected by the disease. *Healthy People 2020* has set of goal of increasing the percentage of individuals with the disease or their caregivers who are aware of the diagnosis. Tools and resources are available for these actions to increase early diagnosis, including:

- Educating the public and the medical community about the warning signs of possible dementia and the benefits of early diagnosis
- Educating health care professionals on the importance of discussing memory issues with their adult patients and on the use of validated cognitive assessment tools
- Placing links on public health agency web sites to local, state, and national dementia resources

Educate the public about risk reduction

Action 2

There is a growing scientific consensus that regular physical activity, management of certain cardiovascular risk factors (such as diabetes, smoking, and hypertension), and avoidance of traumatic brain injury can reduce the risk of cognitive decline and may also reduce the risk of dementia. Especially in the absence of a disease-modifying treatment, efforts are needed to increase public awareness and education about known and potentially modifiable risk factors of cognitive decline and dementia. Risk reduction messages for preserving cognitive health can be integrated into public health policies, campaigns, strategies, and action plans. Messaging and community educational resources are available that can be adapted to a tribe's unique culture.

Learn more about each other

Action 3

Molly French, director of public health for the Alzheimer's Association, welcomes your calls. We'd like to learn more about your community's priorities and discuss how the *Public Health Road* Map could be useful. Contact Molly at 202.638.8674 or mfrench@alz.org. Also, background information and videos, research, tools, and resources are available at the Public Health Alzheimer's Resource Center (alz.org/public health) and the Healthy Aging Program, Centers for Disease Control and Prevention (cdc.gov/aging).

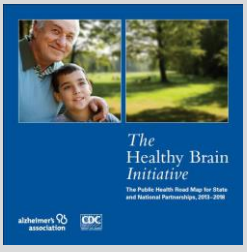
The Public Health Road Map

In 2013, the Centers for Disease Control and Prevention (CDC) and the Alzheimer's Association released *The Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, 2013-2018* to advance cognitive health as a vital, integral component of public health.

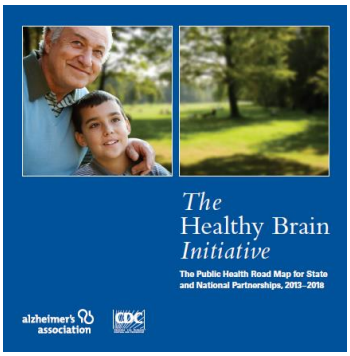
The *Public Health Road Map* identifies 35 specific action items that public health agencies can do to promote cognitive functioning, address cognitive impairment, and help meet the needs of caregivers.

Organized into four domains:

- ***Monitor and Evaluate***
- ***Educate and Empower the Nation***
- ***Develop Policy and Mobilize Partnerships***
- ***Assure a Competent Workforce***



View the complete report at **alz.org/publichealth**.



ROAD MAP ACTION ITEMS:

Resources and Examples for Public Health Officials

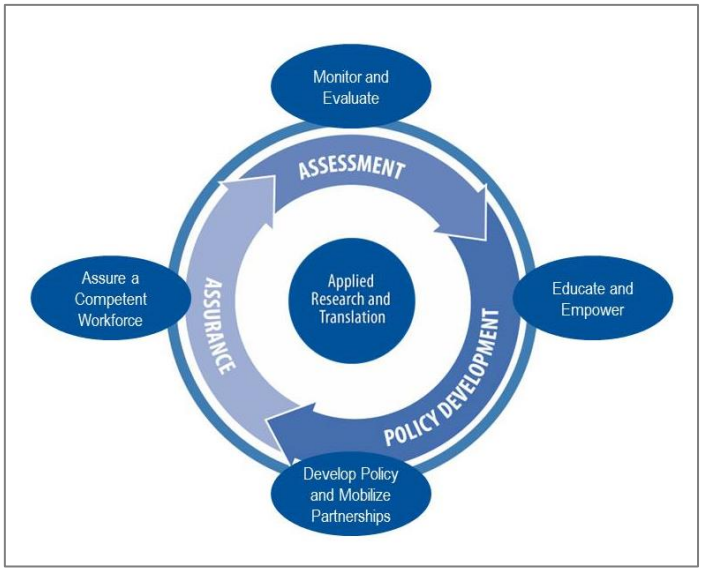
This ready-for-action guide provides select examples of how the public health community is implementing various action items in *The Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, 2013-2018*. The guide also includes links to free, existing resources that can support implementation by public health officials.

About *The Public Health Road Map*

In 2013, the Centers for Disease Control and Prevention (CDC) and the Alzheimer's Association released *The Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, 2013-2018* to advance cognitive health as a vital, integral component of public health. View the complete report at alz.org/publichealth.

The "Road Map" identifies 35 specific action items that public health agencies can do to promote cognitive functioning, address cognitive impairment, and help meet the needs of caregivers. These actions are organized into four domains of the Essential Services of Public Health:

- Educate and Empower the Nation (E)
- Monitor and Evaluate (M)
- Develop Policy and Mobilize Partnerships (P)
- Assure a Competent Workforce (W)



This resource guide to support implementation of Road Map action items has four sections that correspond with these four domains.

Educate and Empower

Public Awareness about Brain Health, Alzheimer's Disease, and Dementia

E-01 Identify and promote culturally appropriate strategies designed to increase public awareness about dementia, including Alzheimer's disease, to reduce conflicting messages, decrease stigma, and promote early diagnosis.

Public Health Education Resources

Administration for Community Living (ACL): community education kits	http://www.acl.gov/Get_Help/BrainHealth/Index.aspx
Brain Health as You Age: You Can Make a Difference! (English & Spanish)	
Brain Injury	
Medicine, Age, and Your Brain	
ACL: *What Is Brain Health?*	*http://www.brainhealth.gov*
Alzheimer's Association: Many community education programs, brochures, and workshops	*Healthy Living for Your Brain and Body: Tips from the Latest Research*
	Know the 10 Signs
	http://www.alz.org/apps/findus.asp (directory of chapters for their materials and educational programs)
Federal portals for consumers	http://alzheimers.gov
	http://www.eldercare.gov
Institute of Medicine: cognitive aging action guide for individuals and families	http://iom.nationalacademies.org/~/media/Files/Report%20Files/2015/Cognitive_aging/Action%20Guide%20for%20Individuals%20and%20Families_V3.pdf
National Institute on Aging:	https://www.nia.nih.gov/alzheimers/publication/understanding-memory-loss/introduction
Understanding Memory Loss: What To Do When You Have Trouble Remembering (booklet in English and Spanish)	
Understanding Alzheimer's Disease: What You Need to Know (booklet in English and Spanish)	https://www.nia.nih.gov/alzheimers/publication/understanding-alzheimers-disease/introduction

Examples

Georgia (Atlanta)	Developing billboard campaign to promote public awareness of dementia and an 800-number for more information/help.
Georgia (Atlanta)	Created ministerial alliance on Alzheimer's and other dementias to work with state government in promoting awareness in the African-American community through faith-based organizations.
Hawaii	Adapted and disseminated existing print materials that encourage people to talk to health care professionals about memory problems for placement in doctors' offices.
Maine	Maine Public Health Association devoted an issue of its e-newsletter to raising awareness about Alzheimer's and other dementias.
Minnesota	With legislative support, Minnesota Department of Health created new program focused on providing outreach and dementia education to African-Americans, African-born residents, and Asian and Hispanic populations.
Minnesota (Northfield)	Held a summit for individuals from the health care sector and community organizations to highlight the need for early detection and diagnosis.

Oregon	To promote early detection of Alzheimer's disease among Hispanic populations, the Aging and Disability Resource Center (ADRC) of Oregon adapted an English-language fotonovela -- an educational tool with photos and a story narrative -- for Spanish-language communities. Involvement of promotoras enhanced cultural relevancy. The Alzheimer's Association, Oregon Chapter, the Oregon Health Authority, and many other partners now promote and distribute the new fotonovela to Spanish-speaking communities, in part through public health networks.
Puerto Rico	Puerto Rico Department of Health leads a partnership to implement the Commonwealth's state Alzheimer's plan by organizing *Un Café por el Alzheimer*. Through in-person and social media platforms, the initiative facilitates conversations among experts and community members about cognitive health and Alzheimer's disease (via an NACDD grant).
South Carolina	Department of Health and Environmental Control works with the South Carolina Chapter to distribute 48,000 of the Alzheimer's Association's *Know the 10 Signs* brochures through its regional offices to raise awareness, especially among African Americans.
Texas (San Antonio)	Published a column on Alzheimer's disease in the local Spanish-language paper, with an emphasis on increasing awareness and promoting early detection and diagnosis.

Website Linkages

E-03 Encourage public health entities to provide links on their websites to local, state, and national dementia resources, including those specific to Alzheimer's disease and caregiving.

Consumer-Oriented Online Resources

Federal portals for consumers	http://alzheimers.gov http://www.eldercare.gov
Alzheimer's Association webpage	http://alz.org
Know the 10 Signs awareness campaign	http://alz.org/10signs
CDC general health information about aging	http://cdc.gov/aging/aginginfo/index.htm
Medicare Annual Wellness Visits	http://medicare.gov/coverage/preventive-visit-and-yearly-wellness-exams.html

Examples

California Department of Public Health	http://www.cdph.ca.gov/programs/alzheimers/Pages/default.aspx
Georgia Department of Public Health	http://dph.georgia.gov/other-chronic-conditions-alzheimers-disease
Maine Center for Disease Control and Prevention	http://www.maine.gov/dhhs/mecdc/navtabs/topics.htm
New York State Department of Health	https://www.health.ny.gov/healthaz/
Oregon Health Authority	https://public.health.oregon.gov/DiseasesConditions/DiseasesAZ/Pages/diseases.aspx
Wisconsin Department of Health Services	https://www.dhs.wisconsin.gov/dementia/communities.htm

Evidence-Based Messaging about Risk Reduction

E-04 Disseminate evidence-based messages about risk reduction for preserving cognitive health.

Public Health Education Resources

Administration for Community Living: *Brain Health as You Age: You Can Make a Difference!*	http://www.acl.gov/Get_Help/BrainHealth/Index.aspx
Brain Injury	
Medicine, Age, and Your Brain	

Alzheimer's Association:	http://www.alz.org
Healthy Living for Your Brain and Body, *Know the 10 Signs*, and many other community education brochures and workshops	
Messages for public health to use in existing health education and health promotion campaigns	Available upon request: mfrench@alz.org
Summary of the evidence on modifiable risk factors for cognitive decline and dementia: A population-based perspective	http://www.alzheimersanddementia.com/article/S1552-5260(15)00197-1/fulltext
National Institute of Neurological Disorders and Stroke (NINDS): *Mind Your Risks*, a public health campaign to educate people about controlling blood pressure in midlife to help reduce risk of stroke and possibly dementia	https://mindyourrisks.nih.gov/
University of California, San Francisco: *Maintaining Your Brain:*	http://memory.ucsf.edu/brain/aging/maintenance

Examples

California	California Department of Public Health developed educational infographic flyers for the public about protecting brain health.
New Mexico	Department of Health created and disseminated a notice to state and local public health professionals that encouraged use of ACL's community education resources on brain health.
South Carolina	Department of Health and Environmental Control is integrating messages about brain health into existing health education campaigns.
Vermont	802Quits (the Vermont Department of Health) integrates information about cognitive decline into smoking cessation campaign: http://802quits.org/resources/helpful-links/

Effective and Sensitive Communication

E-06 Identify and promote strategies for the public about how to communicate effectively and sensitively with persons with dementia, including Alzheimer's disease, and their families.

Information and Resources

Alzheimer's Association: *Effective Communications Strategies* (free, online training session)	http://www.alz.org/training
South Carolina: Arnold School of Public Health (USC) and the SC Department of Health: *Dementia Dialogues* – 5-part training session on care for those with Alzheimer's (CME credit)	http://www.sph.sc.edu/osa/programs_dementia.html

Examples

Minnesota (Chisago County)	Chisago County Public Health Department supported training of local law enforcement and first responders on how to effectively communicate with and serve people with dementia.
Texas (San Antonio)	Educated and trained all transit employees, senior center employees, and the police department on the basics of Alzheimer's, the early warning signs, and dealing with people with dementia.

Workforce Development

Introductory Materials for Public Health Professionals

W-02 Develop introductory, basic materials for public health professionals on cognitive health and impairment to help them understand their role.

Information and Resources

Alzheimer's Association e-learning: *The Basics: Memory Loss, Dementia and Alzheimer's*	http://www.alz.org/care/alzheimers-dementia-care-training-certification.asp#elearning
Alzheimer's Association: Educational materials and curriculum for public health professionals and schools of public health	http://alz.org/publichealth/education.asp
Missouri: Saint Louis University's College for Public Health and Social Justice: recorded educational webinars on Alzheimer's for public health professionals	https://www.youtube.com/watch?v=PjI8nbAx4MI https://www.youtube.com/watch?v=UihIczRuEpM

Examples

Hawaii	The Hawaii Director of Health sent a "Dear Colleague" letter to physicians encouraging early detection and diagnosis, including through the use of the Medicare Annual Wellness Visit benefit. The letter recommended training and informational resources.
Maine	Distributed the *State Plan for Alzheimer's Disease and Related Dementias in Maine* – a special insert for health care providers on cognitive assessment tools, early detection, and the value of early diagnosis – to primary care professionals through hospital and health systems.
Missouri	The Saint Louis University's College for Public Health and Social Justice worked with the Missouri Department of Health and Senior Services and the Alzheimer's Association, St. Louis Chapter to send care partner brochures and resource sheets to all local public health agencies in the state.
New York	The state's Commissioner of Health sent a "Dear Colleague" letter promoting the importance of early detection and diagnosis, noting the availability of reimbursement through the Medicare Annual Wellness Visit and local support resources for both health care professionals and their patients.
Wisconsin	Wisconsin Department of Health Services published *Building Dementia-Friendly Communities* toolkit: https://www.dhs.wisconsin.gov/dementia/healthy-brain-initiative.htm

Healthcare Provider Education on Early Diagnosis and Detection

W-03 + W-06 Support continuing education efforts that improve healthcare providers' ability to recognize early signs of dementia, including Alzheimer's disease, and to offer counseling to individuals and their care partners. (W-03)

Educate healthcare providers about validated cognitive assessment tools that could be administered in such settings as physician offices, clinics, emergency rooms, and acute care hospitals' admission offices. (W-06)

Information and Resources

Alzheimer's Association: information for health care professionals	http://www.alz.org/health-care-professionals/health-care-clinical-medical-resources.asp
Institute of Medicine: cognitive aging action guide for healthcare professionals	http://iom.nationalacademies.org/~/media/Files/Report%20Files/2015/Cognitive_aging/Action%20Guide%20for%20Individuals%20and%20Families_V3.pdf
Georgia: Department of Public Health: online training for physicians on Alzheimer's, including early detection and diagnosis	http://www.provaeducation.com/CME_Event.asp?eventCode=510K4D5P14

ACT on Alzheimer's: *Dementia Education* *Provider Practice Tools* *Video Tutorials on Assessment Tools*	http://www.actonalz.org
National Association of Geriatric Education Centers: education/training for health care professionals, including on cognitive health, impairment, and functioning.	http://www.nagec.org/
NIA: *Assessing Cognitive Impairment in Older Patients: A Quick Guide for Primary Care Physicians* covers the benefits of early screening and ways to screen quickly, accurately	https://www.nia.nih.gov/alzheimers/publication/assessing-cognitive-impairment-older-patients
NIA: *Talking with Your Older Patient: A Clinician's Handbook*, with a chapter on assessing for cognitive impairment	https://d2cauhfh6h4x0p.cloudfront.net/s3fs-public/talking-with-your-older-patient-a-clinicians-handbook.pdf?Ca7sLH6qBAMavIjpVswlK3EsUqLg4pPt
South Carolina: Arnold School of Public Health (USC) and the SC Department of Health: *Dementia Dialogues* – 5-part training session on care for those with Alzheimer's (CME credit)	http://www.sph.sc.edu/osa/programs_dementia.html
University of Kentucky: Alzheimer's training for health care professionals	http://www.cecentral.com/dementia

Examples

Georgia	Georgia Department of Public Health hosts educational webinar for physicians on dementia awareness, Medicare Annual Wellness Visit, and the importance of early detection and diagnosis. Continuing Medical Education (CME) credit available for successful completion.
Nebraska	The University of Nebraska Medical Center and the Alzheimer's Association, Nebraska Chapter trained Alzheimer's navigators across the state.
Vermont	University of Vermont College of Medicine engaged public health students in obtaining the medical community's views about assessing for dementia and preferences for training. Students developed online course for medical community.
Vermont	Vermont Department of Health partnered with the Alzheimer's Association, Vermont Chapter to conduct a webinar for public health professionals on early detection and diagnosis.
West Virginia	Alzheimer's Association, West Virginia Chapter is providing education and training on Alzheimer's and dementia in partnership with aging and disability resource centers, the West Virginia Geriatric Education Center, the West Virginia Hospital Association, and the Bureau for Senior Services.

Stay Connected

Keep up-to-date on emerging programs, resources, policies, and issues related to Alzheimer's disease and other dementias.

Alzheimer's Association: ***Alzheimer's Public Health News*** (newsletter/9 issues per year)	http://www.alz.org/publichealth/public-health-news.asp
National Association of Chronic Disease Directors: quarterly phone-based interest group on Alzheimer's disease and other dementias to discuss recent state experiences and lessons learned	Send a message to David Hoffman for information: david.hoffman@healthy.ny.gov

Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

Peer Support Services

Northwest Portland Area Indian Health Board
Quarterly Board Meeting
August 9, 2016

Agenda

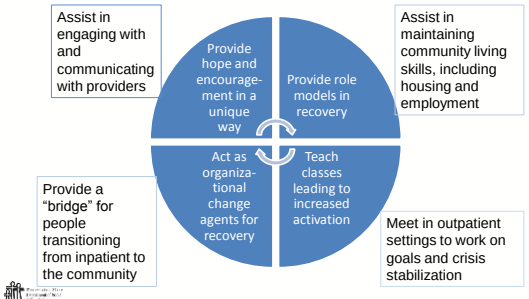
1. What are peer support services?
   a. General description
   b. DBHR staff lead contact if you have any questions
2. How do tribes bill for peer support services?
   a. What are the billing requirements for this service?
   c. Is this service eligible for the IHS encounter rate?
   d. Some billing examples
   e. Other payable peer support counselor services
3. Questions and Answers

PEER SUPPORT SERVICES: DESCRIPTION

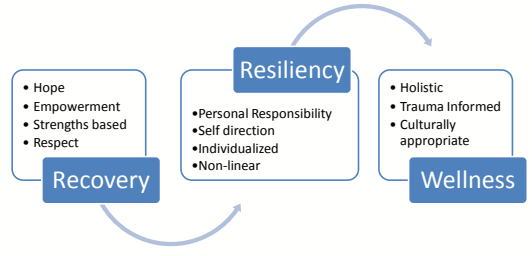
Peer Support Services

- Peer support is a service provided to improve recovery outcomes through connections with people with shared lived experience.
- In Washington State, peer supporters whose services are Medicaid reimbursable are called Certified Peer Counselors.
- Peer supporters are important members of the clinical team, and enhance services that can be provided.

Examples of Peer Counselor Roles



Peer Support Values



The Certification Process

Peers must:

- Be mental health consumers
- Apply for training and be accepted as a candidate
  - Attest to consumer status (including as parent of consumer)
  - Adequate reading and writing skills
  - In recovery at least one year
- Complete the 10 hour online course and the 40 hour in-person class
  - DBHR offers about six classes per year, and organizations can also purchase trainings from an approved contractor.
- Take and pass the state test
- If employed by a licensed agency, gain Agency Affiliated Counselor credential from DOH

Other Considerations

- Peer Services can only be billed by DBHR certified peers
- Must be supervised by a mental health professional
- May be employed by a health agency or subcontracted to a peer run organization
- Should receive on-going continuing education as well as role-specific training
- Employment expectations should be equal to other employees

Peer Support Outcomes

- Satisfaction
  - Almost universal satisfaction and appreciation by individuals and families
- Outcomes
  - Decrease in symptoms
  - Increased coping skills and awareness of early warning signs
  - Fewer hospitalizations, shorter lengths of stay
  - Improved social functioning
  - Increased feelings of hopefulness, self-advocacy and empowerment

Peer specialists say **"We are the evidence"**

DBHR Contact

Jennifer Bliss, Senior Manager,
Office of Consumer Partnerships
Peer Support Program Administrator

Jennifer.bliss@dshs.wa.gov
360-725-3709

PEER SUPPORT SERVICES: BILLING

Peer Support: Billing

This service is payable today

- This service has been payable in ProviderOne since April 1, 2015 for all dates of service

Peer Support: Billing Requirements

Client: Medicaid-enrolled AI/AN or clinical family member (CFM)

Peer Support Service Provider: Certified Peer Support Counselor

Minimum Time per Client: 10 minutes

Daily Maximum Time per Client: 4 hours

Payment Rate: $60 per hour (¼ hour increments)

Site of Service: Any location that meets privacy requirements

Support Group Peer Counselor-to-Client Ratio: No more than 1-to-20

Procedure Code: H0038 - "Self-help/peer services, per 15 minutes"

Procedure Code Modifier:

- "HE" for AI/AN client
- "SE" for non-AI/AN clinical family member client

Peer Support: Billing Requirements

Billing NPI: IHS or Tribal 638 facility

Billing Taxonomy: 2083P0901x

Servicing NPI: Supervising ProviderOne-enrolled Mental Health Professional who understands rehabilitation and recovery

Servicing Taxonomy: As applicable

Diagnosis Code: Valid ICD-10 diagnosis as appropriate for service

Referring NPI: Not required

Prior Authorization: Not required other than EPA (see next)

Expedited Prior Authorization (EPA): Required - 870001349

"Either: (1) client has elective exemption from Medicaid Managed Care under 42 U.S.C.1396u-2 (e.g., client is AI/AN); or (2) client is a Clinical Family Member."

Peer Support: IHS Encounter Rate

The services of certified peer support counselors are not eligible for the IHS encounter rate.

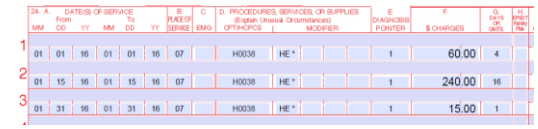
- Peer support counselors are not included in the State Plan list of IHS encounter-eligible provider types.

Peer support services are considered a mental health service.

- The facility may not bill for the peer support counselor's services if the facility receives an IHS encounter payment for mental health services for the same client during the same 24-hour period.

Peer Support: Billing Examples

Date of Service	Procedure Code	Modifier	EPA	Billed Amount	Billed Units
1/5/01	H0038	HE (AI/AN) or SE (CFM)	870001349	$60.00	4
1/6/01	H0038	HE (AI/AN) or SE (CFM)	870001349	$240.00	16
1/15/01	H0038	HE (AI/AN) or SE (CFM)	870001349	$15.00	1



	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H.
1	01	01	16	01	01	16	07		H0038	HE *		1	60.00	4	
2	01	15	16	01	15	16	07		H0038	HE *		1	240.00	16	
3	01	31	16	01	31	16	07		H0038	HE *		1	15.00	1	

Peer Support Counselors: Other Payable Services

- **Day Support**
  H2012 - "Behavioral health day treatment, per hour"
  - Rate: $31.05 per hour
- **Medication Monitoring**
  H0034 - "Medication training and support, per 15 minutes"
  - Rate: $22.47 per 15 minutes
- **Therapeutic Psycho-Education**
  H0025 – "Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)"
  - Rate: $6.58 per service

  H2027 – "Psycho-educational service, per 15 minutes"
  - Rate: $12.01 per 15 minutes

Peer Support: Q&A

Thank you!

HCA
Office of Tribal Affairs & Analysis
Jessie Dean
Administrator
Direct Dial: 360-725-1649

Mike Longnecker
Operations & Compliance Manager
Direct Dial: 360-725-1315

- Email: tribalaffairs@hca.wa.gov
- Website: http://www.hca.wa.gov/tribal/Pages/index.aspx

DSHS
Division of Behavioral Health & Recovery
David Reed
Acting Office Chief
Direct Dial: 360-725-1457

Loni Greninger
Tribal Administrator
Direct Dial: 360-725-3475

- Email: greniar@dshs.wa.gov
- Website: https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery

NWTEC 2016 Survey Results

PRESENTED BY:
NANETTE STAR YANDELL, MPH
PROJECT DIRECTOR & EPIDEMIOLOGIST
NYANDELL@NPAIHB.ORG

Introduction

- Survey conducted in Fall 2015
- Completed by 26 Tribes
- Purpose:
  - Feedback for EpiCenter
  - Health Priorities
  - Public Health Policies

What is the EpiCenter doing well?

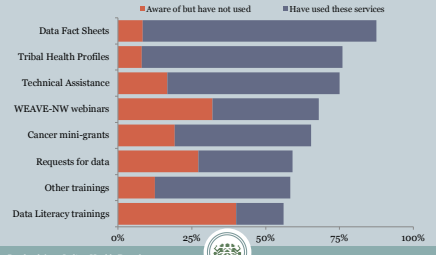
- ✓Data reports
  - ✓http://www.npaihb.org/resource-lib/
- ✓Public health information – general
- ✓Grants, financial assistance
- ✓Responsive and friendly staff

What can we improve?

- More outreach to programs outside of administrative
- Tribal government public health policy
- Provide best practices, esp. tribally adapted & culturally appropriate
- Tribal data warehouse
- Technical Assistance for NextGen
- Better communication of what the EpiCenter does

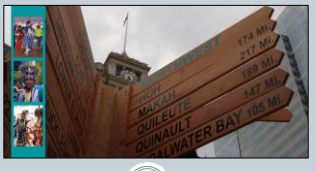
Epicenter Services

Data products such as fact sheets and health profiles were the most commonly used

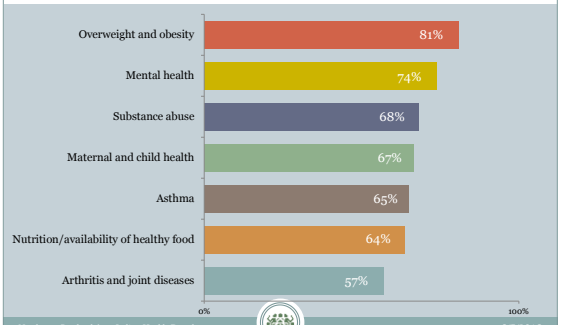


Top Three Health Priorities

1. Overweight and obesity (10)
2. Substance Abuse (7)
3. Mental health (6)

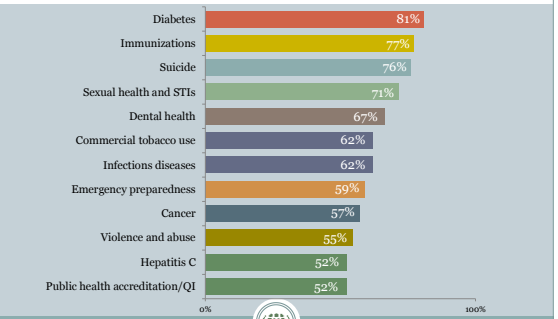


EpiCenter could do more about…



Northwest Portland Area Indian Health Board 8/5/2016

EpiCenter is doing well to address…



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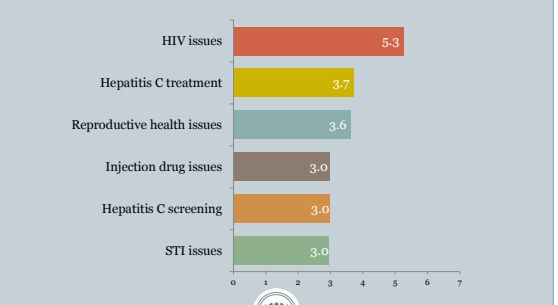
Top Sexual Health Priorities



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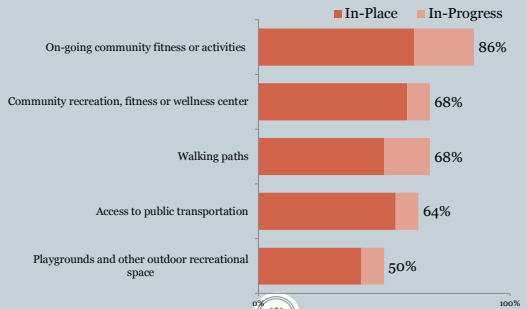
Policy, Systems & Environment

<u>Policy</u> passing of or change to a law, ordinance, resolution, regulation or rule designed to guide or influence behavior

<u>System</u> involves change made to organizational procedures

<u>Environment</u> change made to the physical surroundings

Top 5 Physical Activity PSEs



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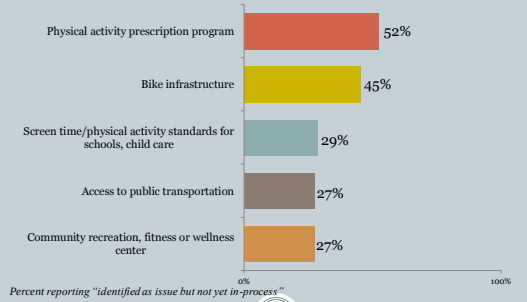
Identified Opportunities



Percent reporting "identified as issue but not yet in-process"

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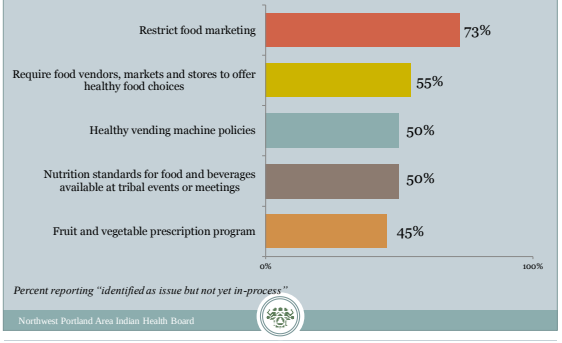
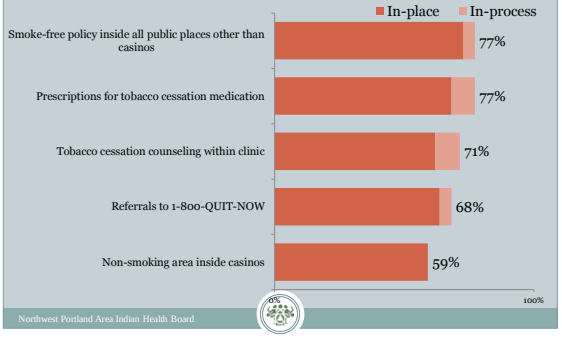
Top 5 Food & Nutrition PSEs

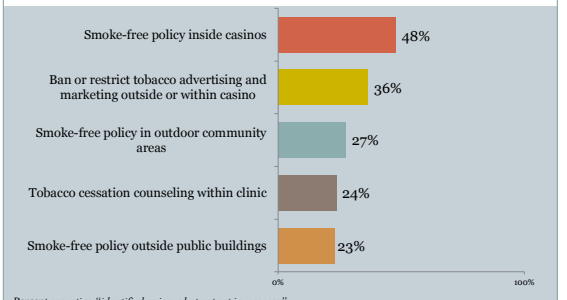
Identified Opportunities



Top 5 Commercial Tobacco PSEs



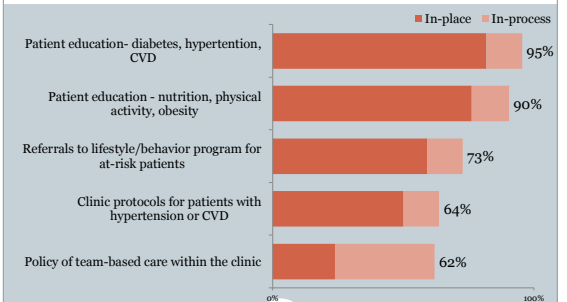
Identified Opportunities



Percent reporting "identified as issue but not yet in-process"

Northwest Portland Area Indian Health Board

Top 5 Health System PSEs



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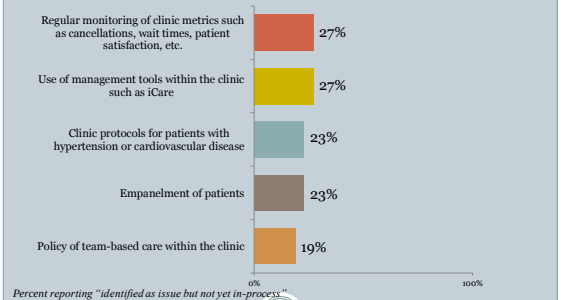
Identified Opportunities



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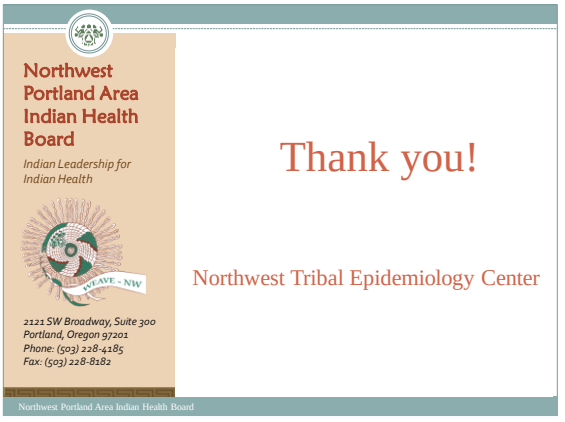

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health
WEAVE - NW
2121 SW Broadway, Suite 300
Portland, Oregon 97201
Phone: (503) 228-4185
Fax: (503) 228-8182
Thank you!
Northwest Tribal Epidemiology Center
Northwest Portland Area Indian Health Board

Native Cancer Wellness

From Salish Cancer Center

Dr. Eiko Klimant, MD, ABHIM, FACP
Medical Oncologist, Medical Director

Salish CANCER CENTER
The Puyallup Tribe's Integrative Approach to Healing

Disclosures

- No Conflicts of Interest to Disclose

Objectives

- Recognize the unique challenges of Native cancer care.
- Examine the integrative model of oncology care.
- Recognize the benefits of combining traditional healing services in the care of Native American cancer patients.
- Recognize the Salish Cancer Center, the first tribally owned cancer center in the nation.

The Native American Population

- An estimated 4.5 million people are classified as American Indian or Alaska Native
- 1.5 percent of the total population
- Over 560 Federal and 100 State-recognized tribes nationally

American Indian/Alaska Native Profile. CDC Office of Minority Health. Updated 2007 http://www.cdc.gov/omhd/populations/AIAN/AIAN.htm

The American Indian and Alaska Native Population: 2000 Census Brief. Updated 2002 http://www.census.gov/prod/2002pubs/c2kbr01-15.pdf

Native Cancer Incidence

New Cancer Cases per 100,000 - Men (2011)			
Cancer	American Indian Men	Non-Hispanic White Men	American Indian/Non-Hispanic White Ratio
All Sites	393.4	518.1	0.8
Colon and Rectum	63.3	43.4	1.5
Lung	52.3	63.5	0.8
Pancreas	17.4	14.4	1.2
Prostate	63.9	134.0	0.5
Stomach	20.0	8.4	2.4
New Cancer Cases per 100,000 – Women (2011)			
Cancer	American Indian Women	Non-Hispanic White Women	American Indian/Non-Hispanic White Ratio
All Sites	359.1	433.5	0.8
Breast	104.0	137.0	0.8
Cervical	9.5	6.5	1.5
Colon and Rectum	45.7	34.2	1.3
Lung	41.5	50.2	0.8
Pancreas (2010)	12.9	11.0	1.2
Stomach (2010)	13.0	3.6	3.6

Source: CDC. 2015. Health United States, 2014. Table 40. http://www.cdc.gov/nchs/data/hus/hus14.pdf

Higher Native Cancer Mortality

Cancer Sites	AI/AN MIR (95% CI)	White MIR (95% CI)	AI/AN:White Ratio[a]
All cancers	0.49 (0.48, 0.50)	0.39 (0.39, 0.39)	1.26
Bladder	0.24 (0.20, 0.27)	0.20 (0.20, 0.20)	1.19
Breast (female)	0.22 (0.21, 0.24)	0.18 (0.18, 0.19)	1.22
Cervical (female)	0.38 (0.33, 0.44)	0.28 (0.27, 0.29)	1.36
Colorectal	0.42 (0.40, 0.44)	0.36 (0.36, 0.36)	1.16
Hodgkin disease	0.21 (0.14, 0.30)	0.15 (0.14, 0.15)	1.40
Kidney and renal pelvis	0.35 (0.32, 0.38)	0.30 (0.29, 0.30)	1.18
Leukemia	0.60 (0.55, 0.67)	0.58 (0.57, 0.58)	1.05
Liver/intrahepatic bile duct	0.91 (0.83, 0.99)	0.91 (0.90, 0.93)	1.00
Lung and bronchus	0.83 (0.80, 0.86)	0.77 (0.77, 0.78)	1.07
Ovary (female)	0.68 (0.61, 0.77)	0.66 (0.65, 0.67)	1.03
Pancreas	0.96 (0.88, 1.05)	0.95 (0.94, 0.96)	1.02
Prostate (male)	0.23 (0.21, 0.25)	0.17 (0.17, 0.17)	1.40
Stomach	0.70 (0.64, 0.78)	0.56 (0.55, 0.57)	1.27
Uterus (female)	0.18 (0.16, 0.21)	0.16 (0.16, 0.16)	1.14

Am J Public Health. 2014 June; 104(Suppl 3): S377–S387.

Cancer Care in Native Population

- Lower overall incidence but higher overall cancer mortality
- Cultural barriers to prevention and care
- Community and system level barriers to care

The Future of Native Cancer Care

- Improved prevention, screening➔ Decrease Incidence
- Improved cancer care➔ Decrease mortality
- Respect for the culture of native cancer patients
- Whole person approach: Body, Mind, and Spirit I.e.

" A Integrative approach"

What is Integrative medicine?

"The practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals and disciplines to achieve optimal health and healing."

The Consortium of Academic Health Centers for Integrative Medicine (CAHCIM)

Integrative Oncology Care Model

- Medical Oncology
- Lifestyle counseling: Diet and Exercise education
- Naturopathy
- Native plant medicine
- Chinese Medicine
- Acupuncture
- Spiritual support
- Other evidenced based complementary or alternative therapies: biofeedback, massage, music therapy, art therapy, etc.

Native Healing in the Integrative Model of Care

- **Unique treatment goals in the Native American Population:**

1) Overcoming negative patient experiences and gaining trust

2)Overcoming historical trauma related to health care and boarding schools

Integrative Oncology Care

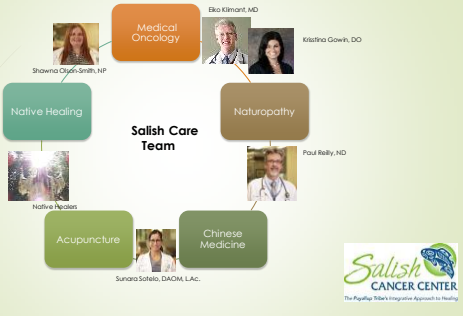
- By optimizing supportive care during treatment beyond:

1) Enhance quality of life
2) Decrease treatment associated side effects (i.e chemotherapy toxicity)
1) Promote wellness and optimized survivorship
2) And potentially even enhance response to therapy

Salish Cancer Center: Addressing the Unique Needs of Native Americans

- **Philosophy:** To blend medical oncology with evidenced-based integrative therapies to treat the whole person — mind, body, and spirit. This unique approach is recognized as "Integrative Oncology".
- **Team:** 2 medical oncologists, 1 nurse practitioner, 1 naturopathic oncologist, 1 Chinese medical doctor and acupuncturist, and highly respected experienced native healers.
- **Services:** State-of-the-art medical oncology including 23 chair infusion center combined with: naturopathic care, acupuncture, moxibustion, cupping, Chinese medicine, essential oil therapy, vitamin infusions, native healing, and survivorship care planning.
- **Patients:** Native and Non-Native with all cancer types with exception of acute leukemia.

Salish CANCER CENTER



Salish CANCER CENTER

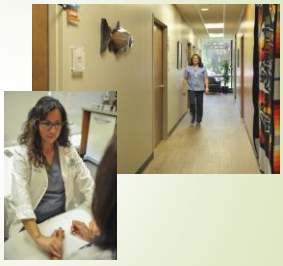
Native traditional healers from various tribes throughout the US

At Salish Cancer Center,

All patients are given an opportunity to supplement their healing process through services offered by our Native American Traditional Healers

Gaining Trust – Optimal Native Healing Environment

- Staff are empathetic compassionate
- Staff Understand various Native communication styles
- The environment is conducive to Native Healing



Salish Cancer Center
Our Initiatives

- 1) **Patient Care Excellence**
  - Developing community partners and optimizing the patient care experience.
  - State of the art EHR
- **2) Survivorship**
  - Program development with a native focus
  - focus on continuum of care for the cancer patient starting with diagnosis and beyond
- 3) **Research**
  - Develop community partners and research network
  - Major areas of focus

Salish CANCER CENTER
The Puyallup Tribe's Integrative Approach to Healing

Salish Initiative : Patient Care Excellence

- Evidence-based standard of care Oncology with adherence to guidelines eg NCCN and ASCO guidelines
- Optimized supportive care with an integrative approach
- New Electronic Health Record: high level documentation to capture outcomes, and show the value of care
- Develop Collaboration with Community partners such as the Franciscans, Multicare, and Group Health

Salish Initiative Survivorship : Current and Projected Cancer Survivors in US

- 14 million survivors (as of January 1, 2012)
- 18 million survivors (as of January 1, 2022)

(Siegel et al., CA Cancer J Clin 2012)

Survivorship: Definition

Who: Anyone who has been diagnosed with cancer

When: From the time of diagnosis through the rest of their lives

How: Survivors embrace their lives beyond their illness

Who else: Family members, friends, and caregivers are also impacted by the survivorship experience

- Covers the physical, psychosocial, and economic issues of cancer, from diagnosis until the end of life
- Includes issues related to the ability to get health care and follow-up treatment, late effects of treatment, second cancers, and quality of life

4 Major Areas of Cancer Survivorship

- Surveillance , screening and prevention of recurrence and new cancers
- Identification and management of late and long-term effects
- Recommendation and promotion of improvements of modifiable health behaviors
- Coordination of care (provider-provider and patient-provider) to ensure that patient health needs are met

Survivorship

- Care Plans and Treatment Summaries
- Patient "companion"
- Multi-Disciplinary Wellness Promotion
- Diet, Exercise, Spirit, and Joy Optimization

Salish Integrative Survivorship Program

- Survivorship medical care plan
- Native drumming and Meditation daily
- Native spiritual healing
- Acupuncture
- Naturopathy
- Nutrition education
- Tai Chi/Qi Gong classes
- Massage, counseling, on-line classes, native healing practices program all in development

Salish Initiative : Research

- 4 main areas : medical oncology, integrative medicine, cannabis, and Native American
- Participate in community based research networks
- Program development in the 4 major areas

Research

- **Current Collaboration** with Bastyr/Mayo Clinic/Arizona State University

-The Canadian/US Integrative Oncology Study (The CUSIOS study)

-Clinical Trial of Yoga in Myeloproliferative Neoplasms

-Clinical Trial of Tai Chi in Multiple Myeloma during Autologous SC Transplant

- **Goals:**

1) To advance integrative medicine and build evidence-base for integrative therapies
2) Develop research questions and collaborative partners with native focus
3) Build research infrastructure: research nurse, statistical support, etc

-If interested in collaborating on native specific or integrative research email krisstina.gowin@salishcancercenter.com

Conclusions:

- Native cancer specific mortality is high
- Native cancer patients have many unique needs and risk factors
- The Integrative model of care offers a whole person system of healing that may address the unique needs of native cancer patients
- Salish Cancer Center is the first tribally owned integrative cancer clinic in the U.S. offering high level evidence-based medicine in combination with integrative services such as native healing.

Contact Information

- eiko.klimant@salishcancercenter.com

THANK YOU!
Questions?

Salish CANCER CENTER
The Puyallup Tribe's Integrative Approach to Healing

3700 Pacific highway, E., Tacoma, WA
253-382-6300
www.salishcancercenter.com

THE TRIBAL RESEARCH MODEL: CAPTURING THE HELICOPTER

DR. TOM BALL, Ph.D
RESEARCH COORDINATOR
x̌smr̓imstn : COLVILLE NARCH

Helicopter Research in Action

Part I: The Project Begins…

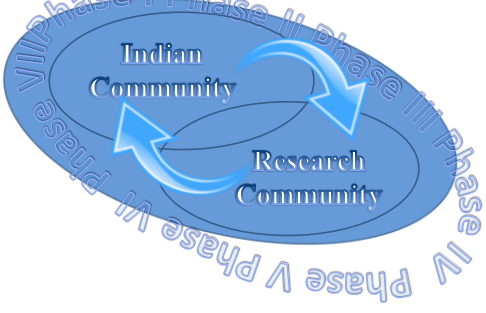
Helicopter Research continued

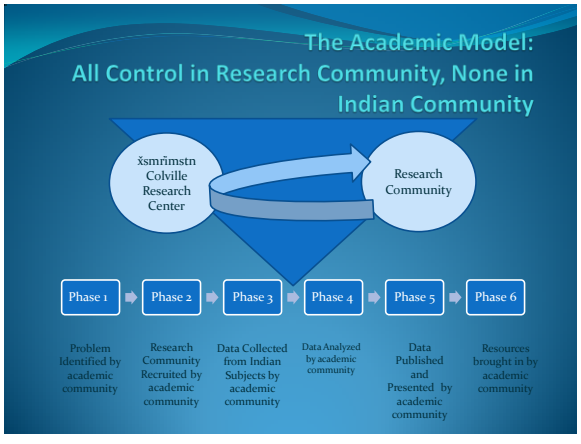
Part 2: The Project Ends…

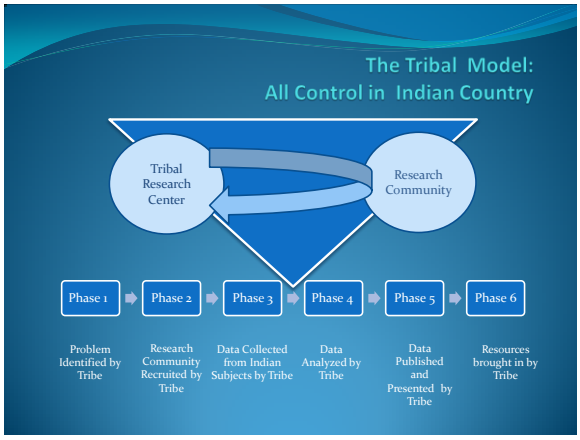
Problems with sustainability and adherence

NARCH Mission: Capture the Helicopter

The Community Empowerment Model: Tom Ball, Alison Ball, Phil Fisher







xsmŕimstn : How are we Implementing Tribal Research?

- Admin Core: Building capacity for future research
- Capacity Building Core: Building capacity for programs to mine their own data
- Research
  - Pilot Project:
  - Men's Diabetes Study: two tribal members hired to work on project

Administrative Core

Facilitating Research by building into the administration processes that will continue to support research activities for the tribe.

continued…..

- Sub-contracting with outside organizations to provide technical assistance in specialized capacities such as curriculum development, epidemiology, or biostatistics.

Continued…

- Budgeting
  - Tribal budgets vs. Federal budgets

Administrative Core continues..

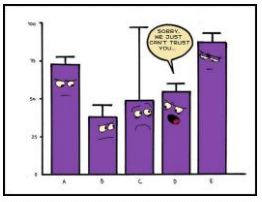
- Tribal Scientific Board is made up of Tribal Council, Office of Reservation Attorneys, Program Managers from Environmental Trust, History & Archeology, CFO, Traditional leaders.
  - Quarterly all day meetings
  - IRB processes
  - Data Sharing Agreements
  - Research Agenda's
  - Policy & Procedures
  - Finance

Capacity Core

- Building sustainability, data capacity in Health Programs to organize, collect, and analyze data

Why Collect Data?

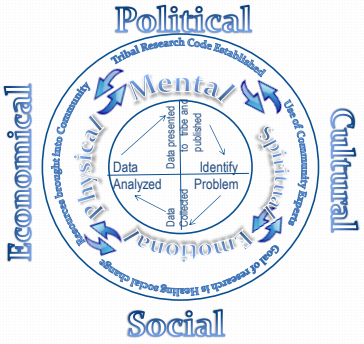
- Grant Applications
- Program Improvement
- Resource Allocation
- Tribal Council
- Data Mining
- Data Analysis
- Study Patterns of Health & Disease



How are we doing it?

- Meet with individual programs.
  - Is the data collected currently answering the questions program managers, directors, CBC?
- Customize data collection.
  - Assist in developing ways to collect data, Excel, Access, etc.
- Collect data sets from programs.
  - Determine how the datasets will be shared, email, secure server, USB, etc.

Shifting the Research Paradigm



Building Your Own

- Colville Tribe has 16 Ph.D.'s
- Need to have a place to do research
- Student research academy – cohort model 10 weeks
- Research methodology
- Research project
- Present at conferences
- Follow up with support; future summer placements, mentoring, small research grants

Building Your Own Cont.

- Training:
  - GIS (Geographic Information Systems)
    - ArcGIS I: Introduction to GIS
    - ArcGIS II: Essential Workflows
  - Microsoft SQL Server
    - Querying Microsoft SQL Server
    - Administering SQL Server Databases
    - Implementing Data Warehouse with SQL Server

Cont...

- Excel:
  - Excel 2013 Parts 2 & 3
  - Intermediate to Data Mining
- Microsoft Access
  - Beginning & Advanced
- Human Subjects
- Grants Management & Financial Accountability

Negative Perception of Research

- Annual Colville Research Conference
  - We've been researched to death
  - We never hear back from researchers

See Tribal students/family members reporting back to community their research findings.

See the potential for research to help the people when research is controlled by the people.

Data ownership: Sovereignty issue. It is your data.

Measure attitude change.

The NARCH Mission

- Capture the Helicopter
- Tribal Research Model
- Colville Researchers doing Colville Research
- Limlimt.

Jamestown Health Department

Agenda

1. **Where Are We Now?**
2. **Where Are We Going?**
3. **Challenges**

Where Are We Now?

Jamestown Family Health Clinic

OVERVIEW
(October 2015 to June 2016)

Total Patients in Epic: 12,000+
Individual Patients Seen YTD: 10,188
Total Visits: 37,009
Providers:

- MD/DO: 12
- ARNP: 9
- PA-C: 5
- Counselor: 3
- Pharmacist: 1

Where Are We Now?

Population Demographics

Payor Mix	%
Commercial	35%
Medicaid	17%
Medicaid HMO	1%
Medicare	41%
Medicare HMO	4%
Other Govt	2%
Self-pay	0%
Worker's Comp	1%

Age Sex	F	M	Total	%
0-12	2	5	7	0%
13-17	68	81	149	1%
18-29	583	415	998	7%
30-39	652	442	1094	7%
40-49	785	525	1310	9%
50-59	1360	916	2276	15%
60-69	2308	1561	3869	26%
70-79	1805	1478	3283	22%
80-89	847	709	1556	10%
90-99	273	183	456	3%
100+	7	2	9	0%
Total	8690	6317	15007	
	58%	42%		

Where Are We Now?

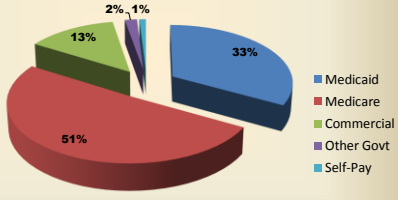
Revenue

- **Payer Mix: significant increase in Medicaid revenue**
  - Currently have about 34% Medicaid; increased by 10%.
  - Open to New Medicaid (Apple Health) and Medicare Patients
- **Medicare and Medicaid Encounter Rates**

Medicaid: $360
Medicare: PPS Rate
- $160.60 EP
- $214.46 NP/AWV/W2M

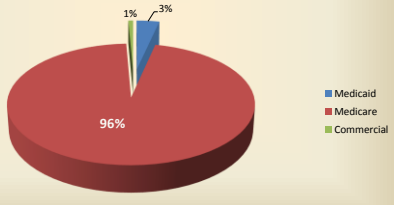
Where Are We Now?

Revenue
Family Medicine



Where Are We Now?

Revenue
Healthy Aging



Where Are We Now?

Dental

- Received 300K Dental Foundation of Washington grant
- Added 4 new dental operatories
- Added Pediatric Dentist

Where Are We Now?

Tribal Wellness

YTD Home Services

- Foot and Nail Care
- Respite Care Clients
- Respite Care Hours
- Home Visits
- Transports
- Other Services
- Phone Calls
- Flu Shot Assistance

Jamestown Health Department

2. Where Are We Going?

- **Operational Goals**
- **Wellness Program**
- **Policy and Government**

Where Are We Going?

Operational Goals

1. Let's Improve the Lives of Our Patients
2. Let's Inspire and Develop Our People
3. Without a Margin, There is No Mission

Where Are We Going?

Let's Improve the Lives of Our Patients

- Create Culture of Patient Centered Care
- Healthy Hearts Initiative
- Improve Patient Experience
- QA/Compliance

Where Are We Going?

Let's Inspire and Develop Our People

- FLIP – Frontline Leadership Initiative Program
- Give a WOW Program
- Create Happy and Dedicated Staff

Where Are We Going?

Without a Margin, There is No Mission

- Communicate Goals and Targets
- Develop Lean Processes
- Increase and Protect Revenue Streams

Where Are We Going?

Tribal Wellness Program

- New Diabetes Program
- New Community Health Re-design
- Better Communication of Programs
- Collaboration of Services

Where Are We Going?

Government and Policy

- Active Participation
  - Northwest Portland Area Indian Health Board
  - American Indian Health Commission
  - Olympic Community of Health
  - Self-Governance
- Policy Tracking
  - Medicaid 1115 Waiver
  - BHO Waiver
  - Legal Utilization of Health Net Profit

Jamestown Health Department

3. Challenges

- Population Health Management
- Value-Based Reimbursement
- How Does a Tribal Health System Fit into Evolving National/State Plans

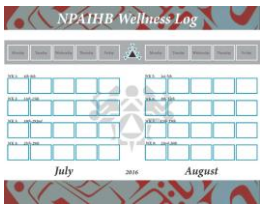
Wellness @ Work

Northwest Portland Area Indian Health Board
Portland, OR

Birdie Wermy, MPH (*S. Cheyenne*)

Wellness @ Work

- NPAIHB Wellness Activities
  - Monthly wellness tips & weekly workouts led by staff
  - Spokane challenge
  - NPAIHB 8 wk fitness challenge – 3rd annual
  - Monthly Birthday recognition
    - Healthy all staff food
  - Quarterly potlucks



Wellness @ Work

- NPAIHB Wellness Activities
  - Executive Director's Annual Hot Dog Feed/Chili Cook Off – Oregon Food Bank
  - Annual Picnic
  - Annual Indian Day Celebration
  - Co-Ed Basketball team (5 staff)
  - TeamHANDS Hood 2 Coast Team

2015 Accomplishments

- Spokane Challenge – 6 weeks
- Valentine's Day Potluck
  - optional workplace activity – February
- St. Patrick's Day Potluck – March
- Graduate Recognition Potluck – June
- 2nd Annual 8 week summer challenge – staff awarded with NPAIHB shirt
- 2 Brown Bag luncheon presentations – nutrition

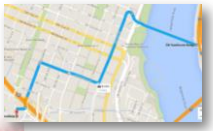
2015 Accomplishments

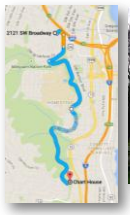
- Box of toiletries – NARA/Indian Day Celebration
- 3 baby showers
- Annual all staff picnic @ Oaks Amusement Park – August
- NICWA gifting program – partnered with BIA for Christmas gift tags
- Hot Dog Feed – Oregon Food Bank – December
- Holiday Party (Jon's Incredible Pizza)– December
- Oregonian Newspaper – Top Workplace award
- Sit-stand desks installed & used daily – 35 total (out of 43 staff)

Workplace Wellness

Weekly 3-5 Mile Runs

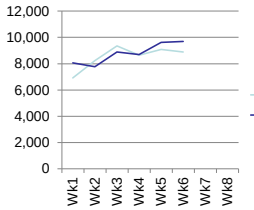
Hawthorne Bridge run





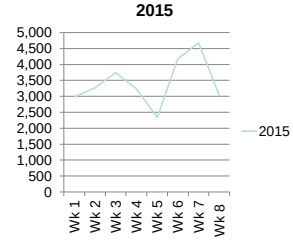
Charthouse Restaurant run

Fitness Challenges



- 2014 & 2015 - 6 week Spokane Fitness Challenge
- 24 & 25 participants
- Log weekly minutes with a minimum goal of 150/week
- Aggregate reports
- Incentives
- 2016 update – 8 week
  - 1.08.16-3.07.16

Fitness Challenges



- **2014** NPAIHB 8 week Fitness Challenge
- 18 participants – honor system
- **2015** NPAIHB 8 week Fitness Challenge
- 22 participants
- T-shirt incentive & raffle drawing
- **2016** NPAIHB 8 week Fitness Challenge
- 32 participants!!

2015 NPAIHB staff avg = 3,427 mins/wk
Individual avg = 163 mins/wk

2015 NPAIHB Wellness Survey

- **Survey was previously completed in 2012 & 2015**
- **2.02.15 – Wellness Survey administered to all staff in office (40) 8 questions**
- **29 respondents; 28 use their 30 mins of Wellness @ work**
  - 24 staff members reported their use in 2014
  - Others use it at the gym
  - Cycle
  - Swim

Wellness Conferences

Native Fitness

Sept. 1-2, 2015
Beaverton, OR

Aging Well & Sports Speed System

- **Native Fitness Training**
  - Beaverton, OR
  - Sept. 1-2 2015
- **Native Women's & Men's Wellness Conference**
  - San Diego, CA.
  - 2013, 2014 & 2015
- **Wellness @ Work Steering Committee - quarterly**
  - Oregon Public Health Institute
- **Improve Employee Health & Well Being -** OPHI Webinar
- **Sedentary Work:** Implications & Interventions for Worker Safety & Health
- **Moore Institute Symposium –** Nutrition of Girls & Women in Oregon

2016 Goals

- Send weekly workouts/monthly wellness tips
- Initiate 8 week challenge (summer)
  - Participate in other Tribal fitness challenges
  - Shamrock run, Race for the Cure, AIDS walk
- Continue to implement suggestions from NPAIHB Wellness survey
  - Secret Pal board – 6 months
  - Brown bag presentation(s)
  - Yoga sessions/videos & other weekly workouts (bike riding & meditation etc.)
- HANDS Hood to Coast Team (August)

NPAIHB Wellness Committee Members

2016


Candice


Tam


Erik

Left to right (back row): Victoria (co-chair), Colbie, Jacqueline, Luella, Ryan, Nora (front row): Tara, Tanya, Birdie (chair) & baby Eddie

A'ho (Thank You)!

NPAIHB Wellness Committee Contact
Birdie Wermy, MPH (*S. Cheyenne*)
bwermy@npaihb.org
Direct Line 503-416-3252

Northwest Portland Area Indian Health Board
2121 SW Broadway, Suite 300
Portland, Oregon 97201
www.npaihb.org

Front row: Nora, Birdie, Monika, Antoinette. Back row: Ryan, Jessica, Stephanie, Maggie, Celena. Not pictured: Erik, Nanette & Gavin.

WHAT IS HOOD TO COAST?

DATES: August 26 - 27, 2016

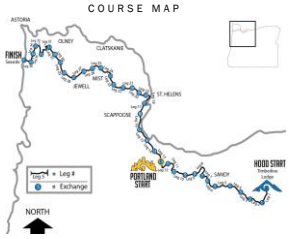
TOTAL TEAMS: 1,050 teams of 12 runners (minimum of 8)

RACE COURSE: Hood To Coast is 198 miles long.

TOTAL PARTICIPANTS: The 2016 event will include 12,600 runners and 3,600 volunteers

ORIGIN: HTC began in 1982 with 8 teams and has filled the team cap on the opening day of registration for the last 18 years straight!

COURSE MAP



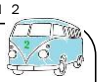
THE MOTHER OF ALL RELAYS!

TEAM HANDS VANS

VAN 1

RUNNERS:
(1) Maggie
(2) Birdie
(3) Jessica
(4) Nora
(5) Erik
(6) Gavin

VAN 2



RUNNERS:
(7) Celena
(8) Antoinette
(9) Monika
(10) Nanette
(11) Stephanie
(12) Ryan

HOW IT WORKS

TIMBERLINE LODGE
(Mt. Hood)
- VAN 1 START
- VAN 2 drive to SANDY, OR to START

SANDY HIGH SCHOOL
(37400 SE Bluff Rd Sandy, OR)
- VAN 2 RUN
- VAN 1 REST in PORTLAND, OR

HAWTHORNE BRIDGE
(Portland, OR)
- VAN 1 RUN
- VAN 2 REST in SCAPPOOSE, OR

HOW IT WORKS

COLUMBIA FAIRGROUNDS
(58892 Saulser Rd, St Helens, OR 97051)
- VAN 2 RUN
- VAN 1 REST in SLEEPING AREA at this exchange (TENTS/in VAN)

BIRKENFELD
(13950 Hwy 202 Birkenfeld, OR 97016)
- VAN 1 RUN
- VAN 2 REST in SLEEPING AREA at this exchange (TENTS/in VAN)

ASTORIA
(87232 Hwy 202 Astoria, OR 97103)
- VAN 2 FINISH
- VAN 1 drive to SEASIDE, OR to END

FUNDRAISING EFFORTS

WHY RAISE MONEY?

- **Registration fee: $1,670.00**
- Food
- Travel
- Lodging
- Racing gear e.g. shirts, reflective vests, flashlights, flashers

FUNDRAISING EFFORTS

- **Luncheons:**
  - Posole bowls
  - Spaghetti feed
  - Hot dog feed
  - Pie/Bake sale
  - Indian Taco sale
- **Pop can recycling**
- **QBM Auction**
- **Treats and small snacks for a dollar**
- **$4,000 GOAL – $2,000 currently**

WHY DO IT?!?

- **We LOVE Wellness**
  - NPAIHB advocates for wellness in the workplace and we take advantage
- **We feel lucky!**
  - More than 2,800 teams from all 50 states and over 38 countries applied and ONLY 1,050 got in!
- **We are Healthy Active Natives Doing Something!**
  - Our team is NOT about becoming expert runners, our team IS about the joy of being physically active and healthy – walk the talk!

Hood to Coast is rewarding experience. It's more than just a run. It's a bonding experience. It's a way to express what your body can do. And it's just plain fun! You walk away feeling like "Wow I did that" or more likely "Wow WE did that."

WORKPLACE WELLNESS

- **Changing the workplace wellness dynamic** – more staff are using their 30 minutes of wellness/fitness challenges!
- Different group activities! More staff are getting out to exercise!
- **Supportive workplace for everything we do!**
- Wellness is a big DEAL!
- Secretly challenging one another!
- **Discipline**
- Walk the talk!
- **MORE to come!!!**

NPAIHB teamHANDS Hood to Coast Go Fund Me Page
https://www.gofundme.com/2uz4nauk

A'HO!
H2C 2016 TEAMHANDS

NPAIHB teamHANDS Hood to Coast Go Fund Me Page
https://www.gofundme.com/2uz4nauk

THE TRIBAL RESEARCH MODEL: CAPTURING THE HELICOPTER

Dr. Tom Ball P.h.D Research Coordinator
Tracy Kieffer Senior Research Associate
Hayley Cohen Research Associate II
x̌sm̓imstn : COLVILLE NARCH

Helicopter Research in Action

Part I: The Project Begins…

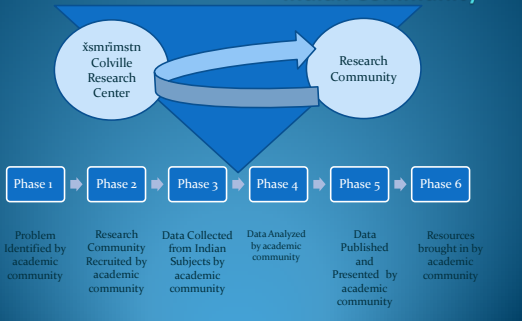
Helicopter Research continued

Part 2: The Project Ends…

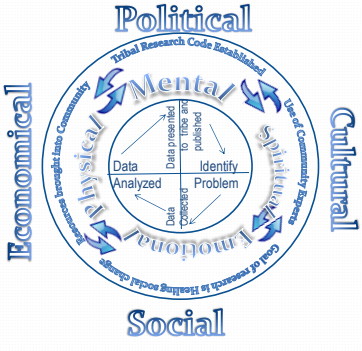
Problems with sustainability and adherence

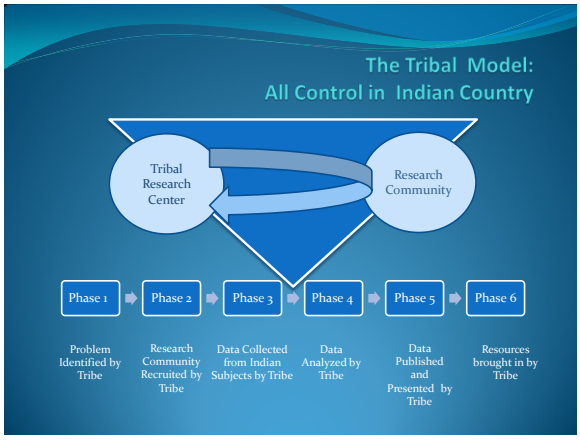
NARCH Mission: Capture the Helicopter

The Academic Model: All Control in Research Community, None in Indian Community



Shifting the Research Paradigm





xsmŕimstn : How are we Implementing Tribal Research?

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continued…..

- Sub-contracting with outside organizations to provide technical assistance in specialized capacities such as curriculum development, epidemiology, or biostatistics.

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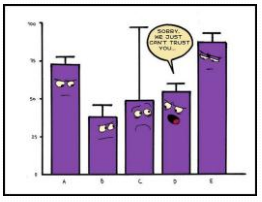
  - Research Agenda's
  - Policy & Procedures
  - Finance

Capacity Core

- Building sustainability, data capacity in Health Programs to organize, collect, and analyze data

Why Collect Data?

- Responding to Tribal Council requests
- Grant Applications
- Program Improvement
- Resource Allocation
- Data Mining
- Data Analysis
- Study Patterns of Health & Disease



How are we doing it?

- Meet with individual programs.
  - Is the data collected currently answering the questions program managers, directors, CBC?
- Customize data collection/data management.
  - Assist in developing ways to collect data, Excel, Access, etc.
- Collect data sets from programs.
  - Determine how the datasets will be shared, email, secure server, USB, etc.

Building Your Own

- Colville Tribe has 16 Ph.D.'s
- Need to have a place to do research
- Student research academy – cohort model 10 weeks
- Research methodology
- Research project
- Present at conferences
- Follow up with support; future summer placements, mentoring, small research grants

Building Your Own Cont.

- Training:
  - GIS (Geographic Information Systems)
    - ArcGIS I: Introduction to GIS
    - ArcGIS II: Essential Workflows
  - Microsoft SQL Server
    - Querying Microsoft SQL Server
    - Administering SQL Server Databases
    - Implementing Data Warehouse with SQL Server

Cont...

- Portland Area Indian Health Board Summer Research Institute
- Excel:
  - Excel 2013 Parts 2 & 3
  - Intermediate to Data Mining
- Microsoft Access
  - Beginning & Advanced
- Human Subjects
- Grants Management & Financial Accountability

Partnerships

- Portland Area Indian Health Board
- IREACH-WSU
- IWRI-UW
- Empire Health
- Frontiers of Innovation
- NARCH

Negative Perception of Research

- Annual Colville Research Conference
  - We've been researched to death
  - We never hear back from researchers

  See Tribal students/family members reporting back to community their research findings.

  See the potential for research to help the people when research is controlled by the people.

  Data ownership: Sovereignty issue. It is your data.

  Measure attitude change.

The NARCH Mission

- Capture the Helicopter
- Tribal Research Model
- Colville Researchers doing Colville Research
- Limlimt.

CHAP Expansion:
Opportunities for Best Possible Outcomes in Lower 48

August 10, 2016
NPAIHB QBM
Pam Johnson, Native Dental Therapy Initiative Specialist

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

IHS Draft Policy Statement Creating a National Community Health Aide Program

June 1, 2016

Indian Health Service (IHS) released a Dear Tribal Leader Letter and a policy statement titled, "Creating a National Indian Health Service Community Health Aide Program." Their goal is to see community health aides utilized to the fullest extent permissible in IHS and tribally run hospitals and clinics

What is CHAP?

The Community Health Aide Program is a tribally-created, tribally-run healthcare delivery system in Alaska that uses a series of practitioners, recruited from their communities, to improve oral, behavioral, and overall health outcomes. They have served as the frontline of healthcare in their communities since the 1960s.

Certification

CHAP Certification Board
Federal Authority, 11 members

Standards and Procedures
Individuals, Training Centers, Curricula

468 individuals certified
357 CHA/Ps certified
63 Dental Health Aides certified
48 Behavioral Health Aides certified

Community Health Aides and Community Health Practitioners

There are 5 levels of Community Health Aides that build upon each other:

Community Health Aide I, CHA II, CHA III, CHA IV and the top level, Community Health Practitioner (CHP).

What can CHA/P's do?

Depending on their level of certification, CHAs can provide services such as:

- Emergency first aid
- Patient examinations
- Carrying out treatment recommendations
- Patient and family focused education and instruction
- Preventive health programs
- Infection and disease control
- Immunizations
- Store and dispense prescription drugs (with physician instructions)

eCHAM

Alaska Community Health Aide/Practitioner Manual

BHA
Behavioral
Health Aide

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

BHA Scope of practice

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

BHA-II
- Substance abuse assessment and treatment

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

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

Who do BHAs provide services to?

BHAs also serve their communities

Types of Dental Health Aides (DHA)

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

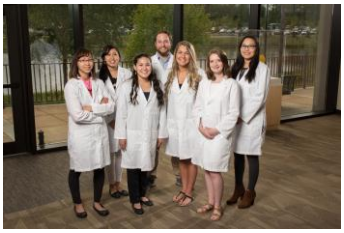
Supervised providers

Teams led by Licensed Dentists

Chelsea Shoemaker, Bonnie Johnson, Corrina Cadzow (DHAT students) providing fluoride varnish treatment for a Head Start student.

DHA Success

- 51 certified DHA
- DHAT in 80+ communities
- 40,000+ access to direct care



2016 Transitioning Class of DHAT.

Expansion of CHAP Would Benefit the Tribes in the Lower 48

- Provides routine, preventive, and emergent care within the community;
- Respects the knowledge and resources in the Tribal community and grows providers from that source through accessible and achievable training programs;
- Delivers patient-centered quality care that comes from providers that understand the history, culture, and language of their patients;
- Fosters a team approach to delivering health care services, increasing the efficiency of the entire healthcare team;
- Provides continuity of care in communities that face recruitment and retention challenges;
- Results in cost savings to Tribes and individuals that no longer have to travel long distances or receive care outside of the IHS system.

DHATs are critical to CHAP Expansion

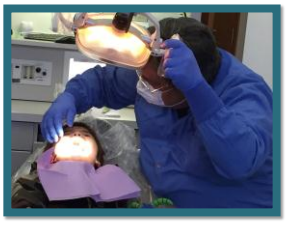
Legislative Fix needed to expand DHAT to lower 48

After losing its court battle in Alaska to prevent DHATs from providing services to Native Villages, the following language was inserted in the re-authorization of the Indian Health Care Improvement Act (as part of the Affordable Care Act):

Expansion of the Indian Health Service Community Health Aide Program "*shall exclude dental health aide therapist services from services covered under the program…*" Unless requested by *"an Indian tribe or tribal organization located in a State (other than Alaska) in which the use of dental health aide therapist services or midlevel dental health provider services is authorized under State law to supply such services in accordance with State law."*

Swinomish Indian Tribal Community

On January 4, 2016, Daniel Kennedy, an experienced DHAT, joined the Swinomish Dental Team in making history by becoming the first Tribally licensed Dental Therapist providing services in the lower 48 states.



DHATs coming to Oregon Tribes

Naomi Petrie, Conf. Tribes of Coos, Lower Umpqua and Siuslaw Indians, Class of 2017

Oregon Class of 2018

Alexandria Jones, Coquille Indian Tribe | Jason Mecum, Coquille Indian Tribe | Marissa Gardner, Confed. Tribes of Coos, Lower Umpqua and Siuslaw Indians

Behavioral Health Aides Can Play a Key Role in Mental Health and Substance Abuse Care

Native communities face behavioral health service delivery issues that are complicated by personnel shortages, limited health care resources, and distances to obtain services. There also are other issues that inhibit access to appropriate behavioral health services. These include referrals from school, detention, court, housing, primary care, child welfare, and other systems.

Suggested process comments

- IHS must consult and work with each Area to establish regional Federal CHAP Certification Boards.
- Tribal participation in the CHAP program is optional

Suggested Process Comments

- IHS should host a 2-3 day national conference and workshop to educate tribal and health leaders about the CHAP program and start the dialogue for national expansion.

Suggested Process Comments

- IHS should convene a CHAP expansion workgroup with representation from those with experience and expertise in the areas of the providers, certification process, and legal issues

Suggested Process Comments

IHS Must Foster an Internal Culture that Supports Mid-Levels to Ensure the Success of an Expansion

Next Steps

- Encourage your Tribe to send a letter of support. Template letter available
- **Comments Due October 27, 2016**
- IHS telephone consultation October 4, 2016 at 12pm PST
- In person consultations:
  - NIHB ACC in Scottsdale on September 19th
  - NCAI's Annual Convention in Phoenix, October 9th.

QUESTIONS?

Northwest Portland Area
Indian Health Board
Indian Leadership for Indian Health

CHAIRMAN REPORT
APRIL-AUGUST 2016

This past quarter I attended over 10 events as Board chair.

In April, I attended the Tribal Self-Governance conference in Orlando, Florida. At the Self-Governance conference I participated in the Indian Health Service 2016 to 2018 Budget update and was involved in the tribal consultation on the IHS Contracts Support Costs Policy.

The following week I was at the Tribal Emergency Preparedness Conference in Spokane. It's always good to attend events near home!

In May, I attended the HHS Region X Tribal Consultation meeting in Suquamish. Our Northwest Tribal Leaders brought many issues to the attention of Susan Johnson, Region X Director for HHS as well as other HHS leadership. Another Contract Support Costs Policy consultation took place at the Region X conference which I participated in. CMS leadership was asked many questions about managed care and its impact on Northwest tribes.

In May, I also had the opportunity to travel to Anchorage and participate in the Kellogg Alaska DHAT program education tour. I was able to see how the Alaska

DHAT Education Program operates and meet dentists and stakeholders from other states who are interested in the program.

I attended the ATNI mid-year conference at Spirit Mountain and we worked on several important issues there. At ATNI, tribal leaders supported several resolutions including a tribal exemption from the Affordable Care Act large employer mandate.

In June, I travelled to DC to provide testimony to HHS on IHS funding as part of my work with the IHS Budget Formulation Workgroup.

I also attended a Facilities Appropriation Advisory Board (FAAB) meeting in Anchorage. The FAAB is a standing committee of Tribal and IHS representatives. FAAB makes recommendations to leadership at IHS on matters involving all Office of Environmental Health and Engineering (OEHE) programs.

In June I also attended the NCAI mid-year conference in Spokane. It was great to see so many Northwest Tribal Leaders at the meeting. Several important resolutions were passed including the one ATNI moved forward requesting a tribal exemption from the large employer mandate.

In July, I attended the Portland Area Direct Service Tribes meeting in Portland and the IHS Budget Formulation meeting in Denver, Colorado.

At the end of this month, I'll be attending the IHS Direct Service Meeting, Rapid City, South Dakota and in September I'll be at the ATNI fall convention in Tulalip.

NPAIHB QBM August 2016 – Omak, WA – hosted by Colville Tribes

Elder Committee Meeting

Attendees: Dan Gleason (Chehalis), Patty Kinswa Gaiser (Cowlitz), Janice Clements (Warm Springs), Sandy Mostler (Klamath), Andy Joseph (Colville)

NPAIHB Staff: Clarice Charging, Bridget Canniff

Dan Gleason opened the meeting with a prayer.

Dan made a motion to approve the meeting notes from the April committee meeting, seconded by Patty, and approved unanimously.

TRIBAL UPDATES

Cowlitz

- Opened their casino in April
- Patty is teaching cultural classes at the tribe, reaching youth, working hrough the mental health program and others, on her own scheduling, but keeping busy

- Patty Kinswa Gaiser is the new Council Chair, taking Steve Kutz' place (though he is still on Council)
- The elders at St. Mary's have flowers that are growing beautifully – a local nursery is donating flowers and they also have a huge vegetable garden
- Patty Kinswa Gaiser and Dan Gleason are going to NICOA, sponsored by NPAIHB – Bridget is traveling with them as NPAIHB staff support

Colville

- Colville elders are also traveling to NICOA, not as many as in the past because of the travel distance, but about 10 elders are attending

Warm Springs

- 12 elders are going to NICOA
- Honor Senior Day happened in May – healing, information for grandparents – they have more younger elders now

Chehalis

- There was a day program for Elders, but they didn't have much staff, so that got shut down
- A group of 80 Elders are going to Hawaii in October

- There was an Elders trip to Safeco field for Ken Griffey Jr.'s retirement ceremony last Saturday

Klamath

- The Elder program doesn't have major funding right now, but they have been going on picnics in small towns, transportation provided, and are offering classes in flower arrangement, basket making, etc.
- The Huckleberry Day trip was cancelled because Jackson County has removed the picnic tables, bathrooms, and well – since there are no services, they stopped taking elders up there.
- Question was asked about whether Klamath has Title VI grant for elders? These applications are due in fall, and funding starts in April.

Possible Elder-related topic for October meeting

- Report back from NICOA attendees

Motion to adjourn by Dan, seconded by Patty, approved unanimously.

Elders Health Committee

Tuesday August 9, 2016
12 Tribes Hotel & Casino, Omak, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	DAN GLEASON	CHEHALIS	360-273-5911 dgleason@chehalistribe.org
2	Patty Kinswa Gaiser	~~Colville~~ Colville	360-520-2578 pattygaiser@gmail.com
3	Janice Clements	Warm Springs	541-553-1196 or CASSIC
4	Sandy Mostller	Klamath Tribes	541-539-5463
5	Andy Joseph Jr.	Colville Tribes	509 631 4406
6	Clarice Charley	Stopp	
7	Bridget Cannaff	NPAIHB	
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NPAIHB Behavioral Health Committee
Tuesday August 9, 2016- 12 Tribes Hotel & Casino, Omak, WA

Meeting Attendees:

Candice M. Cruz
Confederated Tribes of Warm Springs
Caroline.cruz@wstribes.org

Marilyn M. Scott
Trubal Council Member
Health Education Policy Analyst
Upper Skagit Tribe

Lisa Guzman (invited for site visit in Spokane)
Kalispel Tribe
lguzman@camashealth.com

Sharon Stanphill
Cow Creek Tribe
sstanphill@cowcreek.com

Michael Stickler
NARA
mstickler@Naranorthwest.org

Meeting Minutes:

- Youth Residential Treatment October meeting – NARA (Michael has contact information for this)
- Request for possibly NPAIHB to conduct an assessment of the facilities that are available for the Area tribal communities and what types of services are provided.
    - This could be a "Resource Directory" for easy referral of care.
    - Could be housed on the NPAIHB website.
- Discussion on Transitional Living:
    - Northern Quest in particular: MOUs with tribes to ensure beds are readily available for tribal members of the service area
    - Is there a requirement for payment that you have to be a licensed facility?
        - If yes, how can the tribes possibly go around this requirement of license? Could addition MOUs help?
    - For Transitional Housing what are the IHS requirements of what can and can't be done under different licensure?
    - Does FICA cover providers? For example, with residential monitors what training is required and what job title would they fall under? Suggestion to look at Oxford house as a cross reference to the training component and see what requirements they currently have.
    - What process are others going through with transitional housing?
- Mobile Shelter Showers:
    - Warm Springs has "Road Warriors" – those that wonder the roads and do not have a place to live nor family that will take them in. Especially during wintertime the need to get them a warm place to sleep and have access to showers. The mobile shelter/showers is a traveling RV that can provide this type of assistance. Many communities need a place for these

community members. Possibly connect regarding this topic at the Tribal Forum in Spokane end of August?

- ACES: can this be a topic for this committee to discuss?
    - Cow Creek (Sharon) recently provided a training. SAHMSA grant Native Connections.
    - (Caroline) has a PowerPoint she will share.
- Government Taskforce on Intertribal Therapist Consortium Workgroup.
    - How to make sure there is actual tribal representation here for this group?
    - How does mental health integrate with physical health?
- Discussion on the link between Providers and the community. Specifically, Medical Social Workers that include house viits and are able to be billed under medical case managers as they are working on their LCSW.
- Request to invite someone from SAMHSA to attend a QBM:
    - National Behavioral Health Agenda is set by NIHB, SAMHSA, HIS
    - (Nanette) will follow up with NIHB regarding how to have more of a connection with representation by PNW Tribes.

Public Health Committee
Tuesday, August 9, 2016
12 Tribes Hotel & Casino, Omak, WA

In attendance:
Mike Splaine, consultant Alzheimer's Association
Tim Noe, OHA/PHD
Carrie Sampson, Yellowhawk Tribal Health Center
Karen Hansen, Kootenai Tribe of Idaho
Jim Steinruck, Tulalip Tribes
Victoria Warren-Mears, NWTEC Staff

Meeting announcements:

Native Fitness – August 30 -31, Beaverton, OR
Public Health Forum - August 30 -31, Spokane, WA

Briefly discussed the Seattle Pain Clinic WA State emergency response. NWTEC has sent out updates.

Health Modernization in Oregon was discussed. Currently, the state is undertaking an assessment of capacity and expertise in the Local Health Jurisdiction and state capacity.
The state is setting up meetings prior to January with Tribes and their respective LHJs. So far meetings with 4 of 9 tribes have been established.

Tulalip discussed their relationship with Snohomish County. A meeting was held between Tribal departments working on Public Health and respective county agencies. They currently meet on a quarterly basis.
The county works with data and the tribe has worked with the county to determine how the regions are reported.
Also the THD is on the county health board.

An issue now is an active TB patient who is essentially homeless. It is challenging to determine how to address this patient.

Northwest Portland Area Indian Health Board
Quarterly Board Meeting
Personnel Committee Meeting Minutes

August 9, 2016

Start Time: 12:00 pm

Members Present: Cassandra Sellards-Reck, Shawna Gavin, Bonnie Sanchez

Members Absent:

Staff Present: Andra Wagner

- Personnel update was read by Andra Wagner
    - 0 new hires
    - 1 promotion
    - 2 transfers into new positions
    - 4 temporary employees
    - 0 resignations
- All employee evaluations are up-to-date
- NPAIHB won 2015 Oregonian Top Workplaces Award
- Employment application was revised to comply with new state regulation

Personnel Committee

Tuesday August 9, 2016
12 Tribes Hotel & Casino, Omak, WA

	Name and Title	Organization	Phone/FAX/E-mail
1	Andrea Wagner HR Coordinator	NPAIHB	awagner@npaihb.org
2	Cassandra S Reed	Coulee Tribe	cselland@nedu@hotmail.ca
3	Shawna Gavin	CTUIR	shawnagavin@ctuir.org
4	Bonnie Sanchez	Squaxin Island	bsanchez@squaxin.us
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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Confederated Tribes of Colville
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians
Confederated Tribes of Grand Ronde
Confederated Tribes of Siletz 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-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
Upper Skagit Tribe
Yakama Indian Nation

2121 SW Broadway
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.npaihb.org

Resolution No.:16-04-01
Northwest NARCH 9 Program

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

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

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

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people, which include cancer prevention, HIV and sexually transmitted disease prevention, and improved management for children with asthma;

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

WHEREAS, the Northwest Native American Research Center for Health is a program administered by NPAIHB, within the Northwest Tribal Epidemiology Center (TEC); and

WHEREAS, the strategies and programs developed and evaluated by NARCH have furthered the education and health research goals of the Board; and

WHEREAS, the NARCH program provides technical assistance to tribes in the Northwest and nationwide to improve tribal health related research; and

WHEREAS, the goals of the NW NARCH program are aligned with those of the EpiCenter (TEC) and of the Board; and

WHEREAS, NW NARCH program has had a long funding stream with the federal NARCH program; and

WHEREAS, the NW NARCH application to the federal NARCH program will not compete with funding for the Northwest Tribes for similar projects

NOW THEREFORE BE IT RESOLVED that the Northwest Portland Area Indian Health Board supports the application of the NW NARCH program as it strives to reduce health disparities for tribal peoples in the Northwest and beyond.

CERTIFICATION

NO. 16-04-01

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 3 **for,** 3 **against,** 0 **abstain on** July 12, **2016.**

Andrew C. Joseph Jr.

Chairman

July 12, 2016
Date

Gregory J. Abrahamson
Secretary

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Confederated Tribes of Colville
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians
Confederated Tribes of Grand Ronde
Confederated Tribes of Siletz 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-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
Upper Skagit Tribe
Yakama Indian Nation

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Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.npaihb.org

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

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

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

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

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

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

WHEREAS, the prevention of harm to the health and well-being of tribal members is an essential aspect of the purpose of the NPAIHB; and

WHEREAS, any in utero exposure of the fetus to alcohol can cause FASD and is entirely preventable; and

WHEREAS, community-based understanding and accommodation of those impacted by FASD is the most effective way to increase the quality of life of those who have been harmed by exposure to alcohol; and

WHEREAS, IHS has funded the NPAIHB $145,000 since 1997 to conduct prevention and education activities on FASD to tribes in the Portland Area; and

WHEREAS, the NPAIHB has retained specialists who work with and within communities to provide information and support to tribal prevention efforts and to enrich the lives of those impacted by FASD; and

WHEREAS, the NPAIHB has also contracted with the University of Washington to provide prevention services to pregnant AI/AN women and in some instance access to its diagnostic clinic; and

WHEREAS, the IHS funding to NPAIHB has been the only funding available to the Portland Area that prevents FASD and assists the families and community to accommodate the disorders and thereby significantly enrich the lives and possibilities for achievements of those impacted by FASD; and

WHEREAS, the NPAIHB recently learned that IHS FASD funding would no longer be provided to the NPAIHB and would be redirected to an IHS National Behavioral Health Program involving telemedicine.

THEREFORE BE IT RESOLVED, that the Northwest Portland Area Indian Health Board opposes the termination and/or redirection of FASD funding for the Portland Area tribes to a national program and requests continued funding for this project; and

BE IT FURTHER RESOLVED, that the NPAIHB requests additional funding to expand the FASD services to its member tribes to prevent and mitigate the impacts of FASD to Northwest Tribes.

CERTIFICATION

NO. 16-04-02

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 25 **for,** 25 **against,** 0 **abstain on** August 11**, 2016.**

Andrew C. Joseph Jr.

Chairman

August 11, 2016
Date

Gregory J. Abrahamson
Secretary